Technical Proposal

West Virginia Department of Administration
Third Party Liability Services /CRFP BMS2100000001

ORIGINAL

RESPONSE DUE:
December 15, 2020, 1:30 p.m. EST

Health Management Systems, Inc. 5615 High Point Drive, Irving, TX 75038
Phone: 630.269.1495 Fax: 469.359.4413

DESIGNATED CONTACT: Vendor appoints the individual identified in this Section as the Contract Administrator and the initial point of contact for matters relating to this Contract.

Colleen Fournier, Vice President, Government Solutions
(Name, Title)

Colleen Fournier, Vice President, Government Solutions
(Printed Name and Title)

HMS, 5615 High Point Dr., Irving, TX 75038
(Address)

Phone: 630.269.1495; Fax: 469.359.4413
(Phone Number) / (Fax Number)

colleen.fournier@hms.com
(email address)

CERTIFICATION AND SIGNATURE: By signing below, or submitting documentation through wvOASIS, I certify that I have reviewed this Solicitation in its entirety; that I understand the requirements, terms and conditions, and other information contained herein; that this bid, offer or proposal constitutes an offer to the State that cannot be unilaterally withdrawn; that the product or service proposed meets the mandatory requirements contained in the Solicitation for that product or service, unless otherwise stated herein; that the Vendor accepts the terms and conditions contained in the Solicitation, unless otherwise stated herein; that I am submitting this bid, offer or proposal for review and consideration; that I am authorized by the vendor to execute and submit this bid, offer, or proposal, or any documents related thereto on vendor's behalf; that I am authorized to bind the vendor in a contractual relationship; and that to the best of my knowledge, the vendor has properly registered with any State agency that may require registration.

Health Management Systems, Inc. (HMS)
(Company)

Executive Vice President, Chief Financial Officer
(Authorized Signature) (Representative Name, Title)

Jeffrey S. Sherman, Executive Vice President, Chief Financial Officer
(Printed Name and Title of Authorized Representative)

December 8, 2020
(Date)

Phone: 972.894.8896; Fax: 469.359.4413
(Phone Number) (Fax Number)

Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

State of West Virginia
Centralized Request for Proposals
Service - Misc

Proc Folder: 762875			**Reason for Modification:**
Doc Description: THIRD PARTY LIABILITY (TPL) SERVICES			
Proc Type: Central Master Agreement			
Date Issued	**Solicitation Closes**	**Solicitation No**	**Version**
2020-09-24	2020-10-22 13:30	CRFP 0511 BMS2100000001	1

BID RECEIVING LOCATION

BID CLERK
DEPARTMENT OF ADMINISTRATION
PURCHASING DIVISION
2019 WASHINGTON ST E
CHARLESTON WV 25305
US

VENDOR

Vendor Customer Code: 000000103904
Vendor Name : Health Management Systems, Inc. (HMS)
Address : HMS, 5615 High Point Dr., Irving, TX 75038
Street : 5615 High Point Dr.
City : Irving **Country :** Dallas **Zip :** 75038
State : TX
Principal Contact : Colleen Fournier, Vice President
Vendor Contact Phone: 630.269.1495 **Extension:** none

FOR INFORMATION CONTACT THE BUYER
Crystal G Hustead
(304) 558-2402
crystal.g.hustead@wv.gov

Vendor Signature X **FEIN#** 13-277433 **DATE** 12/08/20

All offers subject to all terms and conditions contained in this solicitation

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: CRFP BMS2100000001

Instructions: Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment form. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

Acknowledgment: I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

Addendum Numbers Received:
(Check the box next to each addendum received)

[X] Addendum No. 1	[ ] Addendum No. 6
[ ] Addendum No. 2	[ ] Addendum No. 7
[ ] Addendum No. 3	[ ] Addendum No. 8
[ ] Addendum No. 4	[ ] Addendum No. 9
[ ] Addendum No. 5	[ ] Addendum No. 10

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any state personnel is not binding. Only the information issued in writing and added to the specifications by an official addendum is binding.

Health Management Systems, Inc. (HMS)
Company

Authorized Signature

December 8, 2020
Date

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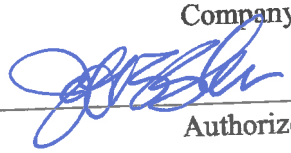

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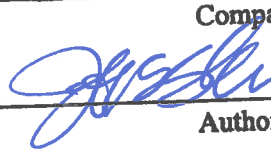

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Revised 6/8/2012

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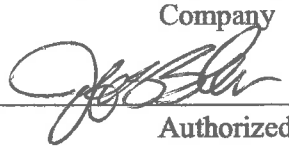

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Revised 6/8/2012

TITLE PAGE

State the RFP subject, number, Vendor's name, business address, telephone number, fax number, name of contact person, email address, and Vendor signature and date.

The table below provides responses to the Title Page requirements described in RFP Section 5.

Information about Health Management Systems, Inc. (HMS)

RFP Item	HMS Response
RFP Subject	Third Party Liability Services
RFP Number	CRFP BMS2100000001
Vendor's Name	Health Management Systems, Inc. (HMS)
Vendor's Business Address	HMS, 5615 High Point Dr., Irving, TX 75038
Vendor's Telephone Number	630.269.1495
Vendor's Fax Number	469.359.4413
Vendor's Contact Person	Colleen Fournier, Vice President, Government Solutions
Contact Person Email Address	colleen.fournier@hms.com
Signature	>>Jeff Sherman's signature
Date	December 8, 2020

December 8, 2020

Ms. Crystal Hustead
Senior Buyer
Department of Administration, Purchasing Division
2019 Washington Street, East
Charleston, WV, 25305-0130

Re: West Virginia Department of Administration (DOA), Purchasing Division (Purchasing Division) on behalf of West Virginia Department of Health and Human Resources (DHHR), Bureau for Medical Services (BMS) Request for Proposal CRFP BMS2100000001 Third Party Liability Services

Dear Ms. Hustead:

The West Virginia Bureau for Medical Services (BMS) provides valuable healthcare services and options to its most vulnerable populations. protecting and promoting the health of West Virginians. Third Party Liability (TPL) programs are an important aspect of program sustainability by avoiding unnecessary costs and recovering monies for which other entities are liable.

As demonstrated throughout decades of services to BMS and described in our proposal, Health Management Systems, Inc. (HMS®) has experience delivering every service BMS seeks—for all TPL Mandatory and Optional Services.

Our response demonstrates our in-depth knowledge of BMS, and the commitment of the experienced HMS TPL project team and senior leadership you know and trust. By expanding our long-standing partnership, we have a unique opportunity to work together to bring innovative solutions that drive results for BMS, WVCHIP, members, providers, and Medicaid managed care organizations. We will ensure continuous focus on TPL enhancements and results by leveraging our modernization investments, capabilities, expertise, and leadership.

> HMS is BMS' no-risk choice to maintain operations, generate increased revenue, and identify cost avoidance without interruption while implementing additional scope elements required for the new contract term.

We will deliver services that are comprehensive, efficient, effective, and specific to meeting the goals and objectives West Virginia has set forth in the RFP. By selecting HMS for this new contract, BMS will ensure continued recovery services and rapid and effective implementation of new service scope and enhancements. Our data match and cost avoidance, referral-processing, and claims recovery services deliver, on average, more than $140 million annually in cost avoidance savings and $8 million annually in recoveries—and the results continue to grow each

year. Our confidence in our proposed solution for BMS offers no risk or stakeholder disruption during this time of great uncertainty in the healthcare and government environment. It is important, now more than ever, to continue to have trusted, capable partners by your side. This collaboration ensures that operations are sustained, recoveries/cost savings continue to flow and be maximized, and timely solutions are brought forward as needs evolve both during and after the COVID-19 pandemic.

We are also committed to supporting BMS in achieving their move to modularity. We have the resources and expertise to successfully facilitate this transition, as we have assisted other states through the MECT Certification process. When the State decides to move forward with its modernization roadmap, we can share the learning and experience gained from other clients who have successfully completed certification. We understand the business processes, operational goals, and financial objectives of Medicaid programs, as well as the best methods to provide for BMS' unique program needs.

Our approach to delivering a sound and results-driven TPL solution is based on widely recognized and accepted project management practices, hands-on TPL experience in West Virginia, insights and best practices deployments across the nation, and a seasoned TPL project team with experience implementing projects that are in alignment with MECT requirements.

HMS is privileged to have served the WV Medicaid program and value our long-term relationship with BMS and its TPL project stakeholders. We look forward to building on our shared successes as the payment accuracy needs of the State evolve.

Colleen Fournier, Vice President, will serve as our Executive Sponsor for this project. Please do not hesitate to contact her via telephone at 630.269.1495 or email at colleen.fournier@hms.com with any questions about HMS or our services. We thank you for the opportunity to submit this proposal and to continue to serve BMS.

Sincerely,

Jeffrey S. Sherman
Executive Vice President, Chief Financial Officer and Treasurer

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CRITICAL SERVICES

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APPENDICES

APPENDIX 1

APPENDIX 2

HMS' ITEM-BY-ITEM RESPONSE TO THE RFP

Our proposal provides a comprehensive and detailed response to all Request for Proposal (RFP) requirements as indicated in **Exhibit 1**.

Exhibit 1 Master Compliance Table

RFP Reference	RFP Requirement	HMS Proposal Section
Section 5	Section 5: Vendor Proposal	
5.3.2	State the RFP subject, number, Vendor's name, business address, telephone number, fax number, name of contact person, email address, and Vendor signature and date	Signed Forms: Title Page
5.3.3	Clearly identify the material by section and page number.	Table of Contents
5.3.4	The Vendor must include Section 7: Certification and Signature Page, completed and signed by an authorized signatory legally binding the Vendor in the labeled "Original Proposal."	Signed Forms: Certification and Signature Page
5.3.5	Provide a high-level summary of the Vendor's response and proposed solution. Executive summary should not exceed two (2) pages.	Executive Summary
Attachment 3	Attachment 3: Vendor Qualifications and Experience	
3.1	This section of the Vendor's Technical Proposal should include details of the Vendor and subcontractor overview. The Vendor's Technical Proposal should include organization overview, corporate background, Vendor's experience in public sector, and certifications.	3.1
3.1.1	Provide all relevant information regarding the general profile of the Vendor. (Reproduce Table from the RFP)	3.1.1
3.1.2	If the proposal includes the use of Subcontractor(s), provide all relevant information regarding the profile of each Subcontractor. This section may be duplicated in its entirety and a page created per Subcontractor included. The Vendor should complete the Disclosure of Interested Parties to Contract Form, located at (http://www.state.wv.us/admin/purchase/VRC/Ethics DisclosureInterestedParties_2018.pdf)	3.1.2
3.2	This section details the mandatory qualifications. The Vendor must complete this section to demonstrate that it has the experience needed to meet requirements set forth in this RFP.	3.2
3.2.1	Table 9: Mandatory Qualifications below lists each mandatory qualification; the Vendor must provide narrative demonstrating fulfillment of the requirement.	3.2.1
3.2.2	The Vendor must list each project experience separately and completely every time it is referenced.	3.2.1
3.3	Describe any existing or recent (within the last five [5] years) business relationships the Vendor or any of its affiliates or proposed subcontractors have with the State, the State's counties, and/or the State's local municipalities.	3.2.2
3.4	Provide details of any disciplinary actions and denote any that are pending litigation or terminated contracts for Cause or Convenience and associated reasons. Also denote any other administrative actions taken by any jurisdiction or person against the Vendor. List and summarize all judicial or administrative proceedings involving your sourcing activities, claims of unlawful	3.2.3

RFP Reference	RFP Requirement	HMS Proposal Section
	employment discrimination, and anti-trust suits in which you have been a party within the last five (5) years. If the Vendor is a subsidiary, submit information for all parent companies. If Vendor uses subcontractors, associated companies, or consultants that will be involved in any phase of this project, each of these entities will submit this information as part of the response.	
3.5	The Bureau for Medical Services (BMS) will conduct reference checks to verify and validate the past performance of the Vendor and its proposed subcontractors. 5.1 Vendor (Prime) References Form S.1.1 Include at least three (3) references from projects performed within the last three (3) years that demonstrate the Vendor's ability to perform the scope of work described in this RFP. S.1.2 The Vendor should provide three (3) different clients/projects in order to demonstrate its experience. 5.1.3 Vendor should include project description, contract dates, and contact information (customer points of contact, addresses, telephone numbers, and email addresses). S.1.4 The Vendor should explain whether it performed the work as a prime contractor or as a subcontractor. 5.1.5 The Vendor should provide a response using Table 10: Vendor References. Vendors are NOT to change any of the pre-filled cells in the following tables. The Vendor may add additional Vendor References Tables as necessary.	3.3
3.6	If the Vendor's proposal includes the use of subcontractor(s), provide three (3) references for each subcontractor. BMS prefers references that demonstrate where the Prime and subcontractors have worked together in the past. (Reproduce Table as needed)	3.4
3.7	The Vendor should provide the following components for this section:	3.5
3.7.1	Dun & Bradstreet (D&B) Ratings	3.5.1
3.7.2	The Vendor should provide the industry standard D&B Ratings that indicate its financial strength and creditworthiness, assigned to most United States and Canadian firms (and some firms of other nationalities) by the United States firm D&B. These ratings are based on a firm's worth and composite credit appraisal. Additional information is given in credit reports (published by D&B) that contain the firm's financial statements and credit payment history	3.5.1
3.7.3	Vendors may provide financial strength and credit ratings from the following alternative agencies, provided the rating has been completed within one (1) year of submission of the response: 7.3.1 AM. Best Rating Services, Inc.; 7.3.2 DBRS, Inc.; 7.3.3 Egan-Jones Ratings Co.; 7.3.4 Fitch Ratings, Inc.; 7.3.5 HR Ratings de Mexico, S.A. de C.V.; 7.3.6 Japan Credit Rating Agency, Ltd.; 7.3. 7 Kroll Bond Rating Agency, Inc.; 7.3.8 Moody's Investors Service, Inc.; 7 .3.9 S&P Global Ratings	3.5.2
Attachment 4	**Attachment 4: Project Organization and Staffing Approach**	
4.1	Staffing strategies are to be employed by the Vendor to ensure all requirements and service levels are met to the satisfaction of the Bureau for Medical Services (BMS). 1.1 Toe evaluation of the Vendor's staffing approach by the State shall be based on the ability of the Vendor to satisfy the requirements stated herein. Therefore, the Vendor should present detailed information regarding the expertise of the proposed staff and an Initial Staffing Plan. 1.2 For ease of formatting and evaluation, Attachment 4: Project Organization and Staffing Approach provides the required outline for the Vendor's response to staffing. 1.2.1 The Vendor's response to the following should not exceed 25 pages, excluding key personnel resumes and the forms provided in this Attachment.	4.1

RFP Reference	RFP Requirement	HMS Proposal Section
	1.2.2 Refer to request for proposal (RFP) Section 4.6 Qualification and Experience Information for the details pertaining to staff qualifications, experience, and responsibilities.	
4.2.1	As part of the Vendor's bid response, the Vendor should provide an Initial Staffing Plan. In addition to the requirements described in Appendix I: Detailed Specifications, the Vendor's narrative description of its proposed Initial Staffing Plan should include the following:	4.2
Appendix 1 #PM010	The Staffing Management Plan documents the Vendor's approach to providing and managing qualified human resources for the project, and describes how the roles, responsibilities, and reporting relationships will be structured and addressed in support of the project and operations. Staff should have a working knowledge of the system operations prior to starting on the project. The Vendor should describe its Staffing Management Plan, including, but not limited to, the following:	7.3.3.1
Appendix 1 #PM011	Organizational chart for each phase of the project, identifying all staff to be used for each phase of the project and clearly identifying on-site staff, off-site staff, and subcontractors	7.3.3.2
Appendix 1 #PM012	Description of the roles, responsibilities, and skillsets associated with each position on the organization chart	7.3.3.4
Appendix 1 #PM013	For each key staff member, a brief summary description of the roles, responsibilities, and experience that qualify them for their role on this project	7.3.3.4
Appendix 1 #PM014	If any of the work is performed off-site, including work of subcontractors, describe the assurance of quality and timeliness of the work performed off-site	7.3.3.2
Appendix 1 #PM015	Resource calendar describing the staff required for each phase of the project, if the staff will be on-site or off-site, and the allocation percentage	7.3.3.4
Appendix 1 #PM016	The Bureau's business and technical resources required to support the creation of all deliverables	7.3.3.6
Appendix 1 #PM017	Description of the training personnel who will be used in support of training activities	7.3.3.7
Appendix 1 #PM018	Description of business analyst personnel who will be used in support of this Request for Proposal (RFP)	7.3.3.5
Appendix 1 #PM019	Process for transitioning essential knowledge to the Bureau technical staff and users.	7.3.3.7
Appendix 1 #PM020	Approach to personnel management including hiring and terminations, staff retention and continuity, and employee relocation	7.3.3.8
Appendix 1 #PM021	Staff training, both initial and ongoing, including transfer of system and business knowledge, project management methodologies and processes, and project status to new staff and incumbent staff transitioning between project roles and phases	7.3.3.7
Appendix 1 #PM022	Staff performance monitoring	7.3.3.9
Appendix 1 #PM023	Succession planning, staff replacement, and staff backup	7.3.3.10
Appendix 1 #PM024	Staffing for optional services, as detailed in this RFP	7.3.3.3

RFP Reference	RFP Requirement	HMS Proposal Section
Appendix 1 #PM025	The Staffing Management Plan should support the project and operations while maintaining compliance with all staffing requirements set forth in the Appendix 1: Detailed Specifications and any RFP narrative.	7.3.3.11
4.2.1.1	A succinct description of the Vendor's proposed project team and should exhibit the Vendor's ability and capability to provide knowledgeable, skilled, and experienced personnel to accomplish the Scope of Work (SOW) as described in this RFP.	4.2.1.1
4.2.1.2	A detailed proposal for providing all resources necessary to fulfill the requirements as specified in this RFP. This includes details covering both key and support staff.	4.2.1.2
4.2.1.3	Organization charts for each phase of the project showing the Vendor staff that will be required to support the project. The organization chart should denote all key staff for this project and a summary of each key staff member's high-level responsibilities.	4.2.1.3
4.2.1.4	A narrative describing tools and processes used to screen available staff to fill positions. In addition, a narrative describing the process for replacing key staff within defined timeframes and procedures for backfilling key staff during any transition.	4.2.1.4
4.2.1.5	Resumes (maximum two (2) pages each) for the key staff and any additional staff members the Vendor will have assigned to this project including their licenses, credentials, and experience. BMS considers the key staff resumes as a key indicator of the Vendor's understanding of the skill sets required for each staffing area.	4.2.1.5
4.2.1.6	A letter of intent for each proposed staff member not currently employed by the Vendor. Each letter of intent should be signed by the named individual, indicating that the individual is willing to accept employment if the Vendor is awarded the contract.	4.2.1.6
4.2.1.7	Identification of subcontractor staff, if applicable	4.2.1.7
4.3.1	Key staff consist of the project's senior leadership for the Third Party Liability (TPL) project. These resources are responsible for providing leadership and creating the standards and processes required for the successful implementation, operation, and maintenance of the solution.	4.3
4.3.1.1	The Vendor should make the proposed key staff available for an in-person interview upon BMS request throughout the life of the contract.	4.3.1.1
4.3.1.2	To ensure successful transition to the operations phase, the implementation activities should be led by key staff identified in the list below: 3.1.2.1 Account Manager; 3.1.2.2 Project Manager; 3.1.2.3 Quality Assurance (QA) Manager	4.3.1.2
4.3.1.3	Resumes for key staff named in the Vendor proposal should identify the role of the staff on the TPL project and demonstrate how each staff member's experience and education will contribute to the successful implementation of the TPL solution	4.4
4.3.1.4	Each resume should demonstrate experience relevant to the position proposed. If applicable, resume should include work on projects cited under the Vendor's corporate experience and the specific functions performed on such projects.	4.4
4.3.1.5	The Vendor should complete Table 12: Resumes for Proposed Key Staff and include in this section proposed key staff resumes and the resumes of any additional staff members the Vendor will have assigned to this project.	4.4
4.3.1.6	The Vendor should provide three (3) references for which each proposed key staff candidate has successfully demonstrated meeting the requirements of the RFP. The name of the person, phone number, client name, address, brief description of work, and date (month and year) of employment should be given for each reference. These references should be able to attest to the candidate's specific qualifications.	4.5
4.3.1.7	The reference given should be a person within a client's organization and not a co-worker or a contact within the Vendor's organization. These references should not be anyone from the existing State TPL program.	4.5
4.3.1.8	Vendors should use the format provided in Table 13: Key Staff References. Repeat the rows and tables as necessary.	4.5

RFP Reference	RFP Requirement	HMS Proposal Section
Attachment 5	**Attachment 5: Initial Work Plan**	
5.1	1 Instructions; 1.1 The Vendor should provide an Initial Work Plan.; 1.2 The Vendor's proposed Initial Work Plan should include the following: 1.2.1 Detailed tasks and timelines outlining the major project phases planned by the Vendor.; 1.2.2 Project Schedule for all project deliverables and milestones.; 1.2.3 Identification of resources assigned the responsibility for each deliverable.; 1.3 The Initial Work Plan should be provided as an attachment to the Vendor's Technical Proposal and tabbed as such in the submission.	5.0
Attachment 6	**Attachment 6: Mandatory Requirements**	
6.1	RFP Attachment 6	6.0
Attachment 6 #MR001	The Vendor must design the Third-Party Liability (TPL) solution to support the current and future Medicaid Information Technology Architecture (MITA) goals for the Bureau as defined in the Bureau's MITA State Self-Assessment (SS-A) (https://www.medicaid.gov/medicaid/data-and-systems/mita/index.html).	6.0; MR001
Attachment 6 #MR002	The Vendor must agree that the Bureau retains ownership of all data, procedures, applications, licenses, and all materials developed during design, development, and implementation (DDI) and operations, as well as the licensing for installed commercial off-the-shelf (COTS) software in alignment with 45 Code of Federal Regulation (CFR) §95.615 (https://ecfr.io/Title-45/se45.1.95_1615) and 45 CFR §95.617 (https://ecfr.io/Title-45/se45.1.95_1617). Manufacturers' support and maintenance for the COTS software licensing subsequent to the initial install must be provided only for the life of the contract. The Bureau will not issue change orders related to software cost increases.	6.0; MR002
Attachment 6 #MR003	The Vendor must provide a software and hardware solution that is upgradeable and expandable to meet the Bureau's current and future needs.	6.0; MR003
Attachment 6 #MR004	The Vendor must be responsible for all expenses required to obtain and maintain access to the Bureau's systems. Such expenses include, but are not limited to, hardware, software, network infrastructure, and any licensing costs.	6.0; MR004
Attachment 6 #MR005	The Vendor must have the capability to interface with necessary computer systems in specified formats necessary to accomplish third-party recoveries.	6.0; MR005
Attachment 6 #MR006	The Vendor must provide an automated means of updating the Medicaid Management Information System (MMIS) file with new complete Third-Party Liability (TPL) information within the timeframes specified by the Bureau.	6.0; MR006
Attachment 6 #MR007	The Vendor must operate a Technical Support Call Center that is located within the continental United States, as established in requirements related to handling of Federal Tax Information (FTI) contained in Internal Revenue Service (IRS) Publication 1075 (https://www.irs.gov/pub/irs-pdf/p1075.pdf), Section 5.3 Access to FTI via State Tax Files or through other agencies under the authority granted by United States Code §6013(p)(4)(C) (https://www.govinfo.gov/content/pkg/USCODE-2011-title26/html/USCODE-2011-title26-subtitleF-chap61.htm).	6.0; MR007
Attachment 6 #MR008	The Vendor must ensure that all applications inclusive of internet, intranet, and extranet applications associated with this contract are compliant with Section 508 of the Rehabilitation Act of 1973, as amended by 29 U.S. Code §794d (https://www.govinfo.gov/app/details/USCODE-2011-title29/USCODE-2011-title29-chap16-subchapV-sec794d), and 36 Code of Federal Regulation (CFR) 1194.21 and 36 CFR 1194.22 (https://www.ecfr.gov/cgi-bin/text-idx?SID=0c6038b2b0f453ef6ac2d78411eda5a4&mc=true&node=pt36.3.1194&rgn=div5#se36.3.1194_11).	6.0; MR008

RFP Reference	RFP Requirement	HMS Proposal Section
Attachment 6 #MR009	The Vendor must safeguard information obtained from and exchanged with other agencies and stakeholders in accordance with requirements in 42 Code of Federal Regulation (CFR) Subpart F – Safeguarding Information on Applicants and Beneficiaries (https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5&node=42:1.0.1.4.23).	6.0; MR009
Attachment 6 #MR010	The Vendor must comply with all federal and state laws, regulations, policies and procedures regarding Third-Party Liability (https://ecfr.io/Title-42/sp42.4.433.d).	6.0; MR010
Attachment 6 #MR011	The Vendor's solution must maintain full Health Insurance Portability and Accountability Act (HIPAA) compliance throughout the life of the contract at no additional cost to the Bureau (https://www.hhs.gov/hipaa/for-professionals/privacy/index.html).	6.0; MR011
Attachment 6 #MR012	The Vendor must comply with the baseline security controls for moderate impact information systems as recommended by the National Institute of Standards and Technology (NIST) Special Publication (SP) 800-61 guidance (https://csrc.nist.gov/publications/detail/sp/800-61/rev-2/final), Code of Federal Regulations (CFR), and Centers for Medicare and Medicaid Services (CMS) (https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/InformationSecurity/index.html).	6.0; MR012
Attachment 6 #MR013	The Vendor must ensure that data entered, maintained, or generated to meet the requirements of this Request for Proposal (RFP) is retained and/or accessible according to the federal requirements in 45 Code of Federal Regulation (CFR) Part 75 (https://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75) and/or applicable State and/or federal requirements.	6.0; MR013
Attachment 6 #MR014	The Vendor must agree to incorporate all requirements mandated through federal (https://ecfr.io/Title-42/sp42.4.433.d) and State regulations and legislation (http://www.wvlegislature.gov/wvcode/chapterentire.cfm?chap=9&art=5&section=11), including new reporting requirements. The Vendor must ensure that the Third-Party Liability (TPL) solution is current in its ability to accept and employ new standards and requirements as they occur. Formalized change control will be used for all such changes, during all phases of the project, as defined in the Change Management Plan.	6.0; MR014
Attachment 6 #MR015	The Vendor must not publish or copyright any data using the Bureau's name or logo without prior written approval by the Bureau for every instance. In addition, the Vendor must not publicly distribute any documents, whether finished or unfinished, without prior written approval. Except with respect to any commercial software, the Bureau will be and remain the owner of all data provided to the Bureau by the Vendor or its agents, subcontractors, or representatives pursuant to the contract other than the Vendor's internal administrative procedure records.	6.0; MR015
Attachment 6 #MR016	Vendors proposing commercial off-the-shelf (COTS) components must develop all documentation necessary to support the receipt of federal match related to the implementation of the component, upon request by the Bureau (https://www.ecfr.gov/cgi-bin/text-idx?SID=0a0f2c4293fbf2710236e235ea7ee699&mc=true&node=se42.4.433_110&rgn=div8).	6.0; MR016
Attachment 6 #MR017	The Vendor must comply with 45 Code of Federal Regulation (CFR) 95.617 - Software and Ownership Rights (https://www.ecfr.gov/cgi-bin/text-idx?SID=f24e840d26cda6373cf54e57380d9663&mc=true&node=pt45.1.95&rgn=div5#se45.1.95_1617).	6.0; MR017
Attachment 6 #MR018	Prior to the start of the contract, the Vendor must enter into and maintain trading partner agreements with insurers that provide major medical, pharmacy, vision, dental, Medicare Health Maintenance Organization (HMO), and/or Medicare supplemental coverage. These trading partner agreements will allow the Vendor to receive commercial insurance coverage information for members that they insure in accordance with Department, State (https://dhhr.wv.gov/bms/CMS/SMP/Pages/WV-State-Medicaid-Plan.aspx), and federal requirements (https://www.congress.gov/bill/109th-congress/senate-bill/1932).	6.0; MR018

RFP Reference	RFP Requirement	HMS Proposal Section
Attachment 6 #MR019	The Vendor must provide compliance support services to include providing up-to-date documentation and reporting for regulatory and State compliance auditing.	6.0; MR019
Attachment 6 #MR020	The Vendor must make available to the Bureau the results of any third-party audit conducted on the Vendor's organization, including, but not limited to, Service Organization Control (SOC) 2.	6.0; MR020
Attachment 6 #MR021	The Vendor must adhere to and support all security risks, standards, policies, and procedures of the Bureau, State, and the West Virginia Office of Technology (WVOT). The Vendor must ensure compatibility with the most current WVOT supported versions and standards (https://www.wvdhhr.org/mis/policies.asp), (https://technology.wv.gov/security/Pages/policies-issued-by-the-cto.aspx).	6.0; MR021
Attachment 6 #MR022	The Vendor must be responsible for any lost recoveries due to system deficiencies or deficiencies noted during federal reviews. The Vendor shall be responsible for only the portion of a recovery lost that is determined by the Bureau to be the fault of the Vendor.	6.0; MR022
Attachment 6 #MR023	USE OF DATA (ATTACHMENT 6 ITEM MR0023). The Vendor staff must not access, edit, disclose, or use protected information data, with unauthorized users or in an unauthorized manner, in accordance with Department, State, and federal requirements. This data includes, but is not limited to, Protected Health Information (PHI), Personally Identifiable Information (PII), Federal Tax Information (FTI), and Social Security Information (SSI).	6.0; MR023
Attachment 6 #MR024	The Vendor must immediately replace any of its personnel who refuse to sign a required confidentiality agreement, acknowledgment form, or non-disclosure agreement, or to undergo a fingerprint-based background check (if applicable). When the Vendor performs services under this contract that require the Vendor and subcontractor personnel to access facilities, data, or systems that the Bureau in its sole discretion deems sensitive, the Bureau will require the Vendor and subcontractor personnel with such access to sign individual confidentiality agreements, non-disclosure agreements, and policy acknowledgements before accessing those facilities, data, or systems. The Bureau reserves the right to require certain Vendor and subcontractor personnel with access to certain facilities, data, or systems to undergo fingerprint-based State and federal background checks. Each State agency, board, and commission may require the Vendor and subcontractor personnel to sign different confidentiality agreements, acknowledgement forms, and non-disclosure agreements.	6.0; MR024
Attachment 6 #MR025	The Vendor must provide Bureau stakeholders access to conference space with accommodations for twenty (20) participants at a minimum during the design, development, and implementation (DDI) phase and any audits. The conference space must be sufficient enough to support the responsibilities of the Vendor as defined in this RFP.	6.0; MR025
Attachment 6 #MR026	The Vendor facility must be located within five miles of the Bureau office, located at Capitol Street, Charleston, West Virginia. All key staff members proposed in this Request for Proposal (RFP) for implementation, maintenance, and operations must be located at the Vendor facility.	6.0; MR026
Attachment 6 #MR027	The Vendor must seek and obtain the State's prior written approval for any relocation of the Vendor facility at, from, or through which the services are provided. The Vendor shall mitigate any impact to the State. Any such relocation shall be without additional cost to the State through the life of the contract.	6.0; MR027
Attachment 6 #MR028	The Vendor must operate the Third-Party Liability (TPL) solution, perform all functions described in the Request for Proposal (RFP), and continue all operations from the date of acceptance of each release until each function is turned over to a successor at the end of the contract, including optional renewals.	6.0; MR028

RFP Reference	RFP Requirement	HMS Proposal Section
Attachment 6 #MR029	The Vendor must ensure compliance with all Service-Level Agreements (SLAs) and identified Key Performance Indicators (KPIs) with associated metrics listed in Appendix 3: Service-Level Agreements (SLAs) & Performance Standards.	6.0; MR029
Attachment 6 #MR030	The Bureau may award other contracts for additional or related work, and the Vendor shall fully cooperate with such other contractors and Bureau employees or designated agents. The Vendor must not commit or permit any act that will interfere with the performance of work by any other contractor or Bureau employees.	6.0; MR030
Attachment 6 #MR031	The Vendor must agree to changes in the Scope of Work (SOW) for any additional services as a result of State and federal regulation changes or Bureau operating procedure changes. This will be executed utilizing the change management process as detailed in the approved Change Management Plan.	6.0; MR031
Attachment 6 #MR032	PROJECT MANAGEMENT STANDARDS (ATTACHMENT 6 ITEM MR0032). The Vendor must use industry-standard professional project management standards, methodologies, and processes to ensure the project is delivered on time, within scope, within budget, and in accordance with the Bureau's quality expectations. The Bureau's preferred project management methodology is the Project Management Institute's (PMI®'s) Project Management Body of Knowledge (PMBOK®) methodology. (Reference: https://www.pmi.org/pmbok-guide-standards)	6.0; MR032
Attachment 6 #MR033	The Vendor must maintain audit trails for all system transactions.	6.0; MR033
Attachment 6 #MR034	The Vendor must utilize a lockbox for the Bureau to receive recoveries from third-party resources.	6.0; MR034
Attachment 6 #MR035	The Vendor must respond within one (1) business day to requests from the Bureau for information requested by any state and/or federal auditors or the Centers for Medicare and Medicaid Services (CMS). Response should be in the mode agreed upon (i.e., email, memo, and summary).	6.0; MR035
Attachment 6 #MR036	The Vendor must pay all expenses incurred in the performance of its duties under this contract including, but not limited to, costs associated with marketing, travel, postage, training, and administrative staffing.	6.0; MR036
Attachment 6 #MR037	The Vendor must prepare responses to all inquiries, write articles for publication, and speak at meetings as requested and authorized by the Bureau.	6.0; MR037
Attachment 6 #MR038	As a corrective action, the Vendor must provide increased staffing levels if requirements, timelines, quality, or other standards are not being met, based solely on the discretion of, and without additional cost to, the Bureau. In making this determination, the Bureau will evaluate whether the Vendor is meeting deliverable dates, producing quality materials, consistently maintaining high quality, and meeting the Request for Proposal (RFP) and contract standards without significant rework or revision.	6.0; MR038
Attachment 6 #MR039	Key staff assigned to the project must be employed on a full-time basis and required to be on-site. On-site is defined as being in the West Virginia-based facility between Monday and Friday from 8:00 a.m. Eastern Time to 5:00 p.m. Eastern Time. On-site time excludes the time required to travel to/from the Charleston, West Virginia, facility. Each key staff role is a full-time position, to be filled by one staff member only. Key staff must be fully in place by the agreed-upon date in the Staffing Management Plan.	6.0; MR039
Attachment 6 #MR040	The Bureau has an interest in ensuring that its operations are carried out in an efficient, professional, legal, and secure manner. The Vendor must remove any staff involved in the project, if the Bureau determines that any such staff has interfered or may interfere with the Bureau's interests identified above.	6.0; MR040
Attachment 6 #MR041	The Vendor must accept financial, legal, ethical, and all other forms of responsibility for the conduct of all staff, business partners, independent contractors, subcontractors, and other entities supporting the Vendor or working with the Vendor on the project.	6.0; MR041

RFP Reference	RFP Requirement	HMS Proposal Section
Attachment 6 #MR042	The Vendor must designate one named individual in its proposal as the Vendor's Health Insurance Portability and Accountability Act (HIPAA) compliance officer.	6.0; MR042
Attachment 6 #MR043	The Vendor must coordinate with the Bureau to develop all documentation required by the Centers for Medicare & Medicaid Services (CMS) certification process as defined in the most recent Medicaid Enterprise Certification Toolkit (MECT) (https://www.medicaid.gov/medicaid/data-and-systems/mect/index.html).	6.0; MR043
Attachment 6 #MR044	For any portions of the entire Third-Party Liability (TPL) solution that are to be certified, the Vendor is responsible for preparing all documentation and operational examples to demonstrate criteria are met, and the system and services address all business functions and performance standards and business model expectations for certification. The Vendor must work with the Medicaid Management Information System (MMIS) Vendor as well as any other partner Vendors and subcontractors to achieve Centers for Medicare & Medicaid Services (CMS) certification.	6.0; MR044
Attachment 6 #MR045	The Vendor must perform a data match of the eligibility information received from the health insurers with the Bureau member eligibility file at least monthly.	6.0; MR045
Attachment 6 #MR046	The Vendor must provide the Bureau all verified matched records using the Vendor's match criteria as defined in its response to this Request for Proposal (RFP) and further approved by the Bureau. All verified data match insurance information, as well as any updates thereto, must be transferred to the Bureau electronically using the established Third-Party Liability (TPL) file layout, including the Medicaid ID (MAID).	6.0; MR046
Attachment 6 #MR047	The Vendor must take reasonable measures, pursuant to 42 Code of Federal Regulation (CFR) 433.138 (https://ecfr.io/Title-42/sp42.4.433.d), to determine the legal liability of a liable party to pay for services to members. To ensure that the Bureau is in compliance with the federally mandated cost avoidance requirements to deny and avoid the cost of claims when there is a known liable party, the Vendor must maintain valid Third-Party Liability (TPL) records in the Bureau's third-party leads file database.	6.0; MR047
Attachment 6 #MR048	The Vendor must associate third-party recoveries to individual claims.	6.0; MR048
Attachment 6 #MR049	The Vendor must prepare operational manuals for its cost avoidance and recovery programs, and ensure the operational manuals are kept current to maximize the Bureau's Third-Party Liability (TPL) recoveries and to remain in compliance with federal and State requirements. Any changes shall be coordinated with the Bureau and finalized with a revision completed within thirty (30) calendar days of the operational change. The operational manuals will address all required timeframes per individual recovery program.	6.0; MR049
Attachment 6 #MR050	The Vendor must have a minimum of three (3) years of experience with Third-Party Liability (TPL) work.	6.0; MR050
Attachment 6 #MR051	The Vendor must comply with all changes specified by the Bureau. The Bureau requirements regarding report format, report content, and frequency of submission of reports are subject to change at any time during the term of the contract.	6.0; MR051
Attachment 6 #MR052	The Vendor must perform continued reporting beyond the term of the contract for the finalization of cases, if any, retained by the Vendor beyond the transition to the new Vendor. The Vendor shall comply with all reporting requirements summarized in Appendix 5: Periodic Reports Requirements.	6.0; MR052
Attachment 6 #MR053	The Vendor must document three (3) year's experiences of successful recoveries working with a State Medicaid Agency.	6.0; MR053

RFP Reference	RFP Requirement	HMS Proposal Section
Attachment 6 #MR054	The Vendor must identify and verify all TPL coverage including, but not limited to, medical, dental, vision, and pharmacy.	6.0; MR054
Attachment 6 #MR055	The Vendor shall not seek additional payment for the identification of the same policy that affects members of the same family or household if a member is identified to have third party insurance and the health coverage information is verified,	6.0; MR055
Attachment 6 #MR056	The Vendor must assume software and hardware licensing costs related to legacy and modern solutions beginning upon execution of the contract and extending through completion of the contract.	6.0; MR056
Attachment 6 #MR057	The Vendor must procure the necessary licenses required to support its modernized solution. The Vendor is responsible for all licenses required at project initiation and will procure and renew licenses as needed throughout the project, with no additional cost to and approved by the Bureau.	6.0; MR057
Attachment 6 #MR058	The Vendor must assume up to fifty (50) concurrent Bureau licenses that are required for the User Acceptance Testing (UAT) environment, training environment, and any additional licenses necessary for operations. The Vendor is responsible for all costs associated with solution updates or enhancements that are within the scope of the Request for Proposal (RFP).	6.0; MR058
Attachment 6 #MR059	The Vendor must provide the Bureau ten (10) business days' notice for non-key staffing changes and two (2) business days' notice for key staffing changes.	6.0; MR059
Attachment 6 #MR060	The Vendor must perform cross-reference activities for identified Third-Party Liability (TPL) policies from the State's Managed Care Organizations (MCOs) that impacts members across the Medicaid Enterprise, as applicable.	6.0; MR060
Attachment 7	**Attachment 7: Detailed Specifications Approach**	
	TPL Management	
	TPL Management	
Appendix 1 TM002 Appendix 1 TM003 Appendix 1 TM004	The Vendor should describe its process for conducting initial verification of the insurance coverage information using industry-accepted practices according to the Bureau's timeliness criteria, including, but not limited to, the following: Return of verified and unverified referrals to the Bureau within three (3) business days of initial transmission and ninety (90) calendar days for trauma and/or casualty referrals Return of verified or not verified direct entry referrals into the Vendor's web portal to the Bureau within three (3) business days.	7.1.1.1
Appendix 1 TM008 Appendix 1 TM009 Appendix 1 TM010 Appendix 1 TM011 Appendix 1 TM012	The Vendor should propose its approach to provide customer service support to the West Virginia Third-Party Liability (TPL) program, including, but not limited to, the following: Outreach and educational activities, including materials distribution Reporting activities Call tracking and complaint resolution Complaint resolution processes and notification to the Bureau on a monthly basis.	7.1.1.2
	Casualty-Trauma	

RFP Reference	RFP Requirement	HMS Proposal Section
Appendix 1 TM001	The Vendor should describe how it will recover funds only from the portion of a member's settlement/judgment intended to cover medical items or services, including pharmacy.	7.1.2.1
Appendix 1 TM046	The Vendor is responsible for identifying members who have claims with specific trauma codes that are consistent with injuries that may be covered by liable parties. In accordance with 42 Code of Federal Regulation (CFR) 433.138(e) (https://ecfr.io/Title-42/sp42.4.433.d#se42.4.433_1138), the Vendor is required to identify claims that contain trauma codes utilizing claim information provided by the Bureau. The Vendor will treat all claims identified through this trauma code match process as a new trauma referral. The Vendor is responsible for processing all referrals and determining case type (mass tort case, joint liability case, or total plan case). Sources for referrals include, but are not limited to, the acute care contractors or long-term care contractors, attorneys, insurance companies, providers, and members. The Vendor should propose a strategy to develop, host, and manage a trauma/tort program, including, but not limited to, the following:	7.1.2.2 7.1.2.3 7.1.2.4
Appendix 1 TM047	Workers' compensation, Department of Motor Vehicles (DMV) match, and trauma diagnosis codes	7.1.2.4
Appendix 1 TM048	A methodology to identify casualty/tort cases prior to or during litigation, and notice to the Bureau to join the underlying litigation and pursue potential Third-Party Liability (TPL) lien recoveries and subrogation	7.1.2.5
Appendix 1 TM049	Tracking capabilities	7.1.2.6
Appendix 1 TM050	Reporting	7.1.2.7
Appendix 1 TM051	Communication Plan	7.1.2.8
Appendix 1 TM052	Planned review of Medicaid Management Information System (MMIS) functionality.	7.1.2.9
	Estate Recovery	
Appendix 1 TM016	The Vendor should propose a methodology and approach to develop, host, and manage an Estate Recovery Program consistent with State Plan provisions (https://dhhr.wv.gov/bms/CMS/SMP/Pages/default.aspx), including, but not limited to, the following:	7.1.3.1
Appendix 1 TM017	Filing proofs of claim	7.1.3.1
Appendix 1 TM018	Determining estate values	7.1.3.1
Appendix 1 TM019	Referring cases to the Bureau for State resolution, as applicable	7.1.3.1
Appendix 1 TM022	Reporting	7.1.3.1
Appendix 1 TM021	Tracking capabilities	7.1.3.2

RFP Reference	RFP Requirement	HMS Proposal Section
Appendix 1 TM020	Producing and mailing all marketing materials at no cost to the Bureau, in accordance with Department, State, and federal requirements (https://www.ecfr.gov/cgi-bin/text-idx?SID=3940429768456a3ee990b8eed15a5cac&mc=true&node=se42.4.433_136&rgn=div8)	7.1.3.3
Appendix 1 TM023	Communication Plan	7.1.3.3
	TRICARE, Medicare, Commercial Insurance Recoveries	
Appendix 1 TM034	The Vendor should propose a method to identify Medicaid members with other insurance, including, but not limited to, the following:	7.1.4.1
Appendix 1 TM035	Medicare, Tricare, and commercial insurance	7.1.4.1
Appendix 1 TM036	Submission of claims to the appropriate source for recovery	7.1.4.1
Appendix 1 TM037	A plan and approach to accomplish the work of post-payment recovery, including compliance with requirements for filing claims with third-party resources (e.g., Prescription Benefits Managers [PBMs], plan administrators); the approach for handling Medicare Parts A, B, and D recoveries; and a methodology that generates a posting transaction to the Medicaid Management Information System (MMIS) contractor	7.1.4.2
Appendix 1 TM038	Processes to establish, maintain, and update an accounts receivable file for claims that the Vendor identifies and bills to other insurance carriers; the accounts receivable file should be sufficient to provide an audit trail for State and federal documentation requirements, and is to be transferred to the Bureau at its request or at the termination of the contract resulting from this Request for Proposal (RFP)	7.1.4.3
Appendix 1 TM039	Processes for commercial and Medicare disallowance files to be sent to the Bureau every thirty (30) calendar days.	7.1.4.3
Appendix 1 TM040	The Vendor should provide a solution to post recovery payments for claims identified. After the Third-Party Liability (TPL) information file has been used to successfully update the Medicaid Management Information System (MMIS) TPL file, and following the receipt of the individual paid claims history data, the Vendor should describe their recovery activities, including, but not limited to, the following:	7.1.4.4
Appendix 1 TM041	Issuance of amounts recovered via check and submission to the Lockbox; the State's Accounts Receivables will work the check and the Bureau will be sent a copy of the check along with any paperwork	7.1.4.4
Appendix 1 TM042	Post recoveries to accounts receivable files within seven (7) calendar days after recovery to allow for independent reconciliation by the Bureau of deposits to recoveries recorded	7.1.4.4
Appendix 1 TM043	Updating all recoveries in the accounts receivable file within forty-five (45) calendar days after receipt of recovery; any recoveries not updated after this time period should be transmitted to the Bureau in a format acceptable to Bureau for processing	7.1.4.4
Appendix 1 TM044	Investigate reasons for non-payment by third-party payors and resubmit claims when appropriate. Specific reasons for non-payment will be included in the accounts receivable file.	7.1.4.5
Appendix 1 TM045	The Vendor should describe their process for seeking reimbursement from a liable third party on all claims for which it determines the amount reasonably expected to recover will be greater than the cost of recovery. Recovery efforts must be suspended or terminated only if they are not cost effective as specified by the Bureau.	7.1.4.6

RFP Reference	RFP Requirement	HMS Proposal Section
	Credit Balance Audit	
Appendix 1 TM013	The Vendor should propose a method for performing specific functions for identifying and recovering overpayments (credits owed to Medicaid) from providers via on-site audits and desk reviews, including, but not limited to, the following:	7.1.5.1
Appendix 1 TM015	Methodology for identification of provider overpayments.	7.1.5.1
Appendix 1 TM014	Identification of all refunds owed by Medicaid to third-party payors to correct recoveries or other overpayments with appropriate documentation; upon receipt of this information, the Bureau will verify the accuracy of the recovery and will submit refund to the third-party payor	7.1.5.2
Appendix 1 TM007	The Vendor should describe its detail report for credit balance, including, but not limited to, management of accounts receivable.	7.1.5.3
	Third Party Adds	
Appendix 1 TM032	The Vendor should propose a method to identify Medicaid members with third-party commercial health insurance, then validate and upload this information to the Medicaid Management Information System (MMIS) for cost avoidance, thereby increasing the cost avoidance of claims and reduction of payments made by Medicaid. The Vendor is responsible for contacting the insurance organizations and arranging for data matches.	7.1.6.1
Appendix 1 TM024	The Vendor should propose a method to provide maintenance of Third-Party Liability (TPL) policy and carrier information including, but not limited to, the following:	7.1.6.2
Appendix 1 TM025	Term dates, changes in coverage, group information, and carrier information	7.1.6.2
Appendix 1 TM026	Changes in coverage	7.1.6.2
Appendix 1 TM027	Mass TPL and/or carrier updates, due to changes in carrier status (i.e., office relocations, mergers, or acquisitions), sponsor changes, group number and/or policy number changes	7.1.6.2
Appendix 1 TM028	Methods for correction related to previously transmitted information found to be erroneous.	7.1.6.2
Appendix 1 TM029	Tracking Mechanisms	7.1.6.2
Appendix 1 TM030	Interfaces with the Medicaid Management Information System (MMIS)	7.1.6.2
Appendix 1 TM031	Reporting capabilities.	7.1.6.2
Appendix 1 TM005	The Vendor should describe its process for conducting reverification of active coverage record information every three (3) months on a rolling three (3) month cycle based on the last verification date, or on another timetable, as defined by the Bureau.	7.1.6.3
Appendix 1 TM006	The Vendor should describe its process for transferring all verified insurance information, as well as any updates thereto, to the Bureau electronically using the established Bureau Third-Party Liability (TPL) file layout, inclusive of the insurance carrier identification information.	7.1.6.4

RFP Reference	RFP Requirement	HMS Proposal Section
Appendix 1 TM033	The Vendor should propose a method to transmit pharmacy policies in real time to the Bureau's Point of Sale (POS) system and how the information would be added into the State Medicaid Management Information System (MMIS) daily.	7.1.6.5
	Optional Services	
	Premium Reimbursement Program	
Appendix 1 OS001	The Vendor should propose its approach to operate the State's premium reimbursement program, that will enable the Bureau to purchase health insurance, if cost effective, under the authority of Section 1905(a) of the Social Security Act (SSA), by the use of data matches and Medicaid member files to identify potential resources. This is an optional service. The proposal should contain processes including, but not limited to, the following:	7.2.1.1
Appendix 1 OS002	Verifying members' eligibility for West Virginia Medicaid on a monthly basis	7.2.1.2
Appendix 1 OS003	Verifying cost effectiveness by comparing the estimated costs of the policy to the estimated medial costs of the members	7.2.1.2
Appendix 1 OS004	Validating insurance coverage and premium payment amounts to ensure eligibility	7.2.1.2
Appendix 1 OS005	Forwarding health insurance with all types of coverage per approved members to the Bureau to be added to the Medicaid Management Information System (MMIS) system without additional costs to the State	7.2.1.2
Appendix 1 OS006	Performing an annual comprehensive analysis and recertification of each enrolled member to ensure continued cost effectiveness	7.2.1.2
Appendix 1 OS007	Handling all correspondence and inquiries regarding the premium reimbursement program	7.2.1.2
Appendix 1 OS008	Coordinating benefits with the Third-Party Liability (TPL) Program	7.2.1.2
Appendix 1 OS009	Notifying the Bureau of all approved and denied applicants	7.2.1.2
Appendix 1 OS010	Providing reports with actual cost savings to the State for each enrolled member on a quarterly basis	7.2.1.2
Appendix 1 OS011	Providing documentation (e.g., copies of Explanation of Benefits [EOBs] or paystubs) utilized to produce reports of actual cost savings to the Bureau	7.2.1.2
Appendix 1 OS012	Marketing and outreach in surrounding communities to maximize efforts for recruitment and education of the premium reimbursement program	7.2.1.2
Appendix 1 OS013	Providing a "premium reimbursement program Business Rule" file, documenting all requirements as agreed upon with the Bureau for the program	7.2.1.2
Appendix 1 OS014	Operating a web portal for potential member application process.	7.2.1.2
	Work Incentive Premium Program	

RFP Reference	RFP Requirement	HMS Proposal Section
Appendix 1 OS036	The work incentive program is a work incentive for people with disabilities or chronic health conditions. It allows individuals who work to pay a monthly premium and keep or obtain Medicaid healthcare coverage. The Vendor should propose a strategy that automates the work incentive program process. This is an optional service. The Vendor should describe their approach to operating a work incentive program, including, but not limited to, the following:	7.2.2.1
Appendix 1 OS037	Technical support	7.2.2.1
Appendix 1 OS038	Operational processes, including interfacing with Medicaid Management Information System (MMIS)	7.2.2.1
Appendix 1 OS039	Reporting	7.2.2.1
Appendix 1 OS040	Toll-free number and call center for members	7.2.2.1
Appendix 1 OS041	Proposed staffing plan to fully administer the work incentive program	7.2.2.1
Appendix 1 OS042	Cost effectiveness determination	7.2.2.1
Appendix 1 OS043	Web portal for prospective member online application	7.2.2.1
	Medicare Buy-In	
Appendix 1 OS029	The Vendor should propose a strategy that automates the Medicare Buy-In program by data matching with appropriate federal and State databases to create the Buy-In Export File consisting of six (6) different Medicare Buy-In categories for eligible clients. This is an optional service. The Vendor should describe their proposal including, but limited to, the following:	7.2.3.1
Appendix 1 OS030	Evaluation of current process and recommendation for improvements	7.2.3.2
Appendix 1 OS032	Operational processes, including interfacing with Medicaid Management Information System (MMIS)	7.2.3.3
Appendix 1 OS031	Technical Support	7.2.3.4
Appendix 1 OS034	Toll-free number and call center for members	7.2.3.4
Appendix 1 OS035	Proposed Staffing Plan to fully administer the Buy-In program	7.2.3.4
Appendix 1 OS033	Reporting	7.2.3.5
	Recovery Audit Contractor	

RFP Reference	RFP Requirement	HMS Proposal Section
Appendix 1 OS015	The Vendor should describe its approach to providing Recovery Audit Contractor (RAC) services by auditing claims for Medicaid under/overpayment collections in accordance with Department, State, and federal requirements. This is an optional service. The description should contain processes including, but not limited to, the following:	7.2.4.1
Appendix 1 OS026	Description of the case management system utilized for tracking audits through conclusion/collection and how it will interface with the State system	7.2.4.2
Appendix 1 OS019	Processes for data mining to target providers and claims for review that have not been subject to audit or are currently being audited by another entity, to identify potential coding and billing errors, and to provide trends and patterns analyses	7.2.4.3
Appendix 1 OS020	Processes for provider medical record requests that includes the process for submission for electronic medical records	7.2.4.3
Appendix 1 OS022	Aspects of clinical and coding review of medical records including, but not limited to, coding, and medical necessity	7.2.4.4
Appendix 1 OS025	Examples of audit templates, protocols, and timeframes for identifying and auditing claims	7.2.4.5
Appendix 1 OS016	Providing at all times trained medical professionals, to the satisfaction of the Bureau, who are in good standing with the relevant State licensing authorities, where applicable, to review Medicaid claims	7.2.4.6
Appendix 1 OS017	Providing at all times certified coders, to the satisfaction of the Bureau, for effective review of Medicaid claims	7.2.4.6
Appendix 1 OS018	Working collaboratively with the Bureau to develop an education and outreach program that includes notification to providers of audit policies and protocols	7.2.4.7
Appendix 1 OS021	Refraining from auditing claims that have been audited or are in process of being audited by another entity	7.2.4.8
Appendix 1 OS027	Deconfliction processes	7.2.4.8
Appendix 1 OS028	Workflows for identifying and reporting potential fraud, waste, and abuse with the Bureau and the West Virginia Medicaid Fraud Control Unit (MFCU) and support.	7.2.4.9
Appendix 1 OS023	Reporting of results	7.2.4.10
Appendix 1 OS024	Developing an Improper Payment Prevention Plan, for any RAC-identified vulnerability, to help prevent similar overpayments from occurring in the future	7.2.4.11
	Project Management	
	Communication Management Plan	
Appendix 1 PM001	The Communication Management Plan is a document used to define stakeholder groups, outline key messages, and organize outreach and engagement activities to achieve intended communication objectives, and should detail the varying levels and needs of the project's stakeholders for information regarding the project, status, accomplishments, and impact on stakeholders. The Vendor should describe its Communication Management Plan, including, but not limited to, the following:	7.3.1.1
Appendix 1 PM003	Target stakeholders, maintenance of contact list, messaging preferences, and frequency of communication	7.3.1.2

RFP Reference	RFP Requirement	HMS Proposal Section
Appendix 1 PM002	The Vendor should describe its notification processes to the Bureau for all changes in State and federal regulations affecting services provided under this contract within two (2) business days of publication, including the development of a summary of Proposed and Final Rules and Regulations and an evaluation of program impact and implementation changes within five (5) business days of issuance.	7.3.1.3
Appendix 1 PM004	Reporting, required project communications, resolution approaches, and techniques to address stakeholder engagements	7.3.1.4
Appendix 1 PM005	This deliverable should meet the acceptance criteria established between the Bureau and the Vendor.	7.3.1.5
	Document Management Plan	
Appendix 1 PM006	The Vendor should propose a Documentation Management Plan that describes how project documentation will be managed, including, but not limited to, the following:	7.3.2.1
Appendix 1 PM007	Project types, deliverables, acceptance criteria, meeting materials, artifacts, operations manuals, training materials, and user guides	7.3.2.1
Appendix 1 PM008	Use, access, and management of document repositories	7.3.2.1
Appendix 1 PM009	Approach to document management and version control of all project and operational documentation	7.3.2.1
	Staffing Management Plan	
Appendix 1 PM010	The Staffing Management Plan documents the Vendor's approach to providing and managing qualified human resources for the project, and describes how the roles, responsibilities, and reporting relationships will be structured and addressed in support of the project and operations. Staff should have a working knowledge of the system operations prior to starting on the project. The Vendor should describe its Staffing Management Plan, including, but not limited to, the following:	7.3.3.1
Appendix 1 PM011	Organizational chart for each phase of the project, identifying all staff to be used for each phase of the project and clearly identifying on-site staff, off-site staff, and subcontractors	7.3.3.2
Appendix 1 PM014	If any of the work is performed off-site, including work of subcontractors, describe the assurance of quality and timeliness of the work performed off-site	7.3.3.2
Appendix 1 PM024	Staffing for optional services, as detailed in this RFP	7.3.3.3
Appendix 1 PM012	Description of the roles, responsibilities, and skillsets associated with each position on the organization chart	7.3.3.4
Appendix 1 PM013	For each key staff member, a brief summary description of the roles, responsibilities, and experience that qualify them for their role on this project	7.3.3.4
Appendix 1 PM015	Resource calendar describing the staff required for each phase of the project, if the staff will be on-site or off-site, and the allocation percentage	7.3.3.4
Appendix 1 PM018	Description of business analyst personnel who will be used in support of this Request for Proposal (RFP)	7.3.3.5

RFP Reference	RFP Requirement	HMS Proposal Section
Appendix 1 PM016	The Bureau's business and technical resources required to support the creation of all deliverables	7.3.3.6
Appendix 1 PM017	Description of the training personnel who will be used in support of training activities	7.3.3.7
Appendix 1 PM019	Process for transitioning essential knowledge to the Bureau technical staff and users.	7.3.3.7
Appendix 1 PM021	Staff training, both initial and ongoing, including transfer of system and business knowledge, project management methodologies and processes, and project status to new staff and incumbent staff transitioning between project roles and phases	7.3.3.7
Appendix 1 PM020	Approach to personnel management including hiring and terminations, staff retention and continuity, and employee relocation	7.3.3.8
Appendix 1 PM022	Staff performance monitoring	7.3.3.9
Appendix 1 PM023	Succession planning, staff replacement, and staff backup	7.3.3.10
Appendix 1 PM025	The Staffing Management Plan should support the project and operations while maintaining compliance with all staffing requirements set forth in the Appendix 1: Detailed Specifications and any RFP narrative.	7.3.3.11
	Change Management Plan	
Appendix 1 PM026	The Vendor should propose a Change Management Plan, including a description of the Vendor's approach for change management including, but not limited to, the following:	7.3.4.1
Appendix 1 PM027	Methodologies	7.3.4.1
Appendix 1 PM028	Tools	7.3.4.1
Appendix 1 PM029	Enhancements	7.3.4.1
Appendix 1 PM030	Modifications	7.3.4.1
Appendix 1 PM031	Processes required to appropriate manage and document changes to the system, such as impact analyses and change requests	7.3.4.1
	Implementation Plan	
Appendix 1 PM032	The Implementation Plan details the Vendor's approach to conducting the cutover from the existing solution to the new solution at go-live. This plan provides a detailed sequence of operations or steps that should be carried out to deliver the new solution. The Vendor should propose an Implementation Plan that is a comprehensive plan for rolling out the new solution to users, including, but not limited to, the following:	7.3.5.1
Appendix 1 PM033	Description of major tasks and each implementation step	7.3.5.2

RFP Reference	RFP Requirement	HMS Proposal Section
Appendix 1 PM034	Explanation of the solution configuration	7.3.5.3
Appendix 1 PM035	Explanation of how all components of the solution will be installed and upgraded timely, and where the installation may be split up into multiple procedures	7.3.5.4
Appendix 1 PM036	Points of contact	7.3.5.5
Appendix 1 PM037	Implementation schedule	7.3.5.6
Appendix 1 PM038	Security and privacy safeguards	7.3.5.7
Appendix 1 PM039	Implementation support procedures	7.3.5.8
Appendix 1 PM040	Implementation impacts	7.3.5.9
Appendix 1 PM047	Risks and contingencies	7.3.5.10
Appendix 1 PM041	Configuration management interfaces	7.3.5.11
Appendix 1 PM042	Applicable user documentation	7.3.5.12
Appendix 1 PM043	Personnel and staffing requirements	7.3.5.13
Appendix 1 PM049	Implementation roles and responsibilities for the Bureau, the Project Management Office (PMO), and other Vendors	7.3.5.13
Appendix 1 PM044	Implementation staff training	7.3.5.14
Appendix 1 PM045	Outstanding issues	7.3.5.15
Appendix 1 PM050	Approach to triaging issues and defects prior to, during, and subsequent to solution go-live	7.3.5.16
Appendix 1 PM046	Performance monitoring	7.3.5.17
Appendix 1 PM048	Implementation verification and validation	7.3.5.17
Appendix 1 PM051	This deliverable must meet the acceptance criteria established between the Bureau and the Vendor.	7.3.5.18

RFP Reference	RFP Requirement	HMS Proposal Section
Appendix 1 PM052	The Vendor should describe how they will communicate project status information to the Bureau within the required timeframes and in the agreed-upon format, as defined in the approved Project Management Plan.	7.3.5.19
Appendix 1 PM053	The Vendor should leverage the format, contents, and structure in the RFP attachments, and an identifiable tab sheet should precede each section of the proposal, and each proposal should follow all formatting requirements. All pages, except preprinted technical inserts, should be sequentially numbered.	7.3.5.20
Appendix 1 PM054	The Vendor's in-line responses, inclusive of the text of BMS' specifications, should be as concise as possible and should not exceed 400 pages in total. Vendors should choose a similarly sized typeface (generally 11 point for text and 9 point for tables) for BMS specifications and not use smaller than 9-point fonts to work within the page limit. The page limit counts the front and back of each sheet as separate pages.	7.3.5.20
Appendix 1 PM055	The Vendor's page limit will not apply to administrative forms, resumes, representations and affirmations, response form(s), and other structured forms required under this RFP, specifically the following sections and attachments: Section 3, General Terms and Conditions; Attachment 3: Vendor Qualifications and Experience (only Section 6: Business Disputes and Section 9: Financial Stability); Attachment 4: Project Organization and Staffing Approach (only Section 3: Key Staff, Resumes, and References); and Attachment 5: Initial Work Plan.	7.3.5.20
	Program Integrity	
	Program Integrity	
Appendix 1 PI001	The Vendor should describe its audit program design including, but not limited to, a process for appeals.	7.4.0.1
Appendix 1 PI002	The Vendor should describe its notification processes to the Bureau for all changes in State and federal regulations affecting services provided under this contract within two (2) business days of publication, including the development of a summary of Proposed and Final Rules and Regulations and an evaluation of program impact and implementation changes within five (5) business days of issuance.	7.4.0.2
	Information Management Systems	
	Business Continuity and Disaster Recovery Plan	
Appendix 1 IS001	The Business Continuity and Disaster Recovery (BCDR) Plan defines the resources, actions, and tasks required to protect and recover data and the data infrastructure in the event of a disaster. The Vendor should describe their BCDR Plan, including, but not limited to, the following:	7.5.1.1
Appendix 1 IS002	Vendor Disaster Communication Plan	7.5.1.2
Appendix 1 IS003	Backup and protection plans and procedures, including data files and transaction logs from all environments, software, hardware, and network connectivity	7.5.1.3
Appendix 1 IS004	Detailed backup and recovery procedures for all anticipated types of disasters to ensure that data maintained is properly and routinely purged, archived, and protected from loss, unauthorized access, or destruction, in accordance with all relevant Bureau policies and procedures	7.5.1.3
Appendix 1 IS005	Description of each anticipated class of disaster	7.5.1.4

RFP Reference	RFP Requirement	HMS Proposal Section
Appendix 1 IS006	Risk analysis and risk mitigation for each core business process	7.5.1.5
Appendix 1 IS007	Processes and procedures for testing and reporting for the Business Continuity and Disaster Recovery (BCDR) Plan, including, but not limited to, the following:	7.5.1.6
Appendix 1 IS008	Failover/fallback functionality	7.5.1.6
Appendix 1 IS009	Backup/recovery functionality	7.5.1.6
Appendix 1 IS010	Plans detailing responsibilities, activities, and processes to be used in case of system failure at any time	7.5.1.6
Appendix 1 IS011	Identification of potential go-live system failures and negative events with mitigation strategies and activities	7.5.1.6
Appendix 1 IS012	Plans for training key project resources in recovery procedures	7.5.1.6
Appendix 1 IS013	Processes for updating each plan as necessary throughout the life of the contract	7.5.1.6
Appendix 1 IS014	This deliverable should meet the acceptance criteria established between the Bureau and the Vendor.	7.5.1.6
	Security Plan	
Appendix 1 IS015	"The Security Plan defines the Vendor's plan of action to secure computers, systems, and facilities. The Security Plan provides a systematic approach and techniques for meeting all security controls to protect computers from being accessed by unauthorized users, to guard against worms and viruses, and to identify and respond to any security incident, event, or process that could jeopardize the security of computers, systems, or facilities. Based on the template provided by Centers for Medicare and Medicaid Services (CMS) (https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/InformationSecurity/Downloads/CMS-Information-Security-Requirements.pdf), and in accordance with National Institute of Standards and Technology (NIST) guidelines (https://csrc.nist.gov/publications/detail/sp/800-53/rev-4/final), the Vendor should provide its Security Plan, including, but not limited to, the following:"	7.5.2.1
Appendix 1 IS017	Logical security controls (e.g., privacy, user access and authentication, user permissions)	7.5.2.2
Appendix 1 IS018	Technical security controls and security architecture (communications, hardware, data, physical access, software, operating system, encryption)	7.5.2.2
Appendix 1 IS019	Security processes (e.g., security assessments, risk assessments, incident response)	7.5.2.3
Appendix 1 IS020	Documentation that describes technical controls, including, but not limited to, the following:	7.5.2.4

RFP Reference	RFP Requirement	HMS Proposal Section
Appendix 1 IS021	Network segmentation	7.5.2.4
Appendix 1 IS022	Perimeter security	7.5.2.4
Appendix 1 IS023	Application security	7.5.2.4
Appendix 1 IS024	Intrusion management	7.5.2.4
Appendix 1 IS025	Monitoring and reporting	7.5.2.4
Appendix 1 IS026	Remote access	7.5.2.4
Appendix 1 IS027	Encryption of data at rest and in transit on servers, databases, and personal computers	7.5.2.4
Appendix 1 IS028	Interface security	7.5.2.4
Appendix 1 IS029	Secure communications over the internet	7.5.2.4
Appendix 1 IS030	Annual updates to all security policies, controls, processes, and documentation based on current National Institute of Standards and Technology (NIST) Special Publication (SP) 800-53 (https://csrc.nist.gov/publications/detail/sp/800-53/rev-4/final), all other relevant State and federal regulations, and State Information Security Standards and Policies	7.5.2.4
Appendix 1 IS016	Security policies	7.5.2.5
Appendix 1 IS031	This deliverable should meet the acceptance criteria established between the Bureau and the Vendor.	7.5.2.7
	Critical Services	
	Critical Services	
Appendix 1 CS001	The Vendor must maintain a Third-Party Liability (TPL) web portal that is approved for operations no later than ninety (90) calendar days of contract award date. The system must have capability for distribution of reports to Bureau-approved stakeholders; comprehensive, ad hoc and standard reporting; insurance verifications; searching and tracking of functions; and TPL programs for the Bureau. In addition, the system must provide live update information on all cases.	7.6.0.1
Appendix 1 CS002	The Vendor must have a set of requirements operational for go-live, as agreed upon with the Bureau, within ninety (90) business days of contract award. The remaining requirements must be implemented within a timeline agreed upon by the Bureau.	7.6.0.2
Appendix 1 CS003	Send recovery and accounts receivable files to the Bureau within ninety (90) calendar days following the effective date of the contract and subsequent receipts of recoveries at least every thirty (30) calendar days thereafter	7.6.0.3

RFP Reference	RFP Requirement	HMS Proposal Section
Appendix 1 CS004	Report to the Bureau records of unidentifiable third-party recoveries in a format acceptable to the Bureau within ninety (90) calendar days after the effective date of the contract and at least every thirty (30) calendar days thereafter; the data will be reported within thirty (30) calendar days following discovery of the resource.	7.6.0.4
Appendix 1	**Appendix 1: Detailed Specifications**	
Appendix 1	RFP Appendix 1	Appendix 1

1.0 EXECUTIVE SUMMARY

The Bureau for Medical Services' (BMS') strategic direction and priorities center around streamlining and tailoring West Virginia Medicaid program services to best meet the needs of their enrolled population. BMS leads other states with its innovative ideas and solutions, and BMS' Third Party Liability (TPL) program is a perfect example. This critical program must continue to provide accountability through accurate reporting of revenues and expenditures.

> *"I'm proud of the collaboration that has been central to West Virginia's partnership with HMS for 26 years. Driving cost savings to the state's Medicaid program is essential to your ability to continue delivering quality care to West Virginians when they need it most—including through the state's pioneering M-WIN Medicaid buy-in program. With much at stake, we don't take for granted our work on BMS' behalf--and you have my personal assurance that you will continue to realize maximum value and ROI throughout our next contract term."*
>
> - HMS CEO Bill Lucia

Health Management Systems, Inc. (HMS®) has worked closely with BMS to support best-in-class services, innovation, and maximum cost avoidance and recoveries for the West Virginia Medicaid program. **Since 2011, HMS has helped BMS save more than $1.3 billion and recover more than $91 million** - contributions that are vital to sustaining the Medicaid program. HMS is confident that our TPL solution will meet and exceed BMS' goals and objectives in the new contract term.

HMS–THE LEADER IN TPL SOLUTIONS

HMS' advanced TPL solution increases transparency, provides more actionable information, and drives better outcomes. We invest over $25 million each year in TPL enhancements, such as *COB on Demand*, to enable higher frequency, faster delivery, and greater savings from verified third party insurance coverage for Medicaid members.

Our dedicated team of Medicaid experts work exclusively on enhancing and improving TPL systems and workflows. We do not rely on subcontractors or vendors to complete our core processes. By performing this work internally, we have built and retained a deep understanding of both BMS' Third Party Investigations and Premium Assistance programs, including MMIS record delivery requirements.

Our comprehensive **Third Party Adds** solution includes **Cost Avoidance, Third Party Referral (TPR), and TPR Resource File Revalidation**. HMS' robust cost avoidance services are essential for maximizing cost savings and efficiency by providing medical, vision, dental and other benefit types that build a comprehensive profile of the recipient's coverage options in the MMIS. Since 1994, HMS has helped BMS minimize future Medicaid expenditures by West Virginia Medicaid and West Virginia Children's Health Insurance through cost avoidance of future claim payments. Our **TPR** and **TPR Revalidation** processes are operational and successful. Each week we receive and process policy verification requests and update the State's MMIS. For point of care or claims payment, we process transactions in real-time.

The TPR process enables higher frequency and faster delivery of cost avoidance data. All insurance policy segments identified during the Third Party Adds processes meet HMS' highest level of match quality to qualify for cost avoidance purposes.

To maximize dollars back into the Medicaid program, we perform Recoveries through both provider disallowances and direct billing to Commercial Insurance carriers. To return dollars back to the Medicaid program, we perform Recoveries through provider disallowances and direct billing to Commercial Insurance carriers. We access the largest number of the top health insurance carriers, through trading partner data use agreements, covering 97% of WV lives, which equates to robust and complete data. We accurately identify health coverage for healthcare fee-for-service (FFS) claims through these carriers that were, or could be, erroneously paid by our Medicaid clients.

HMS: An Experienced MMIS/MES Integration Vendor

In the new contract, we will successfully support BMS through certification. Our TPL solutions meet 100% of the MECT checklist requirements for TPL business processes. HMS has worked with our Medicaid clients as they transition between MMIS vendors and now, as they move toward Medicaid Enterprise Systems (MES).

We are currently working with three states that are well-along in executing on their MES modernization roadmap including NM, VA and WY. We have also been awarded MES modules in other states that have been implemented, with plans to re-platform once the integration platform is ready to accept modules.

We will bring experience to BMS, to apply when the State is ready to move forward with its modernization roadmap to make BMS' MES conversion a success.

HMS recognizes that casualty recovery programs are a core Medicaid initiative. We seek to recover funds paid by Medicaid on behalf of injured members for which a third party is liable for payment. Our proven **HMS' Casualty-Trauma Recovery** solution follows our established casualty and mass tort recovery process and industry-best practices. HMS has recovered more than $30 million for West Virginia from across all claim and case types in the current contract term for BMS.

HMS has supported BMS' **Estate Recovery** program since 1995 and has recovered more than $20 million for the State. With this solution, we apply our extensive knowledge of national and WV estate recovery laws to deliver a customized approach to work for the benefit of BMS, with HMS' existing WV referral network, recovery processes, and staffing already in place. With this solution, we apply our extensive knowledge of national and WV estate recovery laws to deliver a customized approach to benefit BMS, with HMS' existing WV referral network, recovery processes, and staffing already in place. Accordingly, we are poised to help the state achieve greater estate recovery results in the new contract term.

Under our current contract, our **Credit Balance Audit** solution for BMS has resulted in more than $4 million in recovered payments. To ensure the most impactful provider experience, HMS maintains strong provider relationships where we collaborate to provide education that helps reduce future overpayments while easing provider burden. HMS also offers solutions for the **optional TPL services**, including support for the West Virginia Premium Reimbursement Program; Work Incentive Premium Program; Medicare Buy-in Program, and RAC Services.

HMS is uniquely positioned to meet BMS' future vision of a transparent and innovative TPL solution. Our depth and breadth of direct experience- leveraging our specialized solutions, established processes, expert knowledge, and commitment to improving the healthcare system for government healthcare payors—makes HMS the best choice.

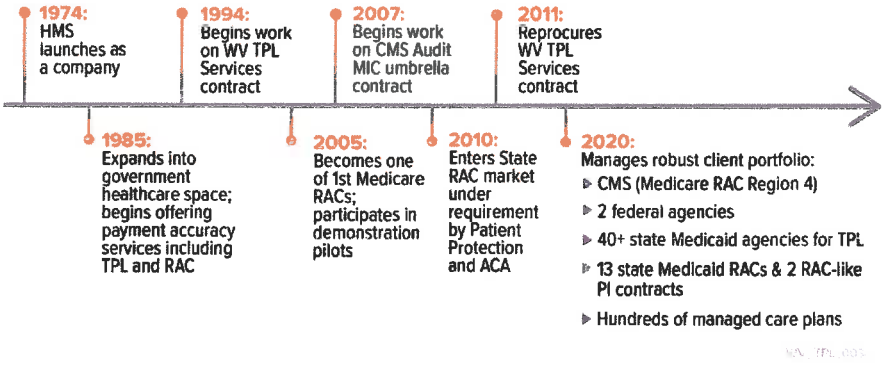
3.0 VENDOR QUALIFICATIONS AND EXPERIENCE

3.1 ORGANIZATION OVERVIEW (ATT 3, SECT. 1)

HMS is singularly focused on advancing the healthcare system for public healthcare programs, like WV Medicaid and WVCHIP, supporting operational efficiencies by reducing costs, generating significant return on investment, and improving health outcomes. Through our industry-leading technology, cost containment, payment analytics and engagement solutions, we save billions of dollars annually while helping consumers lead healthier lives.

For 46 years, Health Management Systems, Inc. (HMS®) has continuously helped healthcare clients, including BMS, meet the unique challenges they face in providing high-quality services amid budget constraints and changing healthcare industry conditions. Since 1985, we began providing cost containment and program integrity services, together now known as payment accuracy, to government and commercial healthcare clients. Our comprehensive and successful services today support more than 40 state Medicaid agencies, 350 Medicaid managed care plans, the Centers for Medicare & Medicaid Services, Department of Veterans Administration, and the Centers for Disease Control and Prevention in managing their healthcare dollars and achieve a high return on investment. As depicted in **Exhibit 3-1,** through our experience over time with these government healthcare clients, we developed a rare understanding of our nation's healthcare system and challenges faced by public healthcare programs.

Exhibit 3-1 HMS' Government Healthcare Payment Accuracy History
Over time, HMS has accumulated best practices to apply to our TPL, PI/RAC, and other contracts.



In turn, each of our public agency clients benefits from the knowledge and insight we have gained by working with similar programs nationwide. We have gained extensive industry thought leadership as well as applied lessons learned and best practices to our Third Party Liability (TPL) and Program Integrity (RAC) contracts to further improve processes for the identification, recovery, and prevention of improper payments to benefit public healthcare programs. We also take our role as the national TPL and RAC expert seriously and routinely provide legislative and regulatory consultations to our clients to enhance their TPL and RAC programs.

Our relationships with health insurers, covering more than 97% of insured lives in West Virginia, as well as with the provider community, means that BMS can minimize the burden on these stakeholders and reduce uncertainty. Regardless of the circumstances, we are ready to continue as BMS' trusted partner.

HMS' innovations in TPL technologies have allowed us to maximize recoveries across all programs. Our TPL solution enables injection of verified third-party insurance coverage at the most cost-beneficial points in the healthcare continuum. We continuously deliver measurable and meaningful enhancements that improve the results for our clients.

HMS does not rely on subcontractors or vendors to complete our core processes. By performing this work internally, we retain a deep understanding of both TPL and RAC programs, including MMIS record delivery requirements--we have over 100 business rules to accommodate accurate service delivery.

Our confidence in our proposed solution for BMS is the result of our prior accomplishments in WV and through ongoing dedication to the industry. HMS is the most experienced government TPL and RAC vendor in the country, in both Fee-for-Service and managed care environments and understands the level of effort required to carry out this contract – our proposed end-to-end solution is the best solution for BMS.

CERTIFICATIONS

INTERNATIONAL ORGANIZATION FOR STANDARDIZATION (ISO) 9001-2015

In 2018, HMS joined an elite group of organizations worldwide who have achieved certification to a globally recognized quality standard: ISO 9001 (current version released in September 2015). ISO 9001 is an international standard that specifies requirements for a quality management system that demonstrates the ability to consistently provide products and services that meet client and regulatory requirements.

ISO 9001 certification provides the processes in place to build quality into everything we do, while continuously looking for opportunities to apply our advanced ongoing improvement methodologies. This certification holds HMS accountable for continuing to:

- Improve our quality management system
- Meet the needs of our clients and enhancing their satisfaction across all contracts.

HEALTH INFORMATION TRUST ALLIANCE (HITRUST)

HITRUST CSF Certified

As part of our corporate compliance and information security program, which we describe more in **Section 7.5.2 Security Plan**, we meet standards mandated by the Health Insurance Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health (HITECH), and other pertinent regulations.

HMS utilizes the HITRUST® Common Security Framework (CSF) and was initially certified in August 2014. We continue to maintain our certification in good standing with annual assessment benchmarks and recertification every two years as required by the HITRUST Alliance.

Our HITRUST certification encompasses the following frameworks:

- Health Information Technology for Economic and Clinical Health (HITECH) (enacted February 17, 2009)
- Health Insurance Portability and Accountability Act (HIPAA) (Public Law 104–191, 110 Statute 1936, enacted August 21, 1996)
- HIPAA Security Rule

Security Awards and Certifications

Over the past seven years, HMS has received many awards and certifications related to our security innovations and data-security measures (**Exhibit 3-2**).

Exhibit 3-2 HMS' Recent IT and Security Awards and Certifications
We are recognized across the industry for our IT and Security excellence.

HMS has extensive experience with many different MMIS and Electronic Data Exchanges and operates according to the EDI rule. This rule defines the different types of transactions covered under HIPAA and the format for each transaction record, governing the way data is electronically transferred. Our HIPAA-compliant EDI procedures can process and provide data in a variety of custom file formats to best meet your data transfer needs.

3.1.1 VENDOR OVERVIEW (ATT 3, SECT 1.1)

In **Exhibit 3-3** (Table 7) below, we have provided all relevant information about our organization, as requested in the RFP.

Exhibit 3-3 Table 7: HMS Overview
HMS is the nation's leading provider of healthcare payment accuracy solutions.

Vendor Overview	
Company Name	Health Management Systems, Inc. (HMS®)
Name of Parent Company (If Applicable)	HMS Holdings Corp.
Industry North American Industry Classification System (NAICS)	Our NAICS numbers are 511210, 518210
Type of Legal Entity	Holdings is a C-type corporation
Company Ownership (e.g., Private/Public, Joint Venture)	HMS is a public company traded on the NASDAQ Global Select Market (ticker symbol: HMSY)
Number of Full Time Employees	HMS currently has 3,117 employees located across the country.
Last Fiscal Year Company Revenue	$626.4 million
Last Fiscal Year Company Net Income	$87.2 million
% of Revenue From State and Local Government Clients in the United States	HMS receives approximately 49% of revenue from state and local governments in the US.
Number of Years in Business	46 years
Number of Years Vendor has been Providing the Type of Services Specified in the request for proposal (RFP)	More than 35 years
Number of Employees Providing the Type of Services Specified in the RFP	HMS' currently has 3,172 employees; 2,826 of those employees provide the TPL and program integrity services, specified in the RFP, across our client base.
Headquarters in the United States	HMS' corporate headquarters are located at 5615 High Point Drive, Irving, TX 75038
Locations in the United States	In addition to our Irving, TX headquarters location, HMS has 26 office locations in: Alabama, Alaska, Arizona, California, Colorado, Connecticut, District of Columbia., Georgia, Idaho, Kansas, Massachusetts, Mississippi, Missouri, Minnesota, Nebraska, Nevada, New Jersey, New York, North Carolina, Ohio, Texas, and West Virginia

3.1.2 SUBCONTRACTOR OVERVIEW (ATT 3, SECT. 1.2)

To allow our Operations team to focus on the delivery of core services, we sometimes use narrow-scope subcontractors. While the ancillary services performed by these subcontractors could be done in-house, subcontracting certain tasks leads to efficiencies for both HMS and BMS. Our Vendor Management team in operations has extensive experience managing the activities and results of subcontractors. In **Exhibits 3-4** through **3-6,** we describe the administrative subcontractors with a description of their roles and provided services. As the prime vendor, HMS takes full responsibility for this engagement with BMS and is ultimately responsible for the results delivered to the State under the TPL Services contract.

All approved vendors will complete and submit a Vendor Registration and Disclosure Statement to the West Virginia Purchasing Division upon contract award. HMS itself is currently registered with the State.

Exhibit 3-4 Table 8: Subcontractor Overview
Exela Technologies, Inc.

Subcontractor Overview	
Company Name	Exela Technologies, Inc.
Name of Parent Company (If Applicable)	SourceHOV
Industry North American Industry Classification System (NAICS)	SIC Code 7389 and NAICS Code 561990
Type of Legal Entity	Limited Liability Company (LLC)
Company Ownership (e.g., Private/Public, Joint Venture)	Public
Number of Full-Time Employees	20699
Last Fiscal Year Company Revenue	$1,562,337
Last Fiscal Year Company Net Income	$508,780
% of Revenue From State and Local Government Clients in the United States	8%
Number of Years in Business	30 years
Number of Years Vendor Has Been Providing the Type of Services Specified in the RFP	30 years
Number of Employees Providing the Type of Services Specified in the RFP	150
Headquarters in the United States	Irving, TX
Locations in the United States	Forest Park, G, Troy, MI, Irving, TX, El Paso, TX, London, KY

Exhibit 3-5 Table 8: Subcontractor Overview
Aptara-iEnergizer.

Subcontractor Overview	
Company Name	Aptara-iEnergizer
Name of Parent Company (If Applicable)	iEnergizer Limited
Industry North American Industry Classification System (NAICS)	SIC Code 73,737. NAICS Code 541512, 323111
Type of Legal Entity	C-type corporation
Company Ownership (e.g., Private/Public, Joint Venture)	Public
Number of Full-Time Employees	13,800
Last Fiscal Year Company Revenue	$177,100,000
Last Fiscal Year Company Net Income	$45,022,168
% of Revenue From State and Local Government Clients in the United States	N/A
Number of Years in Business	32
Number of Years Vendor Has Been Providing the Type of Services Specified in the RFP	20 yrs.
Number of Employees Providing the Type of Services Specified in the RFP	3,500 (for HMS only, 250)
Headquarters in the United States	Falls Church, VA
Locations in the United States	Austin, TX

Exhibit 3-6 Table 8: Subcontractor Overview
LexiCode (an Exela Technologies wholly owned subsidiary).

Subcontractor Overview	
Company Name	LexiCode (an Exela Technologies company)
Name of Parent Company (If Applicable)	SourceHOV
Industry North American Industry Classification System (NAICS)	SIC Code 80. NAICS Code 5416,541
Type of Legal Entity	Limited Liability Company (LLC)
Company Ownership (e.g., Private/Public, Joint Venture)	Public
Number of Full-Time Employees	20699
Last Fiscal Year Company Revenue	$1,562,337
Last Fiscal Year Company Net Income	$508,780
% of Revenue From State and Local Government Clients in the United States	8%
Number of Years in Business	30 years
Number of Years Vendor Has Been Providing the Type of Services Specified in the RFP	30 years
Number of Employees Providing the Type of Services Specified in the RFP	35
Headquarters in the United States	Irving, TX
Locations in the United States	Columbia, SC

3.2 MANDATORY QUALIFICATIONS (ATT 3, SECT. 2)

HMS understands that we must meet mandatory minimum experience qualifications for this RFP and demonstrate this experience by completing the information in this section provided in **Exhibit 3-7**.

3.2.1 MANDATORY QUALIFICATIONS TABLE (ATT 3, SECT. 2.1)

HMS entered the TPL market in 1985. We have been providing TPL services to state Medicaid agencies without interruption for the past 35 years (**Exhibit 3-8**), including our experience performing these specific services for BMS for the past 26 years.

Exhibit 3-7 Table 9: Mandatory Qualifications
HMS affirms we meet the mandatory qualifications through our 35+ years of TPL project experience for state Medicaid agency clients.

Mandatory Qualification Item(s)	Provide a Brief Narrative to Demonstrate Fulfillment of Requirement
The Vendor must have a minimum of three (3) years of experience with Third-Party Liability (TPL) work in a health insurance field.	HMS affirms we meet the minimum experience requirement of a minimum of three years of experience providing TPL services in a health insurance field. To demonstrate this experience requirement, we refer BMS to Exhibit 3-8 below, which includes a sample list of our state Medicaid agency clients for TPL Services, along with number of years we have been providing the specific TPL services to benefit their public health programs.
The Vendor must document a minimum of three years of experience of successful recoveries working with a State Medicaid Agency or a minimum of four years of experience with recoveries in the health Insurance field or with a health insurance organization.	HMS affirms we meet the minimum experience requirement of three years of experience of successful recoveries with a Medicaid Agency, and we also meet the minimum of four years of experience performing recoveries in the health insurance field To demonstrate this experience requirement, we refer BMS to Exhibit 3-8 below, which includes a sample list of our state Medicaid agency clients along with the number of years we have been providing TPL Services to each client, including recoveries.

Exhibit 3-8 HMS' Current State Government Agency Clients

HMS has performed TPL insurance matching and recoupment services continuously for state government Medicaid agencies with public health programs for 35 years.

State	Entity	TPL Services Activities									
		# of Years of Service	Data Match	Cost Avoidance	Post Payment Recovery/ Health Insurance Billing and Recovery	COB Web Portal	Estate Recovery	Casualty-Trauma Recovery	Credit Balance Audits	Premium Reimbursement Program (HIPP)	Program Integrity (Incl RAC Services)
AK	Alaska Department of Health and Social Services	21 years	✓	✓	✓	✓		✓		✓	
AL	Alabama Medicaid Agency	16 years	✓	✓	✓	✓		✓	✓	✓	
AR	Arkansas Department of Human Services	26 years	✓	✓	✓	✓		✓	✓	✓	
AZ	Arizona Health Care Cost Containment System	28 years	✓	✓	✓	✓	✓	✓	✓		✓
CA	California Department of Health Services	22 years	✓	✓	✓	✓			✓		
CA	California Department of Public Health (ADAP – as a sub to Magellan)	1 years	✓		✓						
CO	Colorado Department of Health Care Policy/Financing	25 years	✓	✓	✓	✓	✓	✓	✓	✓	✓
CT	Connecticut Department of Social Services	28 years	✓	✓	✓	✓		✓	✓		✓
DC	District of Columbia - Department of Health Care Finance	22 years	✓	✓	✓				✓		
FL	Florida Agency for Healthcare Administration	27 years	✓	✓	✓		✓	✓	✓	✓	✓
GA	Georgia Department of Public Health (including ADAP)	5 years	✓		✓			✓	✓		
GA	Georgia Department of Community Health	24 years	✓	✓	✓	✓	✓			✓	
HI	Hawaii Department of Human Services	5 years	✓	✓							
ID	Idaho Department of Health and Welfare	14 years	✓	✓	✓	✓		✓			
IL	Illinois Department of Healthcare and Family Services	8 years							✓		✓
IA	Iowa Department of Human Services	15 years	✓	✓	✓	✓	✓	✓	✓		

State	Entity	TPL Services Activities									
		# of Years of Service	Data Match	Cost Avoidance	Post Payment Recovery/ Health Insurance Billing and Recovery	COB Web Portal	Estate Recovery	Casualty-Trauma Recovery	Credit Balance Audits	Premium Reimbursement Program (HIPP)	Program Integrity (Incl RAC Services)
IN	Indiana Department of Family EDS (Sub)	12 years	✓	✓	✓	✓					
KS	Kansas Department of Health & Environment	13 years					✓	✓			
KS	Kansas Department of Health & Environment – Gainwell (Sub)	13 years	✓	✓	✓						
LA	Louisiana Department of Health and Hospitals	35 years	✓	✓	✓	✓	✓		✓		
MA	Executive Office of Health and Human Services	29 years	✓	✓	✓					✓	
MD	Maryland Department of Health & Mental Hygiene	7 years	✓	✓	✓	✓		✓	✓		
ME	Department of Health and Human Services	10 years							✓		
MN	Minnesota Department of Human Services	11 years	✓	✓	✓						
MO	Missouri Department of Social Services	22 years	✓	✓	✓	✓			✓		
MS	Mississippi Division of Medicaid	11 years	✓	✓	✓	✓	✓	✓	✓		
NJ	New Jersey Department of Human Services	32 years	✓	✓	✓	✓		✓	✓		
NM	New Mexico Human Services Department	9 years	✓	✓	✓	✓	✓	✓	✓		✓
NV	Nevada Department of Health and Human Services	16 years	✓	✓	✓	✓		✓	✓	✓	✓
NY	New York Office of the Medicaid Inspector General	25 years	✓	✓	✓	✓	✓	✓	✓		✓
NC	North Carolina Department of Health and Human Services	25 years	✓	✓	✓	✓	✓	✓	✓	✓	✓
OH	Ohio Department of Medicaid	21 years	✓	✓	✓	✓		✓			
OK	Oklahoma Health Care Authority	17 years	✓	✓	✓	✓					
OR	Oregon Department of Human Services	9 years									✓
PA	Pennsylvania Department of Human Services	8 years	✓	✓	✓	✓		✓			

State	Entity	TPL Services Activities									
		# of Years of Service	Data Match	Cost Avoidance	Post Payment Recovery/ Health Insurance Billing and Recovery	COB Web Portal	Estate Recovery	Casualty-Trauma Recovery	Credit Balance Audits	Premium Reimbursement Program (HIPP)	Program Integrity (Incl RAC Services)
PA	Pennsylvania Department of Aging	9 years	✓	✓	✓	✓					
PA	Pennsylvania Department of Aging, PACE (ADAP – Sub to Magellan)	15 years	✓	✓	✓	✓					
RI	Department of Human Services – Sub to Gainwell Technologies	16 years		✓							
SC	Department of Health and Human Services	New									✓
SD	South Dakota Department of Social Services	14 years	✓	✓	✓						
TN	State of Tennessee (TennCare)	14 years	✓	✓	✓		✓	✓			
TX	Texas Health and Human Services* (ADAP, RAC, Estate Recovery) *TX HHSC – scope of work changed agencies within TX but is currently under HHSC	7 years	✓	✓	✓		✓				✓
UT	Utah Department of Health	10 years									✓
VA	Virginia Department of Medical Assistance Services	21 years	✓	✓	✓	✓					
WI	Department of Health Services	7 years						✓			
WI	Department of Health Services, Office of Inspector General	6 years							✓		✓
WI	Department of Health Services – Gainwell Technologies (Sub)	10 years	✓	✓	✓						
WV	West Virginia Bureau for Medical Services	26 years	✓	✓	✓	✓	✓	✓	✓	✓	
WY	Wyoming Department of Health	New	✓	✓	✓	✓	✓	✓	✓	✓	

3.3.1 EXISTING BUSINESS RELATIONSHIPS WITH THE STATE (ATT 3, SECT. 3.1)

HMS is currently contracted with the State of West Virginia Department of Health and Human Resources Bureau for Medical Services. We have been in a business relationship with the state for over 26 years, beginning in 1994. HMS has no other contracts with the State, the State's counties, and/or the State's local municipalities.

3.4.1 BUSINESS DISPUTES (ATT 3, SECT. 4.1)

Since January 1, 2016, HMS has received notice of nine administrative charges filed with State and/or Federal EEO agencies by current or former employees asserting discrimination allegations against HMS. HMS was not judged guilty or liable with regard to any of the foregoing administrative charges.

HMS has had no contracts terminated for cause. The following contracts have been terminated for convenience over the past five (5) years:

- HealthPlus of Michigan terminated its contract for convenience effective August 31, 2015 due to State insourcing of TPL services.
- Partnership HealthPlan of California terminated its contract for convenience effective June 30, 2016. No reason was provided.
- Hewlett Packard Enterprises (HPE) terminated its subcontract with HMS for convenience effective December 31, 2016, after Delaware's Division of Medicaid and Medical Assistance terminated its prime contract with HPE.
- Seattle Children's Hospital terminated its contract for convenience for dependent eligibility services effective January 1, 2018, for budgetary reasons.
- CHRISTUS Health Plan terminated its contract for convenience effective March 18, 2018 after exiting the STAR/CHIP market.
- Denver Health Medical Plan terminated its contract for convenience effective January 25, 2020. No reason was provided.
- Michigan Department of Health and Human Services terminated its contract effective November 30, 2020 due to state insourcing of the contract scope of work.

3.5 REFERENCES (ATT 3, SECT. 5)

Below we provide the requested three current clients for which we actively provide Third Party Liability (TPL) and services that include at least three different client references from projects performed within the last three years that demonstrate HMS' ability to perform the scope of work described in this RFP. Each of these Medicaid agencies can attest to our:

- Understanding of and experience performing comprehensive TPL services for government-administered healthcare programs
- In-depth knowledge of the TPL industry and specific state Medicaid programs
- Application of a national payment accuracy perspective and best practices
- Effective recovery and cost savings programs
- Established, proven RAC services and program integrity expertise
- Experienced and successful estate recovery and casualty recovery vendor
- Dedicated and knowledgeable team members
- Commitment to comply with HIPAA and other security and privacy regulations
- Ability to provide secure, data-driven technology solutions
- Ability to deliver accurate, timely and calculable data
- Exceptional customer service
- Initiative in working with clients to develop and enhance services

We welcome BMS' review of the completed reference questionnaires to the State by our client references in **Exhibits 3-9 through 3-12.**

Exhibit 3-9 Table 10: Vendor References

Reference 1: New Mexico Human Services Department (NMHSD)

Vendor Information				
Vendor Name: HMS	Contact Name:	Melissa Rhoades		
	Contact Phone:	214.490.2952		
Customer Information				
Customer Organization: New Mexico Human Services Department (NMHSD)	Contact Name:	Erica Leyba		
	Contact Title:	TPL RAC Contract Manager		
Customer Address: 1 Plaza La Prensa Santa Fe, NM 87507	Contact Phone:	505.827.7743		
	Contact Email:	Erica.leyba@state.nm.us		
Project Information				
Total Vendor Staff:	38			
Project Objectives: To identify overpayments where Medicaid inadvertently paid while a client had a primary insurance.				
Project Description: HMS will data match the eligibility records submitted by NMHSD to its data base of known "other insurance" coverage records. HMS will validate those results and data match to confirm the most current and accurate information. For the Casualty Program, HMS is in contact with attorneys and insurance companies who notify them (and sometimes myself) about a client who had a personal injury or car accident where Medicaid paid for the clients services on the date of loss, and the insurance company or the attorney wants to reimburse Medicaid.				
Vendor's Involvement: HMS is the Medical Assistance, Human Services Department TPL and RAC Contractor.				
Project Benefits: Significant recoveries coming back to NMHSD, regarding overpayments where Medicaid paid primary, but the client's primary insurance should have paid.				
Key Personnel				
Name: Melissa Rhoades	Role: Contract Manager			
Name: Cristhian Bermudez	Role: Program Director			
Project Measurements				
Estimated one-time costs: $431,050	Actual one-time costs:	$547,690		
Reason(s) for change in one-time cost: NMHSD requested an implementation of our FraudCapture™ solution using two different data sources to assist in the migration from the existing MMIS to the new Enterprise Service Bus.				
Original Value of Vendor's Contract: $29,637,373 (Estimated due to contract is based on contingency fee of recoveries)	Actual Total Contract Value: $29,754,013 (Estimated due to contract is based on contingency fee of recoveries)			
Reason(s) for change in value: Additional one-time cost associated with the second data source for FraudCapture as described above.				
Estimated Start & Completion Dates:	From:	1/1/2020	To:	12/31/2023
Actual Start & Completion Dates:	From:	11/4/2019	To:	11/3/2024
Reason(s) for difference between Estimated and Actual dates: The contract was executed sooner than expected. HMS was previously contracted through mid-December 2019; however, the new contract was initiated in November 2019 so work under the new contract began early. In addition, a year was added to the base contract due NMHSD System's Integrator contract being delayed and canceled.				
If the Vendor performed the work as a Subcontractor, the Vendor should describe the scope of subcontracted activities: N/A				

Exhibit 3-10 Table 10: Vendor References

Reference 2: NY Office of the Medicaid Inspector General (NY OMIG)

Vendor Information		
Vendor Name: Health Management Systems, Inc.	Contact Name:	Joseph P. Cunningham
	Contact Phone:	518.724.7839
Customer Information		
Customer Organization: NY Office of the Medicaid Inspector General (NY OMIG)	Contact Name:	Debra L. Hathaway
	Contact Title:	Director, Bureau of Third Party and Payment Oversight
Customer Address: 800 North Pearl Street Albany, NY 12204	Contact Phone:	518.474.2669
	Contact Email:	Debra.Hathaway@omig.ny.gov
Project Information		
Total Vendor Staff:	115	
Project Objectives: Identify, verify, and recover Medicaid overpayments from liable Third Parties for cost savings and recovery purposes. The goal is to help ensure that Medicaid costs are paid by appropriate liable third parties as well as to recover on paid Medicaid claims for which TPL was not known or available at the time of Medicaid payment.		
Project Description: Perform the project modules listed below for the OMIG with minimal impact on State staff and resources: (i) Module 1 – Prepayment Insurance Verification; (ii) Module 2 – Third Party Retroactive Recovery Projects; and, (iii) Module 3 – Estate and Casualty Recoveries		
Vendor's Involvement: Perform all project modules accomplishing the following: (i) develop a Prepayment Verification plan that includes the specific functions for identifying, verifying, and loading new insurance coverage to MMIS; (ii) develop a Third Party Retroactive Recovery Project that includes specific functions for direct billing carriers, conducting provider reviews, and Medicaid managed care recoveries; and, (iii) develop a plan for estate and casualty recoveries for the OMIG as well as develop a case management system.		
Project Benefits: Maximizing recoveries and cost savings and minimizing expenditures for New York Medicaid to make sure Medicaid is the payor of last resort and return dollars back to the State's program.		
Key Personnel		
Name: Michael Samal	Role: Project Manager Module 1	
Name: Alayna Bochenek	Role: Project Manager Module 2	
Name: Meena Hanna	Role: Project Manager Module 3	
Name: Joseph Cunningham	Role: Project Director	
Project Measurements		
Estimated one-time costs: N/A	Actual one-time costs:	N/A
Reason(s) for change in one-time cost: N/A		
Original Value of Vendor's Contract: $108,787,500.00	Actual Total Contract Value: $140,000,000.00	
Reason(s) for change in value: Increase in recoveries and identified insurance policies resulting in exhaustion of original contract value before end of term.		

Estimated Start & Completion Dates:	From:	4/7/2016	To:	4/6/2021
Actual Start & Completion Dates:	From:	4/7/2016	To:	4/6/2021

Reason(s) for difference between Estimated and Actual dates: N/A

If the Vendor performed the work as a Subcontractor, the Vendor should describe the scope of subcontracted activities: N/A

Exhibit 3-11 Table 10: Vendor References

Reference 3: State of Florida, Agency for Health Care Administration.

Vendor Information		
Vendor Name: Health Management Systems	Contact Name:	Melissa DuBois
	Contact Phone:	469.282.2421
Customer Information		
Customer Organization: State of Florida, Agency for Health Care Administration	Contact Name:	Dan Gabric
	Contact Title:	TPL Administrator
Customer Address: 2727 Mahan Drive, Tallahassee, Florida, 32308	Contact Phone:	850.412.4137
	Contact Email:	dan.gabric@ahca.myflorida.com
Project Information		
Total Vendor Staff:	60	
Project Objectives: Operate the Florida TPL Program and conduct other recovery projects in accordance with Federal and State laws. This includes identifying and recovering from all available liable third parties.		
Project Description: The scope of services for the customer consists of seven (7) components: Casualty Recovery, Estate Recovery, Trust and Annuity Recovery, Medicare and Other Third Party Payor Recovery, Cost Avoidance, Health Insurance Premium Program (HIPP); and Other Recovery Projects.		
Vendor's Involvement: HMS conducts subrogation and recovery services which include data mining, audits, provider relations and outreach, customer service hotline, vendor case tracking systems, web portal, and case management.		
Project Benefits: As a result of this contract the State of Florida, Agency for Health Care Administration was able to recover $446,469,724 through our various services during September 2015 to September 2020.		
Key Personnel		
Name: Melissa DuBois	Role: Contract Manager	
Name: Ami Vega	Role: Accounting Manager	
Name: John Cofield	Role: Casualty Manager	
Name: Angel Noble	Role: Estate and Trust and Annuity Manager	
Name: Larry Foster	Role: Medicare and Other Third Party Manager	
Name: Wilma Ramos	Role: Quality Assurance Manager	
Name: Waddy Thompson	Role: Other Recovery Projects Manager	
Name: Grady Williams	Role: Information Technology (IT) Manager	
Name: Alex Boler	Role: Casualty Attorney	
Name: James Bruner	Role: Estate and Trust Attorney	
Project Measurements		
Estimated one-time costs: N/A	Actual one-time costs:	N/A
Reason(s) for change in one-time cost: N/A		
Original Value of Vendor's Contract: Per the contract HMS was not to exceed $50,000.000.00. Per the renewal contract HMS is not to exceed $100,000,000.00.	Actual Total Contract Value: As of September 2020, the contract value is $36,824,459.45	
Reason(s) for change in value: The original contract from September 1,2015 to August 31, 2020 could not exceed $50,000,000 for the scope of services. When the contract renewed in March 2020 the contract amount was increased. The current contract from September 1, 2015 to August 31, 2025 cannot exceed $100,000,000 for the scope of services. Since this is a contingency fee contract based on recoveries and the Vendor is still midterm on contract, the actual value is less than expected original value.		

Estimated Start & Completion Dates:	From:	9/1/2015	To:	8/31/2020
Actual Start & Completion Dates:	From:	9/1/2015	To:	8/31/2020

Reason(s) for difference between Estimated and Actual dates: The term of the original State of Florida, Agency for Health Care Administration contract with HMS was a 5-year contract with a possibility to renew at the end of the contract term. In March 2020, both parties agreed to exercise the first renewal option for a period of 5years beginning September 1, 2020. The new contract term is September 1, 2015 to August 31, 2025.

If the Vendor performed the work as a Subcontractor, the vendor should describe the scope of subcontracted activities: N/A

Exhibit 3-12 Table 10: Vendor References

Reference 4: North Carolina Department of Health and Human Services

Vendor Information		
Vendor Name: HMS	Contact Name:	Bryan Dente
	Contact Phone:	919.714.8492
Customer Information		
Customer Organization: North Carolina Department of Health and Human Services	Contact Name:	Pratrice Partee
	Contact Title:	Third Party Recovery Chief
Customer Address:	Contact Phone:	919.527.7695
	Contact Email:	Pratrice.Partee@dhhs.nc.gov
Project Information		
Total Vendor Staff:	23 staff in the Raleigh local office (Subrogation, TPR, Project Management)	

Project Objectives: The Vendor supplements the efforts of the Division and maximize Third Party Liability initiatives by providing the following services:

a) Identification of third parties who bear responsibility for healthcare payments on behalf of Medicaid recipients;
b) Automated data matching with health insurance carrier files to identify those recipients with an active insurance policy;
c) Automated uploading of data-matches and voice-verified third party insurance policy information into NCTracks;
d) Post-payment recovery of overpayments to providers and direct billing of insurance carriers;
e) Casualty/subrogation recovery;
f) Estate recovery and case management of special needs trusts; and
g) Customer service functions with access by telephone, fax and email.

Project Description: Provide Third Party Liability (TPL) recovery, data matching for cost avoidance, and credit balance audit services for the North Carolina Medicaid and Health Choice (NCHC) programs.

Vendor's Involvement: Vendor performs all items identified in project objectives listed above.

Project Benefits: The project recovers $90M dollars annually and saves the state an additional $1B annually.

Key Personnel	
Name: Bryan Dente	Role: Program Director
Name: Kenya Jones	Role: Subrogation/Estate Recovery Supervisor

Project Measurements				
Estimated one-time costs: $0.00	Actual one-time costs:	$0.00		
Reason(s) for change in one-time cost: N/A				
Original Value of Vendor's Contract: $28,268,553	Actual Total Contract Value: $87,028,290			
Reason(s) for change in value: The contract was initially for 3 years with 2 one-year options. The original contract value was for the original base period. We received an extension for the 2 one-year option periods and an additional one-year option. The actual's include contract to date with the addition of the remainder of the contract forecast.				
Estimated Start & Completion Dates:	From:	12/22/2014	To:	12/22/2017
Actual Start & Completion Dates:	From:	12/22/2014	To:	12/22/2021
Reason(s) for difference between Estimated and Actual dates: The contract was for an original three-year base period. The contract was extended 3 additional years at the conclusion of the original base period.				
If the Vendor performed the work as a Subcontractor, the Vendor should describe the scope of subcontracted activities: N/A				

3.6 SUBCONTRACTOR REFERENCES (ATT 3, SECT. 6)

As already noted, HMS does not rely on subcontractors or vendors to complete our core processes. We do enlist the services of carefully selected, narrow-scope administrative subcontractors to provide our clients with high-quality, competitively priced services. We continually seek opportunities to provide the optimal solutions for our clients—ones that provide the highest return possible with minimal impact to current operations. We have long-standing relationships with our proposed subcontractors Exela (and its wholly owned subsidiary LexiCode) and Aptara-iEnergizer. Both subcontractors regularly support the TPL services listed in our HMS client list in **Exhibit 3-8** above.

As requested, in **Exhibits 3-13 and 3-14** we provide three references for each subcontractor entity. As the same past performance references provided in proposal **Section 5** above for HMS, each of the three references represents a project where HMS and the subcontractors worked together on providing TPL services.

Exhibit 3-13 Table 11: Subcontractor Reference #1 – State of Florida, Agency for Health Care Administration

Exela currently provides administrative services on behalf of HMS (Prime) for the State of Florida TPL Contract

Subcontractor Information		
Vendor Name: Exela Technologies, Inc. (and wholly owned subsidiary, LexiCode)	Contact Name:	Anthony Ramith
	Contact Phone:	1.844.935.2832
Customer Information		
Customer Organization: State of Florida, Agency for Health Care Administration *Note: HMS is the customer of record for this work; Exela provides administrative services on behalf of HMS for the State of Florida TPL contract.	Contact Name:	Dan Gabric
	Contact Title:	TPL Administrator
Customer Address: 2727 Mahan Drive, Tallahassee, Florida, 32308	Contact Phone:	850.412.4137
	Contact Email:	Dan.gabric@ahca.myflorida.com
Project Information		
Total Vendor Staff:	N/A	
Project Objectives: For HMS to operate the Florida TPL Program and conduct other recovery projects in accordance with Federal and state laws. This includes identifying and recovering from all available liable third parties.		
Project Description: The scope of services for the client consists of seven components: Casualty Recovery, Estate Recovery, Trust and Annuity Recovery, Medicare and Other Third Party Payor Recovery, Cost Avoidance, Health Insurance Premium Program (HIPP); and Other Recovery Projects.		
Vendor's Involvement: Exela/Lexicode conducts administrative tasks, listed further below, on behalf of HMS to support the TPL scope of work on the Florida TPL contract.		
Project Benefits: As a result of this contract the State of Florida, Agency for Health Care Administration was able to recover $446,469,724 through our various services during September 2015 to September 2020.		
Key Personnel		
Name: Anthony Ramith	Role: Project Lead, currently leading a team of CRMs on the contracted work and serving as the central point of contact for HMS	
Project Measurements:		
Estimated one-time costs: N/A	Actual one-time costs: N/A	
Reason(s) for change in one-time cost: N/A		
Original Value of Vendor's Contract: See below	Actual Total Contract Value: See below	
Reason(s) for change in value: HMS has proprietary tiered transaction pricing with our administrative subcontractors, which have both quality and turnaround time service levels that apply.		

Estimated Start & Completion Dates:	From:	9/1/2015	To:	8/31/2020
Actual Start & Completion Dates:	From:	9/1/2015	To:	8/31/2020

Reason(s) for difference between Estimated and Actual dates: The term of the original State of Florida, Agency for Health Care Administration contract with HMS was a 5-year contract with a possibility to renew at the end of the contract term. In March 2020, both parties agreed to exercise the first renewal option for a period of 5 years beginning September 1, 2020. The new contract term is September 1, 2015 to August 31, 2025. At present, Exela continues to provide these services on behalf of HMS, to support the Florida TPL contract.

If the Vendor performed the work as a Subcontractor, the Vendor should describe the scope of subcontracted activities: Exela provides keypunch and payment posting services for many of our TPL services contracts. For the Florida project, Exela is performing keypunch of check and remittance advice data; scanning, indexing, and storage of check, remittance advices, and correspondence information. Exela has been a highly successful HMS subcontractor for more than 20 years.

Exhibit 3-13 Table 11: Subcontractor Reference #2 – North Carolina Dept. of Health and Human Services
Exela currently provides administrative services on behalf of HMS (Prime) for the North Carolina TPL contract

Subcontractor Information		
Vendor Name: Exela (and LexiCode)	Contact Name:	Anthony Ramith
	Contact Phone:	1.844.935.2832
Customer Information		
Customer Organization: North Carolina Department of Health and Human Services *Note: HMS is the customer of record for this work; Exela provides administrative services on behalf of HMS for the State of North Carolina TPL contract.	Contact Name:	Pratrice Partee
	Contact Title:	Third Party Recovery Chief
Customer Address: 2508 Mail Service Center, Raleigh, NC 27699	Contact Phone:	919.527.7695
	Contact Email:	Pratrice.Partee@dhhs.nc.gov

Project Information	
Total Vendor Staff:	N/A

Project Objectives: The HMS supplements the efforts of the Division and maximize Third Party Liability initiatives by providing the following services:
a) Identification of third parties who bear responsibility for health care payments on behalf of Medicaid recipients;
b) Automated data matching with health insurance carrier files to identify those recipients with an active insurance policy;
c) Automated uploading of data-matches and voice-verified third party insurance policy information into NCTracks;
d) Post-payment recovery of overpayments to providers and direct billing of insurance carriers;
e) Casualty/subrogation recovery;
f) Estate recovery and case management of special needs trusts; and
g) Customer service functions with access by telephone, fax and email.

Project Description: Provide Third Party Liability (TPL) recovery, data matching for cost avoidance, and credit balance audit services for the North Carolina Medicaid and Health Choice (NCHC) programs.

Vendor's Involvement: Exela/Lexicode conducts administrative tasks, listed further below, on behalf of HMS to support the TPL scope of work on the North Carolina TPL contract.

Project Benefits: The project recoveries are $90 million annually and saves the State an additional $1 billion annually.

Key Personnel	
Name: Anthony Ramith	Role: Project Lead, currently leading a team of CRMs on the contracted work and serving as the central point of contact for HMS

Project Measurements:				
Estimated one-time costs: N/A	Actual one-time costs: N/A			
Reason(s) for change in one-time cost: N/A				
Original Value of Vendor's Contract: See below	Actual Total Contract Value: See below			
Reason(s) for change in value: HMS has proprietary tiered transaction pricing with our administrative subcontractors, which have both quality and turnaround time service levels that apply.				
Estimated Start & Completion Dates:	From:	12/22/2014	To:	12/22/2017
Actual Start & Completion Dates:	From:	12/22/2014	To:	12/22/2021

Reason(s) for difference between Estimated and Actual dates: The project's contract was for an original three-year base period. The contract was extended 3 additional years at the conclusion of the original base period. At present, Exela continues to provide these services on behalf of HMS, to support the North Carolina TPL contract.

If the Vendor performed the work as a Subcontractor, the Vendor should describe the scope of subcontracted activities: Exela provides keypunch and payment posting services for many of our TPL services contracts. For the North Carolina project, Exela is performing keypunch of check and remittance advice data; scanning, indexing, and storage of check, remittance advices, and correspondence information. Exela has been a highly successful HMS subcontractor for more than 20 years.

Exhibit 3-13 Table 11: Subcontractor Reference #3 – New Mexico Human Services Department (NMHSD)
Exela currently provides administrative services on behalf of HMS (Prime) for the New Mexico TPL contract

Subcontractor Information		
Vendor Name: Exela (and LexiCode)	Contact Name:	Anthony Ramith
	Contact Phone:	1.844.935.2832
Customer Information		
Customer Organization: New Mexico Human Services Department (NMHSD) *Note: HMS is the customer of record for this work; Exela provides administrative services on behalf of HMS for the State of New Mexico TPL contract.	Contact Name:	Erica Leyba
	Contact Title:	TPL RAC Contract Manager
Customer Address: 1 Plaza La Prensa, Santa Fe, NM 87507	Contact Phone:	505.827.7743
	Contact Email:	Erica.leyba@state.nm.us
Project Information		
Total Vendor Staff:	N/A	
Project Objectives: To identify overpayments where Medicaid inadvertently paid while a client had primary insurance.		
Project Description: HMS will data match the eligibility records submitted by NMHSD to its data base of known "other insurance" coverage records. HMS will validate those results and data match to confirm the most current and accurate information. For the Casualty Program, HMS is in contact with attorneys and insurance companies who notify them (and sometimes myself) about a client who had a personal injury or car accident where Medicaid paid for the client's services on the date of loss, and the insurance company or the attorney wants to reimburse Medicaid.		
Vendor's Involvement: Exela/Lexicode conducts administrative tasks, listed further below, on behalf of HMS to support the TPL scope of work on the New Mexico TPL contract.		
Project Benefits: Significant recoveries coming back to NMHSD, regarding overpayments where Medicaid paid primary, but the client's primary insurance should have paid.		
Key Personnel		
Name: Anthony Ramith	Role: Project Lead, currently leading a team of CRMs on the contracted work and serving as the central point of contact for HMS	
Project Measurements:		
Estimated one-time costs: N/A	Actual one-time costs: N/A	
Reason(s) for change in one-time cost: N/A		
Original Value of Vendor's Contract: See below	Actual Total Contract Value: See below	
Reason(s) for change in value: HMS has proprietary tiered transaction pricing with our administrative subcontractors, which have both quality and turnaround time service levels that apply.		
Estimated Start & Completion Dates:	From: 1/1/2020	To: 12/31/2023
Actual Start & Completion Dates:	From: 11/4/2019	To: 11/3/2024
Reason(s) for difference between Estimated and Actual dates: The contract was executed sooner than expected. HMS was previously contracted through mid-December 2019; however, the new contract was initiated in November 2019 so work under the new contract began early. In addition, a year was added to the base contract due NMHSD System's Integrator contract being delayed and canceled. At present, Exela continues to provide these services on behalf of HMS, to support the New Mexico TPL contract.		
If the Vendor performed the work as a Subcontractor, the Vendor should describe the scope of subcontracted activities: Exela provides keypunch and payment posting services for many of our TPL services contracts. For the New Mexico project, Exela is performing keypunch of check and remittance advice data; scanning, indexing, and storage of check, remittance advices, and correspondence information. Exela has been a highly successful HMS subcontractor for more than 20 years,		

Exhibit 3-14 Table 11: Subcontractor Reference #1 – State of Florida, Agency for Health Care Administration

Aptara-iEnergizer currently provides services on behalf of HMS (Prime) for the State of Florida TPL contract

Subcontractor Information		
Vendor Name: Aptara-iEnergizer	Contact Name:	J Mohanakrishnan
	Contact Phone:	512.876.5997
Customer Information		
Customer Organization: State of Florida, Agency for Health Care Administration *Note: HMS is the customer of record for this work; Aptara-iEnergizer provides administrative services on behalf of HMS for the State of Florida TPL contract.	Contact Name:	Dan Gabric
	Contact Title:	TPL Administrator
Customer Address: 2727 Mahan Drive, Tallahassee, Florida 32308	Contact Phone:	850.412.4137
	Contact Email:	Dan.gabric@ahca.myflorida.com
Project Information		
Total Vendor Staff:	N/A	
Project Objectives: The goal of this contract is for HMS to operate the Florida TPL Program and conduct other recovery projects in accordance with Federal and State laws. This includes identifying and recovering from all available liable third parties.		
Project Description: The scope of services for the client consists of seven components: Casualty Recovery, Estate Recovery, Trust and Annuity Recovery, Medicare and Other Third Party Payor Recovery, Cost Avoidance, Health Insurance Premium Program (HIPP); and Other Recovery Projects.		
Vendor's Involvement: Aptara-iEnergizer conducts administrative tasks, listed further below, on behalf of HMS to support the TPL scope of work on the Florida TPL contract.		
Project Benefits: At a result of this contract the State of Florida, Agency for Health Care Administration was able to recover $446,469,724 through our various services during September 2015 to September 2020.		
Key Personnel		
Name: J Mohanakrishnan	Role: Senior Manager, currently directs and manages the operations teams working for HMS; serves as main point of contact for HMS.	
Project Measurements:		
Estimated one-time costs: N/A	Actual one-time costs: N/A	
Reason(s) for change in one-time cost: N/A		
Original Value of Vendor's Contract: See below	Actual Total Contract Value: See below	
Reason(s) for change in value: HMS has proprietary tiered transaction pricing with our administrative subcontractors, which have both quality and turnaround time service levels that apply.		
Estimated Start & Completion Dates:	From: 9/1/2015	To: 8/31/2020
Actual Start & Completion Dates:	From: 9/1/2015	To: 8/31/2020
Reason(s) for difference between Estimated and Actual dates: The term of the original State of Florida, Agency for Health Care Administration contract with HMS was a five-year contract with a possibility to renew at the end of the contract term. On March 2020, both parties agreed to exercise the first renewal option for a period of five (5) years beginning September 1, 2020. Therefore, the new contract term is September 1, 2015 to August 31, 2025. At present, Aptara-iEnergizer continues to provide these services on behalf of HMS, to support the Florida TPL contract.		
If the Vendor performed the work as a Subcontractor, the Vendor should describe the scope of subcontracted activities: For the Florida project, Aptara-iEnergizer performs voice and non-voice insurance policy eligibility verifications for cost avoidance through eCare. Aptara-iEnergizer has been a highly successful HMS subcontractor for more than 20 years.		

Exhibit 3-14 Table 11: Subcontractor Reference #2 – North Carolina Dept. of Health and Human Services
Aptara-iEnergizer currently provides administrative services on behalf of HMS (Prime) for the North Carolina TPL contract

Subcontractor Information		
Vendor Name: Aptara-iEnergizer	Contact Name:	J Mohanakrishnan
	Contact Phone:	512.876.5997
Customer Information		
Customer Organization: North Carolina Department of Health and Human Services *Note: HMS is the customer of record for this work; Aptara-iEnergizer provides administrative services on behalf of HMS for the State of Florida TPL contract.	Contact Name:	Pratrice Partee
	Contact Title:	Third Party Recovery Chief
Customer Address: 2508 Mail Service Center, Raleigh, NC 27699	Contact Phone:	919.527.7695
	Contact Email:	Pratrice.Partee@dhhs.nc.gov

Project Information	
Total Vendor Staff:	N/A

Project Objectives: The HMS supplements the efforts of the Division and maximize Third Party Liability initiatives by providing the following services:
a) Identification of third parties who bear responsibility for healthcare payments on behalf of Medicaid recipients;
b) Automated data matching with health insurance carrier files to identify those recipients with an active insurance policy;
c) Automated uploading of data-matches and voice-verified third party insurance policy information into NCTracks;
d) Post-payment recovery of overpayments to providers and direct billing of insurance carriers;
e) Casualty/subrogation recovery;
f) Estate recovery and case management of special needs trusts; and
g) Customer service functions with access by telephone, fax and email.

Project Description: Provide Third Party Liability (TPL) recovery, data matching for cost avoidance, and credit balance audit services for the North Carolina Medicaid and Health Choice (NCHC) programs.

Vendor's Involvement: Aptara-iEnergizer conducts administrative tasks, listed further below, on behalf of HMS to support the TPL scope of work on the North Carolina TPL contract.

Project Benefits: The project recoveries are $90 million annually and saves the State an additional $1 billion annually

Key Personnel	
Name: J Mohanakrishnan	Role: Senior Manager, currently directs and manages the operations teams working for HMS; serves as main point of contact for HMS.

Project Measurements:				
Estimated one-time costs: N/A	Actual one-time costs: N/A			
Reason(s) for change in one-time cost: N/A				
Original Value of Vendor's Contract: See below	Actual Total Contract Value: See below			
Reason(s) for change in value: HMS has proprietary tiered transaction pricing with our administrative subcontractors, which have both quality and turnaround time service levels that apply.				
Estimated Start & Completion Dates:	From:	12/22/2014	To:	12/22/2017
Actual Start & Completion Dates:	From:	12/22/2014	To:	12/22/2021

Reason(s) for difference between Estimated and Actual dates: The project's contract was for an original three-year base period. The contract was extended 3 additional years at the conclusion of the original base period. At present, Aptara-iEnergizer continues to provide these services on behalf of HMS, to support the North Carolina TPL contract.

If the Vendor performed the work as a Subcontractor, the Vendor should describe the scope of subcontracted activities:
For the North Carolina project, Aptara-iEnergizer performs voice and non-voice insurance policy eligibility verifications for cost avoidance through eCare. Aptara-iEnergizer has been a highly successful HMS subcontractor for more than 20 years.

Exhibit 3-14 Table 11: Subcontractor Reference #3 – New Mexico Human Services Department (NMHSD)
Aptara-iEnergizer currently provides administrative services on behalf of HMS (Prime) for the New Mexico TPL contract

Subcontractor Information		
Vendor Name: Aptara-iEnergizer	Contact Name:	J Mohanakrishnan
	Contact Phone:	512.876.5997
Customer Information		
Customer Organization: New Mexico Human Services Department (NMHSD) *Note: HMS is the customer of record for this work; Aptara-iEnergizer provides administrative services on behalf of HMS for the State of Florida TPL contract.	Contact Name:	Erica Leyba
	Contact Title:	TPL RAC Contract Manager
Customer Address: 1 Plaza La Prensa, Santa Fe, NM 87507	Contact Phone:	505.827.7743
	Contact Email:	Erica.leyba@state.nm.us

Project Information	
Total Vendor Staff:	N/A
Project Objectives: To identify overpayments where Medicaid inadvertently paid while a member had a primary insurance	
Project Description: HMS will data match the eligibility records submitted by NMHSD to its database of known "other insurance" coverage records. HMS will validate those results and data match to confirm the most current and accurate information. For the Casualty Program, HMS is in contact with attorneys and insurance companies who notify them (and sometimes myself) about a client who had a personal injury or car accident where Medicaid paid for the clients services on the date of loss, and the insurance company or the attorney wants to reimburse Medicaid.	
Vendor's Involvement: Aptara-iEnergizer conducts administrative tasks, listed further below, on behalf of HMS to support the TPL scope of work on the New Mexico TPL contract.	
Project Benefits: Significant recoveries coming back to NMHSD, regarding overpayments where Medicaid paid primary, but the member's primary insurance should have paid.	
Key Personnel	
Name: J Mohanakrishnan	Role: Senior Manager, currently directs and manages the operations teams working for HMS; serves as main point of contact for HMS.
Project Measurements:	
Estimated one-time costs: N/A	Actual one-time costs: N/A
Reason(s) for change in one-time cost: N/A	
Original Value of Vendor's Contract: See below	Actual Total Contract Value: See below
Reason(s) for change in value: HMS has proprietary tiered transaction pricing with our administrative subcontractors, which have both quality and turnaround time service levels that apply.	

Estimated Start & Completion Dates:	From:	1/20/2020	To:	12/31/2023
Actual Start & Completion Dates:	From:	11/4/2019	To:	11/3/2024

Reason(s) for difference between Estimated and Actual dates: The contract was executed sooner than expected. HMS was previously contracted through mid-December 2019; however, the new contract was initiated in November 2019 so work under the new contract began early. In addition, a year was added to the base contract due NMHSD System's Integrator contract being delayed and canceled. At present, Aptara-iEnergizer continues to provide these services on behalf of HMS, to support the New Mexico TPL contract.

If the Vendor performed the work as a Subcontractor, the Vendor should describe the scope of subcontracted activities: For the New Mexico project, Aptara-iEnergizer performs voice and non-voice insurance policy eligibility verifications for cost avoidance through eCare. Aptara-iEnergizer has been a highly successful HMS subcontractor for more than 20 years.

3.7 Financial Stability (Att 3, Sect. 7)

HMS and its affiliates consolidate their financial results with those of our parent company, HMS Holdings Corp. (Holdings). Holdings, publicly traded on the NASDAQ Global Select Market (ticker symbol: HMSY), is subject to extensive regulatory oversight and public scrutiny. Its reviewers include the Securities and Exchange Commission (SEC), the NASDAQ Global Select Market, various rating agencies, and the general investment community. Holdings is subject to a higher standard of financial transparency and rigor, with a higher reporting frequency, than is a privately-owned company.

In the following sections, we provide our D&B Ratings, which the industry uses to indicate financial strength.

3.7.1 D&B Ratings (Att 3, Sect. 7.1-7.2)

We provide a summary of HMS Holdings Corp's recent Dun & Bradstreet (D&B) ratings, and provide a compilation of these ratings from the most recent report:

- Financial Strength - 5A
- Risk Category – low
- Risk Indicator – 3
- Overall Business – low-moderate

3.7.2 Additional Financial Ratings (Att 3, Sect. 7.3)

HMS has provided our D&B ratings in response to requirements 7.1 and 7.2, as requested.

4.0 Project Organization and Staffing Approach

4.1 Instructions (Att 4, Item 1)

HMS' clients rely on us to engage trusted TPL and program integrity experts to take on today's complex and growing payment accuracy challenges. We have developed and employed thorough staffing strategies, based on our decades of experience in staffing large and complex projects for our government and commercial healthcare clients. This includes the assignment of existing HMS resources to current projects as well as hiring, onboarding, and training new personnel required to fulfill scopes of work. Our specific staffing strategy, customized for BMS, drives the Initial Staffing Plan, which we provide and describe further below.

Per RFP requirements, HMS will use our established TPL project staffing strategies to ensure all project requirements and service levels are met to the satisfaction of BMS. In this section of our proposal, we provide detailed information regarding the expertise of the proposed staff and our Initial Staffing Plan. The organization of this proposal section aligns with the response outline described in RFP Section Attachment 4 and does not exceed 25 pages.

4.2 Initial Staffing Plan (Att 4, Item 2.1)

In this section, we have provided BMS with our proposed Initial Staffing Plan that summarizes our approach for providing knowledgeable, skilled and experienced staff for the TPL Services project. As requested, this Initial Staffing Plan provides:

- Description or our proposed HMS Project team along with our ability to provide qualified staff
- Our plan for providing all resources necessary to fulfill the project requirements
- Preliminary organization charts, by project phase
- Staff screening tools/processes and our process for replacing key staff
- Resumes
- Letter of intent for each proposed staff member not currently employed by HMS
- Identification of subcontractor staff, if applicable

In addition to this Initial Staffing Plan narrative, we have addressed each of the requirements described in RFP Appendix 1: Detailed Specifications in proposal **Section 7.3.3 Staffing Management Plan.**

HMS also acknowledges that we will send a formal Staffing Management Plan, which supplements our overall Project Management Plan, within 90 days after contract award as specified in RFP Appendix 2.

4.2.1.1 HMS' Proposed Team for BMS (Att 4, Item 2.1.1)

Project Team Roles

Our proposed HMS Project team for BMS, consists of key staff and support staff in place today and backed by HMS senior leadership team, project advisory council, and entire HMS organization.

Key Staff

The success of BMS' TPL program relies on the oversight, direction, and support from a highly qualified and stable project team of key staff who are accountable for the performance of designated areas for the duration of the contract and bring knowledge and experience of Medicaid and TPL programs.

In addition to this Initial Staffing Plan, we provide BMS with a detailed Staffing Management Plan as part of the overall Project Management Plan, within 90 days after contract award. A description of our Staffing Management Plan can be found in proposal **Section 7.3.3 Staffing Management Plan**.

Our proposed key staff will lead our efforts to ensure that all implemented services provided by HMS and administered for the State, meet exacting standards for quality as defined by the State as well as by HMS and the industry. They will help customize and enhance processes to ensure BMS meets or exceeds their expectations of the TPL program. We will assure the key staff named in this proposal are available at contract award.

Support Staff

In addition to the key staff, our proposed HMS Project team for BMS includes additional roles we deem critical to the successful performance under the RFP and contract. These roles support the key staff by leading the individual teams necessary to implement, operate, and maintain the tasks and functions required to deliver the entire scope of work. The specialists in these roles include healthcare professionals with multiple years of experience serving government and commercial healthcare programs across the nation and with specific expertise in TPL and program integrity services, including:

- TPL Recoveries
  - TRICARE, Medicare, and Commercial
  - Casualty/Trauma and Mass Tort
  - Estate and Special Needs Trusts
  - Credit Balance Audits

- Third-Party Adds and Cost Avoidance
- Administering Premium Reimbursement Programs
- Program Integrity and Recovery Audit Contract (RAC) Services
- Additional TPL-Related Payment Accuracy Service Areas

We present our draft organizational charts below in proposal **Section 4.2.1.3**, including a description of our project governance structure. Additionally, provide greater detail around each of the Project team roles, including responsibilities and required skillsets, in proposal **Section 7.3.3 Staffing Management Plan.**

OUR PROPOSED PROJECT TEAM

HMS proposes a highly qualified project team for BMS, with key staff and support staff having prior experience, expertise, and functional familiarity with both BMS and the required scopes of work. Our proposed key staff also bring years of healthcare industry experience, all with backgrounds supporting Medicaid and Medicare lines of business and TPL services. These team members have contributed to the successful delivery of our payment accuracy solutions for one or more of the 40+ state Medicaid agency clients in our portfolio. We present a list of these client projects, many of similar size and scope as BMS' project, in **Section 3.0 Vendor Qualifications and Experience.** Through this experience, as well as our staffing approach summarized below in proposal **Section 4.2.1.2**, we demonstrate our ability and capability to provide knowledgeable, skilled, and experienced personnel to accomplish the requested scope of work outlined in the RFP.

We know that BMS requires project team members who understand the unique needs of the TPL Services project and how to maximize results for WV Medicaid and WVCHIP. Our team brings a wealth of relevant industry experience to this project, including WV-specific experience. All key staff currently support BMS on the WV TPL Services contract, which will allow for an efficient and seamless transition for the new contract. Our fully trained project team members are prepared to apply their TPL expertise and skills to fulfill their individual project roles on behalf of the State. We are confident our proposed project team for BMS will provide the necessary management and staff resources to perform all required activities under the new contract.

4.2.1.2 OUR APPROACH FOR PROVIDING ALL PROJECT RESOURCES (ATT 4, ITEM 2.1.2)

With more than 60% of our core business focused on performing TPL services, HMS has the resources necessary to support BMS and fulfill the scope of work requirements as specified in the RFP. Our approach to staffing includes dedicating the right resources in the right roles for this engagement and maintaining appropriate staffing throughout all phases of the contract. Our Human Resources (HR) department has procedures and resources in place to maintain the required number of qualified staff, both key and support staff, throughout the life of this contract

as well as to balance an appropriate workload for these TPL specialists, so they can fulfill the project requirements efficiently and effectively.

Through our staffing approach, HMS assigns fully qualified, experienced individuals to each project team position. We based our staffing model on our detailed project management plan and schedule and have assigned staff to this engagement based on their healthcare and scope-specific technical expertise, requisite skills to successfully execute all work required under this contract and demonstrated knowledge of Medicaid and TPL.

Our staffing strategy for this project is to leverage existing staff familiar with BMS, the State's Medicaid environment, and engaged with the contract. In the following narrative, we describe our staffing process to demonstrate how we staff projects, including the existing and new scopes of work for BMS.

Key staff continuity enhances accountability and quality of the TPL program. HMS will use best efforts to maintain staff continuity throughout the life of our projects.

For the forthcoming BMS engagement, we have analyzed each scope of work to determine the required tasks for the TPL Services contract and mapped those requirements to the appropriate job classifications. Based on the estimated workload, our staffing model then allocates the number and type of FTEs required to accomplish each task and achieve the desired results. As a result of our analysis, we have determined that all proposed roles, both key staff and support staff, can be fulfilled by existing HMS staff either currently working on the WV TPL contract or recruited from our existing HMS employee base with the appropriate qualifications. When assigning projects to our staff, we also assess their workload and time availability to make sure they have the bandwidth to lead a major project. Effective workload distribution enables the team to achieve optimal performance and productivity levels. This approach streamlines the process and time needed to mobilize new project resources.

4.2.1.3 Organization Charts (Att 4, Item 2.1.3)

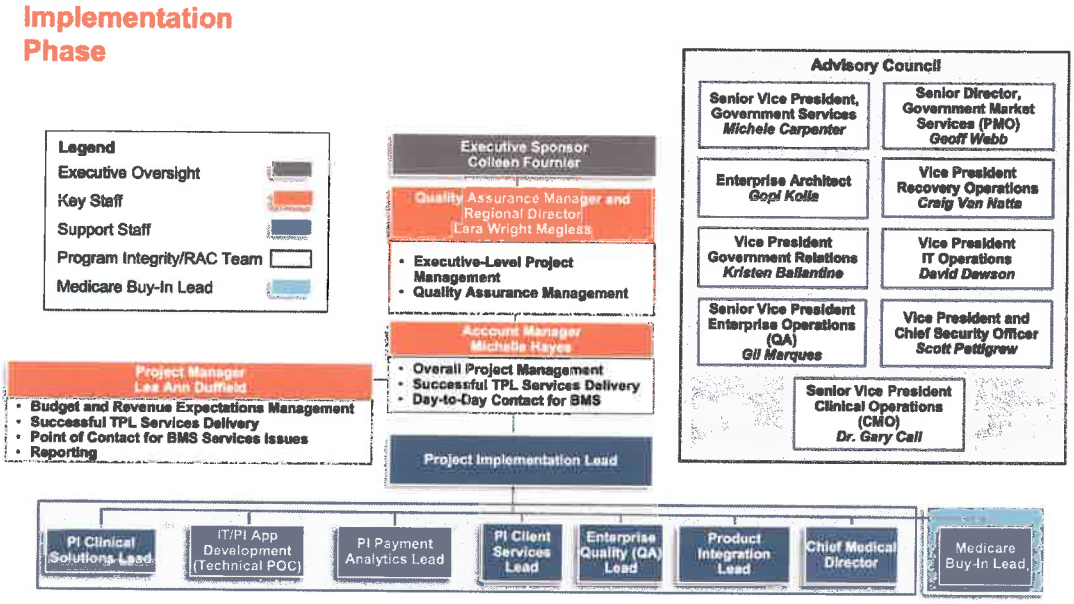
We offer BMS a complete team of professionals sufficiently trained and experienced in the nuances of implementing, supporting, and maintaining the TPL services requested in the RFP.

Below are organization charts for each project phase – Implementation and Operations – showing the HMS staff that will be required to support the project. Each organization chart noted below indicates the roles required to support the project for that phase, noting where roles overlap project phases, and a summary of each key staff member's high-level responsibilities.

- **Implementation.** As described in **Section 7.3.5 Implementation Plan**, the Implementation phase of the project includes our approach to standing up our proposed solution for BMS at go-live. As more than 75% of the proposed services are already in place today, this phase will focus on implementing any new scopes of work, including optional services and reviewing and updating any processes, systems, or reporting for the existing scopes of work. (**Exhibit 4-1**)
- **Operations.** The Operations phase of the project covers the ongoing activities and tasks associated with operating the entire solution for the life of the contract. (**Exhibit 4-2**)

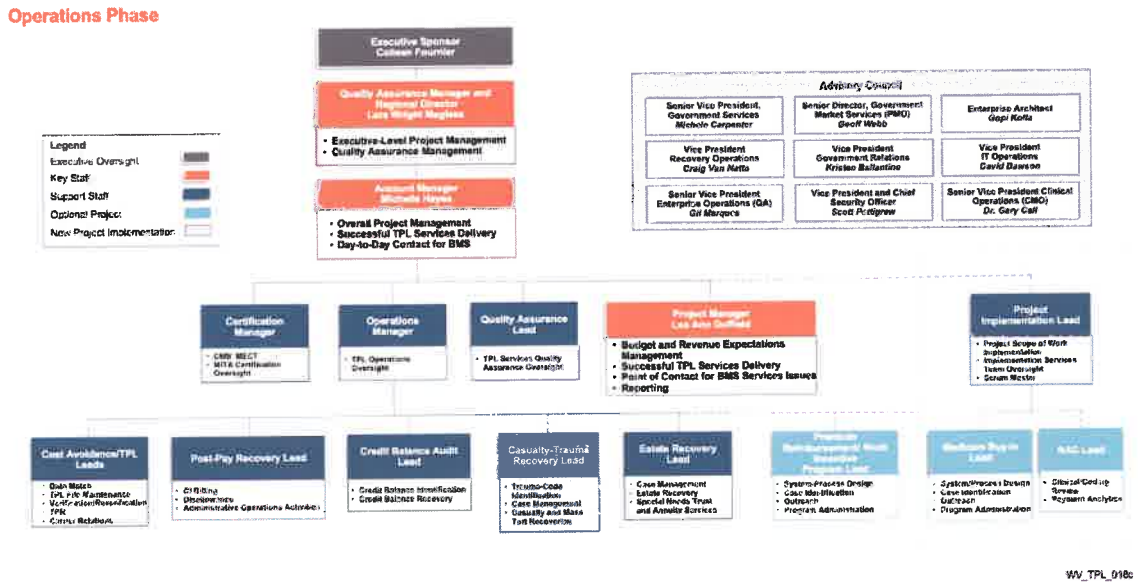
On both charts, we have identified the key staff, along with a high-level summary of their responsibilities. All Project team staff, across both organizational charts, are located off-site., Per the revised requirement in RFP Addendum 4, we affirm that key staff, and other necessary resources, are available to be onsite for monthly meetings and ad hoc onsite assistance, with advanced notice, at no additional cost to BMS. Our assigned project manager, Lea Ann Duffield is local to Charleston, WV.

Exhibit 4-1 HMS Project Team Organization: Implementation Phase
During the Implementation phase, our team will evaluate current scopes and rollout new scopes of work



WV_TPL_017c

Exhibit 4-2 HMS Project Team Organization: Operations Phase
During the Operations phase, our team will perform ongoing tasks to operate the solution for the contract life.



Our approach to project management includes establishing clear lines of responsibility and authority that facilitate the communication and distribution of relevant information and management of daily project operations.

EXECUTIVE SPONSOR

Colleen Fournier, Vice President, Government Services will serve as the Executive Sponsor, working closely with the HMS Project team and BMS to supervise operations and achieve project goals. A TPL thought leader, she works with several state government agencies, to bring new ideas to this engagement. Colleen brings extensive Medicaid program knowledge and expertise, particularly through her leadership role in payment accuracy work for Medicaid Agencies over the past eight years. Overseeing multiple cost containment and program integrity contracts for various states, Colleen helps Medicaid clients deploy effective payment accuracy practices. With a BA from Purdue University, coupled with over 25 years in the public and private healthcare industry, Colleen has the knowledge and leadership skills to serve the contract needs of the BMS.

HMS PROJECT ADVISORY COUNCIL

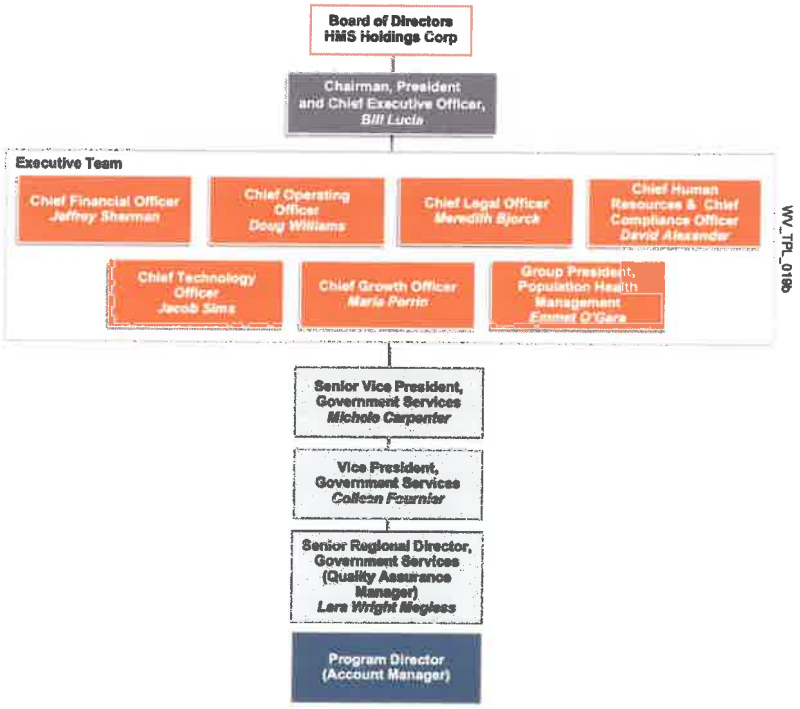
Our HMS Project team for BMS leverages HMS' corporate-wide Medicaid payment accuracy expertise through the specialized knowledge and insight of our project Advisory Council. These industry leaders, noted in our Operations chart, are experts in their respective fields who provide service delivery guidance and support in a broad range of areas, such as state and federal

compliance, MECT/MITA Certification, industry best scope-of-work practices, and innovative solutions. They serve as educators and thought leaders for our Project team members, clients, and other stakeholders.

PROJECT GOVERNANCE

Active and ongoing involvement from our top executive team is integral to our project approach. Our HMS Project team for BMS ultimately reports to the HMS Executive Leadership team as shown in **Exhibit 4-3**. This Management team governs HMS and our business activities, helps set corporate policy, and assumes overall responsibility and accountability for our organization. These industry experts were integral to the preparation of this proposal and continue to support the HMS Project team members during all phases of contract implementation and operations, as needed. This approach ensures that team members can quickly communicate with and/or escalate any issues or operational concerns to the highest levels of the company for resolution.

Exhibit 4-3 HMS' Project Governance Structure
Our HMS Project team for BMS ultimately reports to the HMS Executive team.



Our HMS Executive team members include the following individuals:

- **Bill Lucia, Chairman, President and Chief Executive Officer.** Bill Lucia has served as HMS chairman, president, and chief executive officer since March 2009. He has been a member of the board of directors since May 2008 and was appointed chairman in July 2015. From May 2005 to March 2009, Bill served as HMS president and chief operating officer. He joined the company in 1996 and continues to lead HMS through the evolving healthcare

landscape, demonstrating the ability to formulate and implement key strategic initiatives. Prior to HMS, Bill served as senior vice president of operations and chief information officer for Celtic Life Insurance Company, and senior vice president of Insurance Operations for North American Company for Life and Health Insurance. He serves as chairman of the Council for Medicare Integrity and is a director on the board of Ally Align Health. Bill is a fellow of the Life Management Institute program through LOMA, an international association of insurance and financial services companies engaging in research and educational activities to improve operations.

- **Jeffrey Sherman, Chief Financial Officer.** Jeffrey Sherman serves as chief financial officer and treasurer for HMS. Additionally, he is responsible for corporate strategy and development, including mergers and acquisitions, and security. Jeff has more than 25 years of experience in corporate and hospital-based finance, previously serving as executive vice president and CFO of AccentCare, executive vice president and CFO of LifePoint Hospitals Inc., and holding senior finance and risk management positions at Tenet Healthcare Corporation.
- **Doug Williams, Chief Operating Officer.** Doug Williams serves as HMS' chief operating officer, responsible for leading the company's business development and product strategy. He has more than 25 years of experience in healthcare information technology, sales, and operations, with a focus in healthcare consulting. Prior to HMS, Doug served as chief information officer of Aveta (now part of Optum, Inc.), senior vice president of the payor business unit at MedeAnalytics, global healthcare partner for IBM, and healthcare partner at Protiviti, Inc.
- **Jacob Sims, Chief Technology Officer.** Jacob Sims is chief technology officer for HMS, responsible for leading the technology vision, strategy, and execution of HMS' data science, advanced analytics, and service platform. He brings significant experience leading large-scale healthcare IT organizations and specializes in transformative initiatives and data-centric product cultivation. Prior to HMS, Jacob served as chief technology officer and interim head of product for WebMD, vice president of development and technology for Premise Health, vice president of technology for Xerox, and co-founder chief technology officer for Credence Health.
- **Maria Perrin, Executive Vice President, Chief Growth Officer.** In her role, Maria is responsible for the company's client engagement, business development, corporate strategy, marketing, and government relations teams. Previously with HMS, Maria rejoined HMS in 2019, after leading a successful consulting practice that launched dozens of health tech startups and tech companies in emerging sectors. During her first tenure at HMS, as executive vice president over government and commercial markets from 2008 to 2013, HMS' revenue grew five-fold, and the company successfully entered the federal market, doubled the volume of state contracts, and expanded services to commercial payers. Maria has held financial and operational leadership roles for BestFoods, Nissan, and other Fortune 100 companies. She has a BA in Economics from UCLA and an MBA from the University of Miami.

- **Emmet O'Gara, Group President, Population Health Management.** Emmet has served in his current role at HMS since January 2018, with responsibility for overseeing all aspects of the company's Total Population Management business development, product innovation, and delivery capabilities. He brings more than 25 years of experience in the healthcare payer, provider, and employer markets. Prior to joining HMS, Emmet served as Senior Vice President and Chief Revenue Officer of Cota Healthcare, a healthcare data and analytics company, from August 2017 to December 2017. From September 2009 through July 2017, he served as Senior Vice President and General Manager of Payer and Provider Solutions at MedeAnalytics, a leading healthcare analytics company. During his eight-year tenure, Emmet drove new sales, expanded existing accounts, and accelerated revenue growth. Emmet has also held key leadership roles at Blue Cross Blue Shield of Massachusetts, Accenture Consulting, and Cigna Healthcare.
- **Meredith Bjork, Chief Legal Officer.** Meredith serves as HMS' chief legal officer, where she also serves in the roles of general counsel and corporate secretary. Prior to joining HMS in 2016, Meredith served as Senior Vice President, General Counsel, and Corporate Secretary for Tuesday Morning Corporation, where she was responsible for establishing the company's first Legal Department, and as Deputy General Counsel, Chief Compliance Officer and Corporate Secretary for CEC Entertainment, Inc. Prior to CEC, Meredith was in private practice at Vinson & Elkins LLP and Fulbright & Jaworski LLP. During her career, Meredith was named by Texas Lawyer as 2014 Legal Department of the Year, Outstanding General Counsel by D CEO magazine and Best Corporate Counsel, Rising Star by Dallas Business Journal.
- **David Alexander, Chief Human Resources Officer and Chief Compliance Officer.** David Alexander is HMS' chief human resources and chief compliance officer and reports to the Board of Directors' Compliance Committee. He directs the corporate compliance program for all the company's operating entities, providing adherence to state and federal regulations concerning privacy, security, and transaction processing. David is responsible for policy development and implementation, compliance training and communications, auditing, and issue reporting and resolution. Prior to joining HMS, David worked for Alcon Labs Inc. as head of compliance for the US and Canada. During his tenure at Alcon, David supported Alcon's pharmaceutical and medical device business units, as well as global R&D. David was responsible for establishing, embedding, and enforcing policies pertaining to the Federal Anti-Kickback Statute, the Physician Payment Sunshine Act, the PhRMA and AdvaMed Codes, and the Foreign Corrupt Practices Act.
- **Michele Carpenter, Senior Vice President, Government Services.** Michele Carpenter provides executive oversight for all government agency contracts. By leveraging her more than 30 years of experience in the state government, federal government, and commercial markets, she provides executive advisory and product-development focus for government clients and confirms provision of appropriate company resources for each contract. Additionally, she works with project personnel to help state and federal clients implement solutions and program strategies. With a national perspective, she understands how to apply

successful strategies in one state to deliver enhanced value in another state. Michele will regularly meet with Project team members to monitor status, give advice, and aid in strategic planning to improve our efficiency.

4.2.1.4 Screening and Replacing Staff (Att 4, Item 2.1.4)

We understand BMS requires that we maintain sufficient staffing levels throughout the contract term. As always, we strive for excellence, continuity, and sustainability when selecting and implementing a Project team.

If a key staff member needs to exit contract operations, we rely on the recruiting resources of our HMS Human Resources (HR) Department to apply expansive staffing capabilities and our fast-track rapid recruitment process to commit qualified and experienced full-time key staff. We will notify BMS of such known key staff vacancy, provide an acceptable temporary replacement, and backfill the key staff role within the defined time frames for any .

This Project team has the full support of the HMS organization, including the talents of our hundreds of TPL project professionals nationwide. If a Project team member is unavailable to fulfill his/her responsibilities in support of this engagement, we will quickly and efficiently realign our staffing resources to continue to meet the needs of the BMS project. BMS can be assured that HMS is deploying the latest and most effective approaches guaranteed to achieve the State's goals—and that HMS is allocating the right resources to this engagement.

Staff Screening Tools and Processes

HMS' hiring and employment practices comply with all applicable local, state, and federal laws and regulations including those regarding verification of the employment authorization of employees. Our HR Department uses customized tools and other resources to thoroughly screen employment candidates to identify any issues that may prohibit their ability to best fulfill the staffing needs to which they apply.

A Background and Work Authorization policy is applied to determine and/or confirm within appropriate legal and professional limits the qualifications and suitability of a job candidate/employee for the specific position for which the candidate/employee is being considered. This policy applies to all full-time and part-time employees of HMS, and its subsidiaries including temporary workers. This policy also applies to all contractors and subcontractors who have access to protected health information (PHI).

HMS requires background checks on all job applicants. We perform appropriate pre-employment background checks on all candidates for employment, as well as on current employees, on an ongoing basis for contract and regulatory purposes as well as specific transfers and promotions. All offers of employment at HMS are contingent on clear results of a thorough background check.

The requirements of each candidate's or employee's background check depend on the specific position. For example, we may require certain staff (or subcontractors, if applicable) to undergo

fingerprint-based State and federal background checks, if their role will require access to certain facilities, data, or systems that BMS deems sensitive in the course of delivering the services for WV. HMS may perform identity and address-related verifications and searches, various types of criminal background checks, Office of Inspector General and other exclusion list checks, driving record, education verifications, and prior employment verifications. Examples of the more common background check components we perform are found in **Exhibit 4-4**.

Exhibit 4-4 Common Components of HMS' Background Check Process
The components of each candidate's or employee's background check will depend on the job.

Items Checked	Purpose
Healthcare Sanctions	Search databases, which satisfy the sanction-screening minimum requirements set forth in several Office of the Inspector General Compliance program guidelines, for sanctions
Prohibited Parties	Reveal known terrorists, specifically designated nationals, narcotics traffickers, and other sanctioned persons
Global Sanctions and Enforcements List	Identify prohibited, restricted, and sanctioned individuals (search complies with Federal Deposit Insurance Corporation, Federal Financial Institutions Examination Council, Sarbanes-Oxley Act, and USA PATRIOT Act requirements)
National Sex Offender Database	Search registered sex-offender information in all 50 states, the District of Columbia, Guam, and Puerto Rico
Educational Institutions	Verify educational information, with a minimum of a high school diploma, listed on the employment application
Criminal Records	Search federal, national, state, and county records, except where prohibited by law, for the previous seven years to identify inclusion in criminal cases
Civil Records	Search federal, national, state, and county records, except where prohibited by law, for the previous seven years to identify inclusion in civil cases
Drug Screen	Perform a nine-panel urine or hair screen
Credit Check	Review credit history (when applicable)
Professional Licensing	Verify claimed licenses, including validity and any disciplinary actions, to determine good standing

Once the background-check process is complete, designated HR personnel adjudicate the results based on the findings. Results that might result in a rescinded job offer include, but are not limited to, misdemeanor criminal convictions, unverifiable education/employment information, and inaccurate information listed on the application. Results such as felony criminal convictions and failed drug screens automatically disqualify a candidate from employment consideration. Our HR Department can provide additional information regarding this policy upon request.

In compliance with the Immigration Reform and Control Act of 1986 (IRCA), it is a condition of employment with the Company that each new employee complete the Employment Eligibility Verification Form I-9 ("I-9 Form") and present documentation establishing identity and employment eligibility. We also use E-Verify℠, an internet-based system that compares information from an employee's I-9 Employment Eligibility Verification Form to data from the U.S. Department of Homeland Security and Social Security Administration records, to confirm employment eligibility.

Former employees who are rehired must also complete the I-9 Form if they have not completed one for the Company within the past three years, or if their previous I-9 Form is no longer valid.

Providing false identification as eligibility to work in the United States is grounds for immediate dismissal. Failure to provide acceptable documentation of identity and eligibility to work for the Company within three business days of the employee's first day of employment may result in immediate termination.

This verification process will be conducted digitally utilizing E-Verify in accordance with federal contract requirements. Managers/Human Resources will verify employee documentation within three business days of new hire's first day of employment.

Replacing Staff

HMS' approach to staffing and work force management includes providing the right resources necessary to fulfill all project requirements, maintaining adequate staffing levels throughout the life of the contract, and managing attrition. HMS affirms that we commit to using best efforts to maintain staff continuity throughout the life of the project. As with any long-term project, we realize that attrition may occur, due to any number of unforeseen circumstances that leaves a team member unavailable to fulfill his or her responsibilities.

To address any staff turnover, we have developed contingency plans for the replacement of personnel in the event of loss of named key staff or any support staff. With this planning, we will quickly be able to realign our staffing resources to allow HMS to continue to fulfill contract deliverables for BMS with little-to-no impact. In the event of staff changes, the size of our organization enables us to allocate additional resources to projects, as needed. To meet all BMS' needs, we will use a strategic workload management and allocation system that gives highest priority to projects that are the size of BMS' project. Additionally, given the dynamic nature of the Medicaid environment, we will work closely with WV over the term of this contract to integrate new tools and enhanced systems that fully address its growing needs and potentially impact staffing requirements. Following are a few of the proven methods we use to handle project team turnover generally for client projects:

- **Fill Roles with Existing, Qualified Members of the HMS Workforce.** HMS actively promotes our workforce from within and has experienced staff members available, from across our base of more than 3,100 full-time professionals, who can fulfill all requirements regarding qualifications, credentials, and/or licenses for BMS. These individuals would transition to this project immediately, for as seamless a replacement as possible. We cross-train our team members to certify coverage of all job functions and effective reactions to changes in workload. Because we leverage numerous resources and accommodate fluctuations that occur as part of our business, many of our Operational Support team members who work on multiple engagements have already provided services to West Virginia under previous contracts. Additional and/or replacement personnel will demonstrate comparable qualifications to those of the person(s) replaced. Our key personnel and other Project team leaders will oversee all contract management, including verification that appropriate staffing support is always in place to meet the contract requirements.
- **Recruit New Talent through HMS Human Resources' Internal Recruiters.** Where it is necessary to recruit new talent for a Project team, we also rely on the recruiting resources of

our HR Department, or external recruiters if needed. If a required position is vacated and an internal candidate is not available, our HMS Project team Account Manager will work with leaders to initiate our recruitment process. If we must recruit new talent for the Project team or recruit back-up staff, we rely on the recruiting resources of our HR Department. Through our fast-track rapid recruitment process, HMS can actively recruit skilled staff members who fulfill all requirements with appropriate qualifications, credentials, and/or licenses for BMS. This process leverages a combination of internal and external recruitment experts and multiple advertising and outreach avenues, including online resources, employee referrals, HMS internship programs, veteran recruitment initiatives, career fairs, local resources, and relevant professional organizations. Throughout our 46-year history, HMS has successfully attracted and retained talented employees. By continually and thoroughly training our employees and actively recruiting highly talented job candidates, we foster an organization that constantly strives for excellence.

4.2.1.5 Resumes (Att 4, Item 2.1.5)

In proposal **Appendix 2**, we provide resumes for each of the proposed key staff assigned to our HMS Project team. Each resume describes the individual's current or prior experience working with BMS, previous experience with projects of similar scope and size, educational background, and any relevant certifications, licenses, and/or special skills.

4.2.1.6 Letters of Intent (Att 4, Item 2.1.6)

All the proposed specialists on the HMS Project team for BMS are current HMS employees. For this reason, we do not include any letters of intent for non-employees in our proposal.

4.2.1.7 Subcontractor Staff (Att 4, Item 2.1.7)

As described in **Section 3.0 Vendor Qualifications and Experience**, HMS does not rely on subcontractors or other vendors to complete our core processes. The subcontractors proposed by HMS to support our delivery of best practice TPL services to BMS serve administrative roles only. For this reason, specific subcontractor staff members are not assigned to serve BMS and are therefore not named as part of the HMS Project team.

4.3 Key Staff, Resumes, and References (Att 4, Item 3.1)

The project roles and responsibilities as well as the qualifications and experience of key personnel on the HMS Project team for BMS are described herein.

ACCOUNT MANAGER: MICHELLE HAYES

HMS proposes Michelle Hayes, HMS Program Director, to continue as the Account Manager and primary liaison for BMS to best serve the State's TPL service needs. As a qualified and experienced TPL Services Project Manager, Michelle knows best practice payment accuracy methodologies and tools but most importantly, she knows the WV Medicaid program and how best to maximize payment accuracy results in the near and long terms.

Michelle brings more than seven years of TPL experience and has overseen the current BMS TPL contract for over a year. She has proven her ability to develop and apply innovative solutions that produce value for the State. As Account Manager on the HMS Project team for BMS, Michelle will directly oversee the entire Project team and delivery of all TPL services work performed under the new contract. Please see proposal **Appendix 2** for Michelle's resume that provides a detailed description of her project-specific experience and accomplishments.

PROJECT MANAGER: LEA ANN DUFFIELD

HMS proposes Lea Ann Duffield, HMS Program Manager, to continue as the Project Manager for BMS to best serve the State's TPL service needs. A WV resident, she brings one year of experience managing large-scale payment accuracy projects for HMS on behalf of Medicaid clients. A qualified and experienced professional with more than six years of combined experience in the healthcare and Medicaid industry, Lea Ann continually researches and applies best practice solutions on behalf of her clients.

In addition to her current experience supporting the BMS TPL Services project, Lea Ann works with our internal Operations team to promote understanding of the members' needs for the services we offer. Please see proposal **Appendix 2** for Lea Ann's resume that provides a detailed description of her project-specific experience and accomplishments.

QUALITY ASSURANCE MANAGER: LARA WRIGHT MEGLESS

HMS proposes Lara Wright Megless, HMS Senior Regional Director, to continue as Quality Assurance Manager on the HMS Project team for BMS. Lara applies her in-depth understanding of the WV Medicaid program to provide senior-level project management of the HMS services we deliver to the State. She applies more than eight years of experience managing large-scale cost containment programs for HMS on behalf of our Medicaid clients, which includes government clients in West Virginia, Indiana, Oklahoma, Kansas, Missouri, Tennessee, and Wisconsin. She oversees recovery and cost avoidance contracts in Michigan.

She is an expert in all TPL scopes of work and leverages lessons learned and best practices in other states to improve overall services and results for BMS. Lara's comprehensive HMS project management experience has provided her with a deep understanding of TPL quality as defined by the industry, our clients, and HMS itself. She provides quality assurance and project oversight, working closely with our assigned Account Manager and Project Manager to ensure that all deliverables meet or exceed standards for quality. Please see proposal **Appendix 2** for Lara's resume that provides a detailed description of her project-specific experience and accomplishments.

4.3.1.1 Availability of Key Staff (Att 4, Item 3.1.1)

The key staff proposed by HMS has extensive experience serving the payment accuracy and cost containment needs of BMS. We affirm that our key staff will be available for an in-person interview, upon BMS request, throughout the life of the contract.

4.3.1.2 Implementation Phase Roles: Key Staff (Att 4, Item 3.1.2)

The key staff proposed by HMS for BMS will be an integral part of our proposed Implementation team. They include:

- Account Manager, Michelle Hayes
- Project Manager, Lea Ann Duffield
- Quality Assurance (QA) Manager, Lara Wright Megless

Working hand in hand with our project implementation lead, these individuals will oversee the larger project milestones and ensure all implementation activities for new scopes of work remain on schedule for an efficient and successful transition from implementation to operations. During the Implementation phase, each of the proposed key staff will be comprehensively supported by the efforts of additional Project team members as well as any other personnel resources required to best fulfill the needs of the State.

4.4 Key Staff Resumes (Att 4, Items 3.1.3–3.1.5)

In **Exhibit 4-5**, we provide summary resume information as referenced in RFP Table 12. In addition, detailed resumes for each of our named key staff members on our proposed HMS Project team may be found in proposal **Appendix 2**. In each resume, we have included the following information:

- The role of the team member on the HMS Project team for BMS
- Description of how their experience and education will contribute to the successful implementation of the TPL solution for BMS
- Description of experience relevant to the position proposed

- Description of work on projects cited under the HMS' corporate experience and the specific functions performed on such projects, as applicable

Exhibit 4-5 Resumes for Proposed Key Staff (RFP Table 12)

Name	Proposed Role	Experience in Proposed Role
Michelle Hayes	Account Manager	◉ Current Account Manager on the BMS TPL Services contract with direct responsibility for successful delivery of HMS' comprehensive TPL services for WV Medicaid; accountable for $8+ million in annual recoveries and $160 in annual savings for the BMS TPL project ◉ 7+ years of experience providing TPL services for other state contracts for HMS on behalf of Medicaid members ◉ Demonstrated ability to manage complex projects and daily project operations, with a high-level of skill, to monitor and ensure all services and deliverable fulfill client requirements
Lea Ann Duffield	Project Manager	◉ Current Project Manager on the BMS TPL Services contract, working with internal HMS operations teams and supporting HMS' delivery of comprehensive TPL services for WV Medicaid ◉ 6+ years combined experience in the healthcare and Medicaid industry, including project management activities ◉ In-depth understanding of Medicaid operations and the application of best practice TPL services to maximize recovery and cost avoidance value
Lara Wright Megless	Quality Assurance Manager	◉ Current Quality Assurance Manager for the BMS TPL Services contract, providing quality assurance and project oversight for HMS' delivery of comprehensive TPL services for WV Medicaid ◉ 8+ years of experience providing Quality Assurance management and oversight of large-scale cost containment, program integrity services and TPL services for multiple states ◉ Expert knowledge in all proposed scopes of work ◉ In-depth understanding of Medicaid operations and the application of best practice TPL services to maximize recovery and cost avoidance value

4.5 Key Staff References (Att 4, Items 3.1.6–3.1.8)

As described, the key staff proposed have demonstrated their TPL service expertise for a range of clients, including BMS. Please see **Exhibit 4-6** for information regarding the personal references of our proposal Account Manager, **Exhibit 4-7** for information regarding the personal references of our Project Manager, and **Exhibit 4-8** for information regarding the personal references of our Quality Assurance Manager.

Exhibit 4-6 Personal References: Account Manager

Key Personnel Reference Form					
Key Personnel Name	Michelle Hayes	**Proposed Role:**		Account Manager	
Reference 1					
Client Name:	Pennsylvania Department of Aging	Client Address:	555 Walnut St. 5th Floor, Harrisburg, PA 17101		
Contact Name:	Megan McDaniel	Contact Title:	Operations Manager, PACE Program		
Contact Phone:	(717) 787-7313	Contact Email:	memcdaniel@pa.gov		
Project Name: Pennsylvania Department of Aging TPL Services		Start Date:	01/2019	End Date:	Current
Project Description: Provides third-party recovery and resource identification services to the Pennsylvania Department of Aging (PDA) under an agreement with Magellan Medicaid Administration (MMA), a Magellan Rx Management company.					
Project Role and Responsibilities: Program Director responsible for oversight of Project team and delivery of all TPL services work performed					
Reference 2					
Client Name:	Magellan Rx Management	Client Address:	4000 Crums Mill Rd Suite 301, Harrisburg, PA 17112		
Contact Name	John Wheeler	Contact Title:	Senior Manager, IT Service Owner, PACE		
Contact Phone:	(717) 651-6106	Contact Email:	JKWheeler@magellanhealth.com		
Project Name: Pennsylvania Department of Aging TPL Services		Start Date:	01/2019	End Date:	Current
Project Description: Provides third-party recovery and resource identification services to the Pennsylvania Department of Aging (PDA) under an agreement with Magellan Medicaid Administration (MMA), a Magellan Rx Management company.					
Project Role and Responsibilities: Program Director responsible for oversight of Project team and delivery of all TPL services work performed.					
Reference 3					
Client Name:	Gainwell Technologies	Client Address:	950 N Meridian Street - Suite 1150, Indianapolis, IN 46204		
Contact Name	Margaret Graves	Contact Title:	Attorney/Manager, Third Party Liability		
Contact Phone:	(317) 488-5034	Contact Email:	Margaret.Graves@GainwellTechnologies.com		
Project Name: Gainwell Technologies TPL Services		Start Date:	04/2020	End Date:	Current
Project Description: Provides services to Gainwell Technologies in order to fulfill the objectives of providing Cost Avoidance and Third Party Liability MMIS services to Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning as Gainwell Technologies Supplier for the Project					
Project Role and Responsibilities: Program Director responsible for oversight of Project team and delivery of all TPL services work performed					

Exhibit 4-7 Personal References: Project Manager

Key Personnel Reference Form					
Key Personnel Name	Lea Ann Duffield	**Proposed Role:**	Project Manager		
Reference 1					
Client Name:	Gainwell Technologies	Client Address:	950 N Meridian Street - Suite 1150, Indianapolis, IN 46204		
Contact Name:	Margaret Graves	Contact Title:	Attorney/Manager, Third Party Liability		
Contact Phone:	(317) 488-5034	Contact Email:	Margaret.Graves@GainwellTechnologies.com		
Project Name: Gainwell Technologies TPL Services		Start Date:	04/2020	End Date:	Current
Project Description: Provides services to Gainwell Technologies in order to fulfill the objectives of providing Cost Avoidance and Third Party Liability MMIS services to Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning as Gainwell Technologies Supplier for the Project					
Project Role and Responsibilities: Program Manager supports and coordinates with client and internal Operations team delivery of all TPL services work performed.					
Reference 2					
Client Name:	Gainwell Technologies	Client Address:	950 N Meridian Street - Suite 1150, Indianapolis, IN 46204		
Contact Name	Kylee McGhee	Contact Title:	Casualty Analyst, Third Party Liability		
Contact Phone:	(317) 488-5368	Contact Email:	kylee.dan.mcghee@gainwelltechnologies.com		
Project Name: Gainwell Technologies TPL Services		Start Date:	04/2020	End Date:	Current
Project Description: Provides services to Gainwell Technologies in order to fulfill the objectives of providing Cost Avoidance and Third Party Liability MMIS services to Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning as Gainwell Technologies Supplier for the Project					
Project Role and Responsibilities: Program Manager supports and coordinates with client and internal operations team delivery of all TPL services work performed.					
Reference 3					
Client Name:	Gainwell Technologies	Client Address:	950 N Meridian Street - Suite 1150, Indianapolis, IN 46204		
Contact Name	Steven Myers	Contact Title:	Services Information Developer		
Contact Phone:	(317) 613-9188	Contact Email:	steven.myers@gainwelltechnologies.com		
Project Name: Gainwell Technologies TPL Services		Start Date:	04/2020	End Date:	Current
Project Description: Provides services to Gainwell Technologies in order to fulfill the objectives of providing Cost Avoidance and Third Party Liability MMIS services to Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning as Gainwell Technologies Supplier for the Project					
Project Role and Responsibilities: Program Manager supports and coordinates with client and internal Operations team delivery of all TPL services work performed.					

Exhibit 4-8 Personal References: Quality Assurance Manager

Key Personnel Reference Form					
Key Personnel Name	Lara Wright Megless	**Proposed Role:**		Quality Assurance Manager	
Reference 1					
Client Name:	MO Health Net, MMAC Division	Client Address:	2nd Floor – Jefferson State Office Building, Jefferson City, MO 65102		
Contact Name:	Dale Carr	Contact Title:	Director, Department of Social Services		
Contact Phone:	(573) 522-5633	Contact Email:	Dale.carr@dss.mo.gov		
Project Name: Department of Social Services Missouri Medicaid Audit and Compliance TPL Services		Start Date:	03/2017	End Date:	Current
Project Description: Provides TPL Services (CBA, LTC, CAV, CI Billing, and Disallowance) under agreement with MO Health Net, MMAC Division.					
Project Role and Responsibilities: Deliverable and quality oversight and point of escalation for the Account Management and operations teams					
Reference 2					
Client Name:	WI DHS OIG	Client Address:	1 W Wilson, Madison, WI 53703		
Contact Name	Justin Lawfer	Contact Title:	Advanced Auditor		
Contact Phone:	(608) 266-0540	Contact Email:	Justin.lawfer@dhs.wisconsin.gov		
Project Name: WI Department of Health Services Recovery Audit Contract Services		Start Date:	06/2014	End Date:	Current
Project Description: Recovery Audit Contractor - CBA, Clinical Complex, and Edits/ Analytics Audit Reviews					
Project Role and Responsibilities: Delivery and quality oversight and point of escalation for the Account Management and operations teams					
Reference 3					
Client Name:	IL HFS OIG	Client Address:	2200 Churchill Road, Building A-1, Springfield, IL 62702		
Contact Name	Bradley Hart	Contact Title:	Current - Deputy Director, CMS, Center for Program Integrity Previous - Inspector General, Illinois Department of Healthcare and Family Services		
Contact Phone:	(410) 786-7450	Contact Email:	Bradley.hart@cms.hhs.gov		
Project Name: Illinois Department of Healthcare and Family Services Recovery Audit Contract Services		Start Date:	12/2012	End Date:	05/2019
Project Description: Recovery Audit Contractor - CBA, LTC, Clinical Complex and Edits/ Analytics Audit Reviews					
Project Role and Responsibilities: Delivery and quality oversight and point of escalation for the Account Management and operations teams					

5.0 Initial Work Plan

5.1 Instructions (Att 5.1)

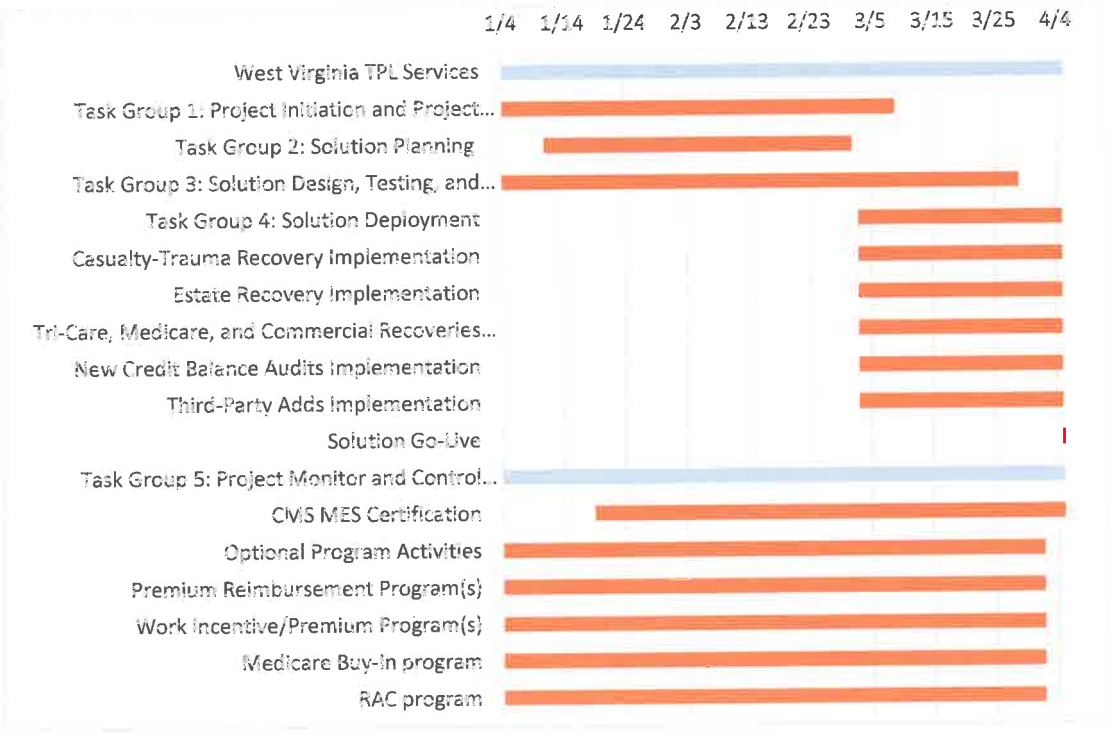
In this section, we provide our Initial Work Plan that responds to BMS' service needs as described in the RFP for both TPL Mandatory Services and the TPL Optional Service activities. Our Initial Work Plan consists of a draft Project Schedule that covers all tasks from contract execution to implementation and through to go-live and beyond. At a high-level, this initial draft Project Schedule includes:

- Detailed tasks and timelines for each project phase
- Identification of all project deliverables and milestones
- Identification of resources assigned to each deliverable

As noted in RFP Appendix 2, we confirm that HMS will provide a draft comprehensive Project Work Plan to BMS for review during the Project Initiation phase. We will collaborate with the applicable BMS stakeholders during project initiation to finalize the Project Work Plan. However, for BMS' immediate reference, in **Exhibit 5-1** we provide a high-level visual showing when the various scopes of work will be implemented and in production.

In the draft Project Schedule, we have indicated "TBD" next to the CMS MES Certification tasks, understanding these will be based on the State's MES Certification timeline. Once the timeline has been determined, HMS will apply more exact dates to these items and will follow necessary steps as part of the State's overall Certification process.

Exhibit 5-1 2021 Project Schedule Snapshot of High-Level Milestones
HMS will collaborate with BMS stakeholders during project initiation to finalize the Project Work Plan.



The Project Schedule includes implementation activities to stand up the new scopes of work for this contract, specifically Optional Services: RAC and Medicare Buy-In. We describe the implementation activities more in proposal **Section 7.3.5 Implementation Plan.**

As the State's incumbent TPL services vendor, all TPL mandatory scopes of work are currently implemented and deployed, with protocols and processes in place and customized for West Virginia. The implemented services include:

- TPL Recoveries:
  - Commercial, Medicare, and TRICARE
  - Casualty-Trauma recovery
  - Estate Recovery
  - Credit Balance Audits
- Third Party Adds (TPL Identification, Cost Avoidance, and Third Party Referral)
- Optional Services:
  - Premium reimbursement program (noted as an optional service in RFP)
  - Work incentive premium program (noted as an optional service in RFP)

From working with BMS over the years, we have gained a unique understanding and perspective that makes this Project Work Plan specifically targeted to BMS' needs.

TPL AND FUTURE MMIS/MES CONSIDERATIONS

As with all Medicaid programs, we understand the challenged BMS faces when operating in an environment of uncertainty, and the coming years are likely no exception. TPL management is a mainstay of the budget management process, saving state Medicaid programs billions of dollars annually. The solution should easily adapt to any technology changes for the near and long term.

Over the past three decades, HMS has successfully interfaced with multiple Medicaid Management Information Systems (MMISs), including West Virginia's, to deliver our TPL services including performing eligibility and other data matches, identifying and pursuing recoveries, and performing audits.

We have also worked jointly with our Medicaid TPL clients throughout the years as many transitioned from one MMIS vendor to another, from a state-operated system to an MMIS vendor, or from an MMIS to Medicaid Enterprise System (MES). As the industry leader in TPL services, we have deigned our solutions to align with modularity and Medicaid Information Technology Architecture (MITA). HMS has remained at the forefront of this initiative and has prepared our TPL platform and solutions to be fully compliant, with Certification in process for NM, WY and VA. Our supporting system are already MITA-aligned and meet the Medicaid Enterprise Certification Toolkit (METC) 2.3 checklist requirements. We are well-positioned to support BMS with any such forthcoming MMIS migration and/or MES transformation initiatives during the new contract.

BMS will benefit from HMS' MES-ready solution and our knowledge of the overall CMS certification protocols and processes, as West Virginia continues to prepare a transition from the current single-system MMIS to a modernized, modular MES that supports all aspects of the Medicaid program and promotes automation, interoperability, and data sharing. Our prior experience with both, along with HMS' hands-on understanding of the CMS Certification process as it relates to both TPL and modularity, provide an excellent starting point for WV in the achievement of CMS Certification.

WBS	RFP Ref	Task Name	Duration	Start	Finish	Predecessors	Resource Names
1		West Virginia TPL Services	1506 days	Mon 1/4/21	Mon 1/4/27		
1.1		Key Dates	1506 days	Mon 1/4/21	Mon 1/4/27		
1.1.1		Key Date - Contract Signed	0 days	Mon 1/4/21	Mon 1/4/21		
1.1.2		Key Date - 1 Project Initiation and Project Management Plan Completed	0 days	Tue 3/9/21	Tue 3/9/21	211	
1.1.3		Key Date - 2 Solution Planning Completed	0 days	Tue 3/2/21	Tue 3/2/21	411	
1.1.4		Key Date - 3 Solution Design, Testing, and Operational Readiness Completed	0 days	Wed 3/24/21	Wed 3/24/21	876	
1.1.5		Key Date - 4 Solution Deployment Completed	0 days	Mon 4/5/21	Mon 4/5/21	1099	
1.1.6		Key Date - WVs TPL Services Go-live	0 days	Mon 4/5/21	Mon 4/5/21	1095	
1.1.7		Key Date - 5 Project Monitor and Control (Recurring Deliverables) Completed	0 days	Mon 1/4/27	Mon 1/4/27	1835	
1.2	1	Task Group 1: Project Initiation and Project Management Plan	44.75 days	Mon 1/4/21	Tue 3/9/21		
1.2.1		Task Group 1 - Deliverables	44.75 days	Mon 1/4/21	Tue 3/9/21		
1.2.1.1	1.1.1	D001 Project Kickoff Meeting	10.5 days	Mon 1/4/21	Tue 1/19/21		
1.2.1.1.1	1.1.1	Review D001 Project Kickoff Meeting Requirements	0.25 days	Mon 1/4/21	Mon 1/4/21	355	Account BA
1.2.1.1.2	1.1.1	Create Draft D001 Project Kickoff Meeting	1 day	Mon 1/4/21	Tue 1/5/21	13	Account BA
1.2.1.1.3	1.1.1	Conduct Internal Work Product Review of D001 Project Kickoff Meeting	1 day	Tue 1/5/21	Wed 1/6/21	14	Account BA
1.2.1.1.4	1.1.1	Revise Draft D001 Project Kickoff Meeting based on Internal Review	0.5 days	Wed 1/6/21	Wed 1/6/21	15	Account BA,Account Quality Mgr
1.2.1.1.5	1.1.1	[illegible]	0 days	[illegible]	[illegible]	[illegible]	[illegible]
1.2.1.1.6	1.1.1	Conduct Work Product Review with Client of Draft D001 Project Kickoff Meeting	0.25 days	Wed 1/6/21	Wed 1/6/21	17	Client Project Mgr[25%],Account Proj Mgr[25%]
1.2.1.1.7	1.1.1	DHHR and Stakeholders Conducts Review of Draft D001 Project Kickoff Meeting	2 days	Thu 1/7/21	Fri 1/8/21	18	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.2.1.1.8	1.1.1	Walkthrough Client Deliverable Review Comments	0.25 days	Mon 1/11/21	Mon 1/11/21	19	Client Project Mgr,Client SME
1.2.1.1.9	1.1.1	Revise D001 Project Kickoff Meeting based on Client Review	2 days	Mon 1/11/21	Wed 1/13/21	20	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.2.1.1.10	1.1.1	Distribute Updated D001 Project Kickoff Meeting to Client for Approval	0.25 days	Wed 1/13/21	Wed 1/13/21	21	Account BA[25%]
1.2.1.1.11	1.1.1	DHHR and Stakeholders Conducts Review of Revisions to D001 Project Kickoff Meeting	1 day	Wed 1/13/21	Thu 1/14/21	22	Account Quality Mgr[20%]
1.2.1.1.12	1.1.1	Milestone - Client Approves D001 Project Kickoff Meeting	0 days	Thu 1/14/21	Thu 1/14/21	[illegible]	[illegible]
1.2.1.1.13	1.1.1	Schedule Kick Off Meeting	0.25 days	Mon 1/11/21	Mon 1/11/21	21SS	Account Proj Mgr
1.2.1.1.14	1.1.1	Hold Kick Off Meeting	1 day	Thu 1/14/21	Fri 1/15/21	24	Account Proj Mgr
1.2.1.1.15	1.1.2	Provide DHHR with Meeting Agenda, Presentation Slide Deck, List of BMS and State Staff Invited, List of Attendees, Meeting Notes	1 day	Fri 1/15/21	Tue 1/19/21	26	Account Proj Mgr
1.2.1.2	1.2.	D002 Project Management Plan	44.75 days	Mon 1/4/21	Tue 3/9/21		
1.2.1.2.1	1.2.	Review D002 Project Management Plan Requirements	0.25 days	Mon 1/4/21	Mon 1/4/21	3	Account BA
1.2.1.2.2	1.2.4.1	Include: Change Management Plan	0 days	Mon 1/25/21	Mon 1/25/21	65	
1.2.1.2.3	1.2.4.2	Include: Communication Management Plan	0 days	Mon 1/25/21	Mon 1/25/21	78	
1.2.1.2.4	1.2.4.3	Include: Cost Management Plan	0 days	Mon 1/25/21	Mon 1/25/21	91	
1.2.1.2.5	1.2.4.4	Include: Documentation Management Plan	0 days	Mon 1/25/21	Mon 1/25/21	104	
1.2.1.2.6	1.2.4.5	Include: Modularity and Reusability Plan	0 days	Mon 1/25/21	Mon 1/25/21	117	
1.2.1.2.7	1.2.4.6	Include: Project Work Plan	0 days	Mon 1/25/21	Mon 1/25/21	118	
1.2.1.2.8	1.2.4.7	Include: Quality Management Plan	0 days	Tue 2/16/21	Tue 2/16/21	143	
1.2.1.2.9	1.2.4.8	Include: Risk and Issues Management Plan	0 days	Tue 2/16/21	Tue 2/16/21	156	
1.2.1.2.10	1.2.4.9	Include: Schedule Management Plan	0 days	Tue 2/16/21	Tue 2/16/21	169	
1.2.1.2.11	1.2.4.10	Include: Scope Management Plan	0 days	Tue 2/16/21	Tue 2/16/21	182	
1.2.1.2.12	1.2.4.11	Include: Staffing Management Plan	0 days	Tue 2/16/21	Tue 2/16/21	195	
1.2.1.2.13	1.2.4.12	Include: Stakeholder Management Plan and Stakeholder Analysis	0 days	Tue 2/16/21	Tue 2/16/21	208	
1.2.1.2.14	1.2.	Create Draft D002 Project Management Plan	3 days	Wed 2/17/21	Fri 2/19/21	30,31,32,33,34,35,36,37,38,39,40,41	Account BA
1.2.1.2.15	1.2.	Conduct Internal Work Product Review of D002 Project Management Plan	1 day	Mon 2/22/21	Mon 2/22/21	42	Account BA
1.2.1.2.16	1.2.	Revise Draft D002 Project Management Plan based on Internal Review	2 days	Tue 2/23/21	Wed 2/24/21	43	Account BA,Account Quality Mgr
1.2.1.2.17	1.2.	[illegible]	0 days	[illegible]	[illegible]	[illegible]	[illegible]
1.2.1.2.18	1.2.	Conduct Work Product Review with Client of Draft D002 Project Management Plan	0.25 days	Thu 2/25/21	Thu 2/25/21	45	Client Project Mgr[25%],Account Proj Mgr[25%]
1.2.1.2.19	1.2.	DHHR and Stakeholders Conducts Review of Draft D002 Project Management Plan	5 days	Thu 2/25/21	Thu 3/4/21	46	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.2.1.2.20	1.2.	Walkthrough Client Deliverable Review Comments	0.25 days	Thu 3/4/21	Thu 3/4/21	47	Client Project Mgr,Client SME
1.2.1.2.21	1.2.	Revise D002 Project Management Plan based on Client Review	2 days	Thu 3/4/21	Mon 3/8/21	48	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.2.1.2.22	1.2.	Distribute Updated D002 Project Management Plan to Client for Approval	0.25 days	Mon 3/8/21	Mon 3/8/21	49	Account BA[25%]
1.2.1.2.23	1.2.	DHHR and Stakeholders Conducts Review of Revisions to D002 Project Management Plan	1 day	Mon 3/8/21	Tue 3/9/21	50	Account Quality Mgr[20%]
1.2.1.2.24	1.2.	Milestone - Client Approves D002 Project Management Plan	0 days	Tue 3/9/21	Tue 3/9/21	[illegible]	[illegible]
1.2.1.3	1.3.	D003 Change Management Plan	15 days	Mon 1/4/21	Mon 1/25/21		
1.2.1.3.1	1.3.	Review D003 Change Management Plan Requirements	0.25 days	Mon 1/4/21	Mon 1/4/21	3	Account BA
1.2.1.3.2	1.3.	Create Draft D003 Change Management Plan	3 days	Mon 1/4/21	Thu 1/7/21	54	Account BA
1.2.1.3.3	1.3.	Conduct Internal Work Product Review of D003 Change Management Plan	1 day	Thu 1/7/21	Fri 1/8/21	55	Account BA
1.2.1.3.4	1.3.	Revise Draft D003 Change Management Plan based on Internal Review	2 days	Fri 1/8/21	Tue 1/12/21	56	Account BA,Account Quality Mgr
1.2.1.3.5	1.3.	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
1.2.1.3.6	1.3.	Conduct Work Product Review with Client of Draft D003 Change Management Plan	0.25 days	Tue 1/12/21	Tue 1/12/21	58	Client Project Mgr[25%],Account Proj Mgr[25%]
1.2.1.3.7	1.3.	DHHR and Stakeholders Conducts Review of Draft D003 Change Management Plan	5 days	Tue 1/12/21	Wed 1/20/21	59	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.2.1.3.8	1.3.	Walkthrough Client Deliverable Review Comments	0.25 days	Wed 1/20/21	Wed 1/20/21	60	Client Project Mgr,Client SME
1.2.1.3.9	1.3.	Revise D003 Change Management Plan based on Client Review	2 days	Wed 1/20/21	Fri 1/22/21	61	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.2.1.3.10	1.3.	Distribute Updated D003 Change Management Plan to Client for Approval	0.25 days	Fri 1/22/21	Fri 1/22/21	62	Account BA[25%]
1.2.1.3.11	1.3.	DHHR and Stakeholders Conducts Review of Revisions to D003 Change Management Plan	1 day	Mon 1/25/21	Mon 1/25/21	63	Account Quality Mgr[20%]
1.2.1.3.12	1.3.	Milestone - Client Approves D003 Change Management Plan	0 days	Mon 1/25/21	Mon 1/25/21	[illegible]	[illegible]

1.2.1.4	1.4.	**D004 Communication Management Plan**	15 days	Mon 1/4/21	Mon 1/25/21		
1.2.1.4.1	1.4.	Review D004 Communication Management Plan Requirements	0.25 days	Mon 1/4/21	Mon 1/4/21	3	Account BA
1.2.1.4.2	1.4.	Create Draft D004 Communication Management Plan	3 days	Mon 1/4/21	Thu 1/7/21	67	Account BA
1.2.1.4.3	1.4.	Conduct Internal Work Product Review of D004 Communication Management Plan	1 day	Thu 1/7/21	Fri 1/8/21	68	Account BA
1.2.1.4.4	1.4.	Revise Draft D004 Communication Management Plan based on Internal Review	2 days	Fri 1/8/21	Tue 1/12/21	69	Account BA,Account Quality Mgr
1.2.1.4.5	1.4.	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
1.2.1.4.6	1.4.	Conduct Work Product Review with Client of Draft D004 Communication Management Plan	0.25 days	Tue 1/12/21	Tue 1/12/21	71	Client Project Mgr[25%],Account Proj Mgr[25%]
1.2.1.4.7	1.4.	DHHR and Stakeholders Conducts Review of Draft D004 Communication Management Plan	5 days	Tue 1/12/21	Wed 1/20/21	72	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.2.1.4.8	1.4.	Walkthrough Client Deliverable Review Comments	0.25 days	Wed 1/20/21	Wed 1/20/21	73	Client Project Mgr,Client SME
1.2.1.4.9	1.4.	Revise D004 Communication Management Plan based on Client Review	2 days	Wed 1/20/21	Fri 1/22/21	74	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.2.1.4.10	1.4.	Distribute Updated D004 Communication Management Plan to Client for Approval	0.25 days	Fri 1/22/21	Fri 1/22/21	75	Account BA[25%]
1.2.1.4.11	1.4.	DHHR and Stakeholders Conducts Review of Revisions to D004 Communication Management Plan	1 day	Mon 1/25/21	Mon 1/25/21	76	Account Quality Mgr[20%]
1.2.1.4.12	1.4.	Milestone - Client Approves D004 Communication Management Plan	0 days	Mon 1/25/21	Mon 1/25/21	77	Client Project Mgr,Client SME
1.2.1.5	1.5.	**D005 Cost Management Plan**	15 days	Mon 1/4/21	Mon 1/25/21		
1.2.1.5.1	1.5.	Review D005 Cost Management Plan Requirements	0.25 days	Mon 1/4/21	Mon 1/4/21	3	Account BA
1.2.1.5.2	1.5.	Create Draft D005 Cost Management Plan	3 days	Mon 1/4/21	Thu 1/7/21	80	Account BA
1.2.1.5.3	1.5.	Conduct Internal Work Product Review of D005 Cost Management Plan	1 day	Thu 1/7/21	Fri 1/8/21	81	Account BA
1.2.1.5.4	1.5.	Revise Draft D005 Cost Management Plan based on Internal Review	2 days	Fri 1/8/21	Tue 1/12/21	82	Account BA,Account Quality Mgr
1.2.1.5.5	1.5.	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
1.2.1.5.6	1.5.	Conduct Work Product Review with Client of Draft D005 Cost Management Plan	0.25 days	Tue 1/12/21	Tue 1/12/21	84	Client Project Mgr[25%],Account Proj Mgr[25%]
1.2.1.5.7	1.5.	DHHR and Stakeholders Conducts Review of Draft D005 Cost Management Plan	5 days	Tue 1/12/21	Wed 1/20/21	85	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.2.1.5.8	1.5.	Walkthrough Client Deliverable Review Comments	0.25 days	Wed 1/20/21	Wed 1/20/21	86	Client Project Mgr,Client SME
1.2.1.5.9	1.5.	Revise D005 Cost Management Plan based on Client Review	2 days	Wed 1/20/21	Fri 1/22/21	87	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.2.1.5.10	1.5.	Distribute Updated D005 Cost Management Plan to Client for Approval	0.25 days	Fri 1/22/21	Fri 1/22/21	88	Account BA[25%]
1.2.1.5.11	1.5.	DHHR and Stakeholders Conducts Review of Revisions to D005 Cost Management Plan	1 day	Mon 1/25/21	Mon 1/25/21	89	Account Quality Mgr[20%]
1.2.1.5.12	1.5.	Milestone - Client Approves D005 Cost Management Plan	0 days	Mon 1/25/21	Mon 1/25/21	90	Client Project Mgr,Client SME
1.2.1.6	1.6.	**D006 Documentation Management Plan**	15 days	Mon 1/4/21	Mon 1/25/21		
1.2.1.6.1	1.6.	Review D006 Documentation Management Plan Requirements	0.25 days	Mon 1/4/21	Mon 1/4/21	3	Account BA
1.2.1.6.2	1.6.	Create Draft D006 Documentation Management Plan	3 days	Mon 1/4/21	Thu 1/7/21	93	Account BA
1.2.1.6.3	1.6.	Conduct Internal Work Product Review of D006 Documentation Management Plan	1 day	Thu 1/7/21	Fri 1/8/21	94	Account BA
1.2.1.6.4	1.6.	Revise Draft D006 Documentation Management Plan based on Internal Review	2 days	Fri 1/8/21	Tue 1/12/21	95	Account BA,Account Quality Mgr
1.2.1.6.5	1.6.	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
1.2.1.6.6	1.6.	Conduct Work Product Review with Client of Draft D006 Documentation Management Plan	0.25 days	Tue 1/12/21	Tue 1/12/21	97	Client Project Mgr[25%],Account Proj Mgr[25%]
1.2.1.6.7	1.6.	DHHR and Stakeholders Conducts Review of Draft D006 Documentation Management Plan	5 days	Tue 1/12/21	Wed 1/20/21	98	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.2.1.6.8	1.6.	Walkthrough Client Deliverable Review Comments	0.25 days	Wed 1/20/21	Wed 1/20/21	99	Client Project Mgr,Client SME
1.2.1.6.9	1.6.	Revise D006 Documentation Management Plan based on Client Review	2 days	Wed 1/20/21	Fri 1/22/21	100	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.2.1.6.10	1.6.	Distribute Updated D006 Documentation Management Plan to Client for Approval	0.25 days	Fri 1/22/21	Fri 1/22/21	101	Account BA[25%]
1.2.1.6.11	1.6.	DHHR and Stakeholders Conducts Review of Revisions to D006 Documentation Management Plan	1 day	Mon 1/25/21	Mon 1/25/21	102	Account Quality Mgr[20%]
1.2.1.6.12	1.6.	Milestone - Client Approves D006 Documentation Management Plan	0 days	Mon 1/25/21	Mon 1/25/21	103	Client Project Mgr,Client SME
1.2.1.7	1.7.	**D007 Modularity and Reusability Plan**	15 days	Mon 1/4/21	Mon 1/25/21		
1.2.1.7.1	1.7.	Review D007 Modularity and Reusability Plan Requirements	0.25 days	Mon 1/4/21	Mon 1/4/21	3	Account BA
1.2.1.7.2	1.7.	Create Draft D007 Modularity and Reusability Plan	3 days	Mon 1/4/21	Thu 1/7/21	106	Account BA
1.2.1.7.3	1.7.	Conduct Internal Work Product Review of D007 Modularity and Reusability Plan	1 day	Thu 1/7/21	Fri 1/8/21	107	Account BA
1.2.1.7.4	1.7.	Revise Draft D007 Modularity and Reusability Plan based on Internal Review	2 days	Fri 1/8/21	Tue 1/12/21	108	Account BA,Account Quality Mgr
1.2.1.7.5	1.7.	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
1.2.1.7.6	1.7.	Conduct Work Product Review with Client of Draft D007 Modularity and Reusability Plan	0.25 days	Tue 1/12/21	Tue 1/12/21	110	Client Project Mgr[25%],Account Proj Mgr[25%]
1.2.1.7.7	1.7.	DHHR and Stakeholders Conducts Review of Draft D007 Modularity and Reusability Plan	5 days	Tue 1/12/21	Wed 1/20/21	111	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.2.1.7.8	1.7.	Walkthrough Client Deliverable Review Comments	0.25 days	Wed 1/20/21	Wed 1/20/21	112	Client Project Mgr,Client SME
1.2.1.7.9	1.7.	Revise D007 Modularity and Reusability Plan based on Client Review	2 days	Wed 1/20/21	Fri 1/22/21	113	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.2.1.7.10	1.7.	Distribute Updated D007 Modularity and Reusability Plan to Client for Approval	0.25 days	Fri 1/22/21	Fri 1/22/21	114	Account BA[25%]
1.2.1.7.11	1.7.	DHHR and Stakeholders Conducts Review of Revisions to D007 Modularity and Reusability Plan	1 day	Mon 1/25/21	Mon 1/25/21	115	Account Quality Mgr[20%]
1.2.1.7.12	1.7.	Milestone - Client Approves D007 Modularity and Reusability Plan	0 days	Mon 1/25/21	Mon 1/25/21	116	Client Project Mgr,Client SME
1.2.1.8	1.8.	**D008 Project Work Plan**	15 days	Mon 1/4/21	Mon 1/25/21		
1.2.1.8.1	1.8.	Review D008 Project Work Plan Requirements	0.25 days	Mon 1/4/21	Mon 1/4/21	3	Account BA
1.2.1.8.2	1.8.	Create Draft D008 Project Work Plan	3 days	Mon 1/4/21	Thu 1/7/21	119	Account BA
1.2.1.8.3	1.8.	Conduct Internal Work Product Review of D008 Project Work Plan	1 day	Thu 1/7/21	Fri 1/8/21	120	Account BA
1.2.1.8.4	1.8.	Revise Draft D008 Project Work Plan based on Internal Review	2 days	Fri 1/8/21	Tue 1/12/21	121	Account BA,Account Quality Mgr
1.2.1.8.5	1.8.	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
1.2.1.8.6	1.8.	Conduct Work Product Review with Client of Draft D008 Project Work Plan	0.25 days	Tue 1/12/21	Tue 1/12/21	123	Client Project Mgr[25%],Account Proj Mgr[25%]
1.2.1.8.7	1.8.	DHHR and Stakeholders Conducts Review of Draft D008 Project Work Plan	5 days	Tue 1/12/21	Wed 1/20/21	124	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.2.1.8.8	1.8.	Walkthrough Client Deliverable Review Comments	0.25 days	Wed 1/20/21	Wed 1/20/21	125	Client Project Mgr,Client SME
1.2.1.8.9	1.8.	Revise D008 Project Work Plan based on Client Review	2 days	Wed 1/20/21	Fri 1/22/21	126	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.2.1.8.10	1.8.	Distribute Updated D008 Project Work Plan to Client for Approval	0.25 days	Fri 1/22/21	Fri 1/22/21	127	Account BA[25%]
1.2.1.8.11	1.8.	DHHR and Stakeholders Conducts Review of Revisions to D008 Project Work Plan	1 day	Mon 1/25/21	Mon 1/25/21	128	Account Quality Mgr[20%]
1.2.1.8.12	1.8.	Milestone - Client Approves D008 Project Work Plan	0 days	Mon 1/25/21	Mon 1/25/21	129	Client Project Mgr,Client SME
1.2.1.9	1.9.	**D009 Quality Management Plan**	15 days	Tue 1/26/21	Tue 2/16/21		
1.2.1.9.1	1.9.	Review D009 Quality Management Plan Requirements	0.25 days	Tue 1/26/21	Tue 1/26/21	3FS+15 days	Account BA

1.2.1.9.2	1.9.	Create Draft D009 Quality Management Plan	3 days	Tue 1/26/21	Fri 1/29/21		132	Account BA
1.2.1.9.3	1.9.	Conduct Internal Work Product Review of D009 Quality Management Plan	1 day	Fri 1/29/21	Mon 2/1/21		133	Account BA
1.2.1.9.4	1.9.	Revise Draft D009 Quality Management Plan based on Internal Review	2 days	Mon 2/1/21	Wed 2/3/21		134	Account BA,Account Quality Mgr
1.2.1.9.5	1.9.	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]
1.2.1.9.6	1.9.	Conduct Work Product Review with Client of Draft D009 Quality Management Plan	0.25 days	Wed 2/3/21	Wed 2/3/21		136	Client Project Mgr[25%],Account Proj Mgr[25%]
1.2.1.9.7	1.9.	DHHR and Stakeholders Conducts Review of Draft D009 Quality Management Plan	5 days	Wed 2/3/21	Wed 2/10/21		137	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.2.1.9.8	1.9.	Walkthrough Client Deliverable Review Comments	0.25 days	Wed 2/10/21	Wed 2/10/21		138	Client Project Mgr,Client SME
1.2.1.9.9	1.9.	Revise D009 Quality Management Plan based on Client Review	2 days	Wed 2/10/21	Fri 2/12/21		139	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.2.1.9.10	1.9.	Distribute Updated D009 Quality Management Plan to Client for Approval	0.25 days	Fri 2/12/21	Fri 2/12/21		140	Account BA[25%]
1.2.1.9.11	1.9.	DHHR and Stakeholders Conducts Review of Revisions to D009 Quality Management Plan	1 day	Tue 2/16/21	Tue 2/16/21		141	Account Quality Mgr[20%]
1.2.1.9.12	1.9	Milestone - Client Approves D009 Quality Management Plan	0 days	[illegible]	[illegible]		[illegible]	[illegible]
1.2.1.10	**1.10.**	**D010 Risk and Issue Management Plan**	**15 days**	**Tue 1/26/21**	**Tue 2/16/21**			
1.2.1.10.1	1.10.	Review D010 Risk and Issue Management Plan Requirements	0.25 days	Tue 1/26/21	Tue 1/26/21	3FS+15 days		Account BA
1.2.1.10.2	1.10.	Create Draft D010 Risk and Issue Management Plan	3 days	Tue 1/26/21	Fri 1/29/21		145	Account BA
1.2.1.10.3	1.10.	Conduct Internal Work Product Review of D010 Risk and Issue Management Plan	1 day	Fri 1/29/21	Mon 2/1/21		146	Account BA
1.2.1.10.4	1.10.	Revise Draft D010 Risk and Issue Management Plan based on Internal Review	2 days	Mon 2/1/21	Wed 2/3/21		147	Account BA,Account Quality Mgr
1.2.1.10.5	1.10.	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]
1.2.1.10.6	1.10.	Conduct Work Product Review with Client of Draft D010 Risk and Issue Management Plan	0.25 days	Wed 2/3/21	Wed 2/3/21		149	Client Project Mgr[25%],Account Proj Mgr[25%]
1.2.1.10.7	1.10.	DHHR and Stakeholders Conducts Review of Draft D010 Risk and Issue Management Plan	5 days	Wed 2/3/21	Wed 2/10/21		150	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.2.1.10.8	1.10.	Walkthrough Client Deliverable Review Comments	0.25 days	Wed 2/10/21	Wed 2/10/21		151	Client Project Mgr,Client SME
1.2.1.10.9	1.10.	Revise D010 Risk and Issue Management Plan based on Client Review	2 days	Wed 2/10/21	Fri 2/12/21		152	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.2.1.10.10	1.10.	Distribute Updated D010 Risk and Issue Management Plan to Client for Approval	0.25 days	Fri 2/12/21	Fri 2/12/21		153	Account BA[25%]
1.2.1.10.11	1.10.	DHHR and Stakeholders Conducts Review of Revisions to D010 Risk and Issue Management Plan	1 day	Tue 2/16/21	Tue 2/16/21		154	Account Quality Mgr[20%]
1.2.1.10.12	1.10.	Milestone - Client Approves D010 Risk and Issue Management Plan	0 days	[illegible]	[illegible]		[illegible]	[illegible]
1.2.1.11	**1.11.**	**D011 Schedule Management Plan**	**15 days**	**Tue 1/26/21**	**Tue 2/16/21**			
1.2.1.11.1	1.11.	Review D011 Schedule Management Plan Requirements	0.25 days	Tue 1/26/21	Tue 1/26/21	3FS+15 days		Account BA
1.2.1.11.2	1.11.	Create Draft D011 Schedule Management Plan	3 days	Tue 1/26/21	Fri 1/29/21		158	Account BA
1.2.1.11.3	1.11.	Conduct Internal Work Product Review of D011 Schedule Management Plan	1 day	Fri 1/29/21	Mon 2/1/21		159	Account BA
1.2.1.11.4	1.11.	Revise Draft D011 Schedule Management Plan based on Internal Review	2 days	Mon 2/1/21	Wed 2/3/21		160	Account BA,Account Quality Mgr
1.2.1.11.5	1.11.	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]
1.2.1.11.6	1.11.	Conduct Work Product Review with Client of Draft D011 Schedule Management Plan	0.25 days	Wed 2/3/21	Wed 2/3/21		162	Client Project Mgr[25%],Account Proj Mgr[25%]
1.2.1.11.7	1.11.	DHHR and Stakeholders Conducts Review of Draft D011 Schedule Management Plan	5 days	Wed 2/3/21	Wed 2/10/21		163	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.2.1.11.8	1.11.	Walkthrough Client Deliverable Review Comments	0.25 days	Wed 2/10/21	Wed 2/10/21		164	Client Project Mgr,Client SME
1.2.1.11.9	1.11.	Revise D011 Schedule Management Plan based on Client Review	2 days	Wed 2/10/21	Fri 2/12/21		165	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.2.1.11.10	1.11.	Distribute Updated D011 Schedule Management Plan to Client for Approval	0.25 days	Fri 2/12/21	Fri 2/12/21		166	Account BA[25%]
1.2.1.11.11	1.11.	DHHR and Stakeholders Conducts Review of Revisions to D011 Schedule Management Plan	1 day	Tue 2/16/21	Tue 2/16/21		167	Account Quality Mgr[20%]
1.2.1.11.12	1.11.	Milestone - Client Approves D011 Schedule Management Plan	0 days	[illegible]	[illegible]		[illegible]	[illegible]
1.2.1.12	**1.12.**	**D012 Scope Management Plan**	**15 days**	**Tue 1/26/21**	**Tue 2/16/21**			
1.2.1.12.1	1.12.	Review D012 Scope Management Plan Requirements	0.25 days	Tue 1/26/21	Tue 1/26/21	3FS+15 days		Account BA
1.2.1.12.2	1.12.	Create Draft D012 Scope Management Plan	3 days	Tue 1/26/21	Fri 1/29/21		171	Account BA
1.2.1.12.3	1.12.	Conduct Internal Work Product Review of D012 Scope Management Plan	1 day	Fri 1/29/21	Mon 2/1/21		172	Account BA
1.2.1.12.4	1.12.	Revise Draft D012 Scope Management Plan based on Internal Review	2 days	Mon 2/1/21	Wed 2/3/21		173	Account BA,Account Quality Mgr
1.2.1.12.5	1.12.	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]
1.2.1.12.6	1.12.	Conduct Work Product Review with Client of Draft D012 Scope Management Plan	0.25 days	Wed 2/3/21	Wed 2/3/21		175	Client Project Mgr[25%],Account Proj Mgr[25%]
1.2.1.12.7	1.12.	DHHR and Stakeholders Conducts Review of Draft D012 Scope Management Plan	5 days	Wed 2/3/21	Wed 2/10/21		176	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.2.1.12.8	1.12.	Walkthrough Client Deliverable Review Comments	0.25 days	Wed 2/10/21	Wed 2/10/21		177	Client Project Mgr,Client SME
1.2.1.12.9	1.12.	Revise D012 Scope Management Plan based on Client Review	2 days	Wed 2/10/21	Fri 2/12/21		178	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.2.1.12.10	1.12.	Distribute Updated D012 Scope Management Plan to Client for Approval	0.25 days	Fri 2/12/21	Fri 2/12/21		179	Account BA[25%]
1.2.1.12.11	1.12.	DHHR and Stakeholders Conducts Review of Revisions to D012 Scope Management Plan	1 day	Tue 2/16/21	Tue 2/16/21		180	Account Quality Mgr[20%]
1.2.1.12.12	1.12	Milestone - Client Approves D012 Scope Management Plan	0 days	[illegible]	[illegible]		[illegible]	[illegible]
1.2.1.13	**1.13.**	**D013 Staffing Management Plan**	**15 days**	**Tue 1/26/21**	**Tue 2/16/21**			
1.2.1.13.1	1.13.	Review D013 Staffing Management Plan Requirements	0.25 days	Tue 1/26/21	Tue 1/26/21	3FS+15 days		Account BA
1.2.1.13.2	1.13.	Create Draft D013 Staffing Management Plan	3 days	Tue 1/26/21	Fri 1/29/21		184	Account BA
1.2.1.13.3	1.13.	Conduct Internal Work Product Review of D013 Staffing Management Plan	1 day	Fri 1/29/21	Mon 2/1/21		185	Account BA
1.2.1.13.4	1.13.	Revise Draft D013 Staffing Management Plan based on Internal Review	2 days	Mon 2/1/21	Wed 2/3/21		186	Account BA,Account Quality Mgr
1.2.1.13.5	1.13.	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]
1.2.1.13.6	1.13.	Conduct Work Product Review with Client of Draft D013 Staffing Management Plan	0.25 days	Wed 2/3/21	Wed 2/3/21		188	Client Project Mgr[25%],Account Proj Mgr[25%]
1.2.1.13.7	1.13.	DHHR and Stakeholders Conducts Review of Draft D013 Staffing Management Plan	5 days	Wed 2/3/21	Wed 2/10/21		189	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.2.1.13.8	1.13.	Walkthrough Client Deliverable Review Comments	0.25 days	Wed 2/10/21	Wed 2/10/21		190	Client Project Mgr,Client SME
1.2.1.13.9	1.13.	Revise D013 Staffing Management Plan based on Client Review	2 days	Wed 2/10/21	Fri 2/12/21		191	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.2.1.13.10	1.13.	Distribute Updated D013 Staffing Management Plan to Client for Approval	0.25 days	Fri 2/12/21	Fri 2/12/21		192	Account BA[25%]
1.2.1.13.11	1.13.	DHHR and Stakeholders Conducts Review of Revisions to D013 Staffing Management Plan	1 day	Tue 2/16/21	Tue 2/16/21		193	Account Quality Mgr[20%]
1.2.1.13.12	1.13	Milestone - Client Approves D013 Staffing Management Plan	0 days	[illegible]	[illegible]		[illegible]	[illegible]
1.2.1.14	**1.14.**	**D014 Stakeholder Management Plan and Stakeholder Analysis**	**15 days**	**Tue 1/26/21**	**Tue 2/16/21**			
1.2.1.14.1	1.14.	Review D014 Stakeholder Management Plan and Stakeholder Analysis Requirements	0.25 days	Tue 1/26/21	Tue 1/26/21	3FS+15 days		Account BA
1.2.1.14.2	1.14.	Create Draft D014 Stakeholder Management Plan and Stakeholder Analysis	3 days	Tue 1/26/21	Fri 1/29/21		197	Account BA
1.2.1.14.3	1.14.	Conduct Internal Work Product Review of D014 Stakeholder Management Plan and Stakeholder Analysis	1 day	Fri 1/29/21	Mon 2/1/21		198	Account BA

1.2.1.14.4	1.14.		Revise Draft D014 Stakeholder Management Plan and Stakeholder Analysis based on Internal Review	2 days	Mon 2/1/21	Wed 2/3/21		199	Account BA,Account Quality Mgr
1.2.1.14.5	1.14.		[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]
1.2.1.14.6	1.14.		Conduct Work Product Review with Client of Draft D014 Stakeholder Management Plan and Stakeholder Analysis	0.25 days	Wed 2/3/21	Wed 2/3/21		201	Client Project Mgr[25%],Account Proj Mgr[25%]
1.2.1.14.7	1.14.		DHHR and Stakeholders Conducts Review of Draft D014 Stakeholder Management Plan and Stakeholder Analysis	5 days	Wed 2/3/21	Wed 2/10/21		202	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.2.1.14.8	1.14.		Walkthrough Client Deliverable Review Comments	0.25 days	Wed 2/10/21	Wed 2/10/21		203	Client Project Mgr,Client SME
1.2.1.14.9	1.14.		Revise D014 Stakeholder Management Plan and Stakeholder Analysis based on Client Review	2 days	Wed 2/10/21	Fri 2/12/21		204	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.2.1.14.10	1.14.		Distribute Updated D014 Stakeholder Management Plan and Stakeholder Analysis to Client for Approval	0.25 days	Fri 2/12/21	Fri 2/12/21		205	Account BA[25%]
1.2.1.14.11	1.14.		DHHR and Stakeholders Conducts Review of Revisions to D014 Stakeholder Management Plan and Stakeholder Analysis	1 day	Tue 2/16/21	Tue 2/16/21		206	Account Quality Mgr[20%]
1.2.1.14.12	1.14.		Milestone - Client Approves D014 Stakeholder Management Plan and Stakeholder Analysis	0 days	Tue 2/16/21	Tue 2/16/21		207	Client Project Mgr,Client SME
1.2.2			Milestone: Task Group 1: Deliverables Complete	0 days	Tue 3/9/21	Tue 3/9/21	24,52,65,78,91,104,117,130,143,156,169,182,195,208		
1.2.3		1	Payment Milestone 1: Project Initiation Complete (Deliverables D001 through D014)	0 days	Tue 3/9/21	Tue 3/9/21		209	
1.3			Milestone: Task Group 1: Project Initiation and Project Management Plan Complete	0 days	Tue 3/9/21	Tue 3/9/21		52	
1.4		**2**	**Task Group 2: Solution Planning**	**35 days**	**Mon 1/11/21**	**Tue 3/2/21**			
1.4.1			**Task Group 2 - Deliverables**	**35 days**	**Mon 1/11/21**	**Tue 3/2/21**			
1.4.1.1	**2.1.**		**D015 Data Management Plan (including Governance and Quality)**	**15 days**	**Tue 2/9/21**	**Tue 3/2/21**			
1.4.1.1.1	2.1.		Review D015 Data Management Plan (including Governance and Quality) Requirements	0.25 days	Tue 2/9/21	Tue 2/9/21	291,304,317,330		Account BA
1.4.1.1.2	2.1.		Create Draft D015 Data Management Plan (including Governance and Quality)	3 days	Tue 2/9/21	Fri 2/12/21		215	Account BA
1.4.1.1.3	2.1.		Conduct Internal Work Product Review of D015 Data Management Plan (including Governance and Quality)	1 day	Fri 2/12/21	Tue 2/16/21		216	Account BA
1.4.1.1.4	2.1.		Revise Draft D015 Data Management Plan (including Governance and Quality) based on Internal Review	2 days	Tue 2/16/21	Thu 2/18/21		217	Account BA,Account Quality Mgr
1.4.1.1.5	2.1.		[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]
1.4.1.1.6	2.1.		Conduct Work Product Review with Client of Draft D015 Data Management Plan (including Governance and Quality)	0.25 days	Thu 2/18/21	Thu 2/18/21		219	Client Project Mgr[25%],Account Proj Mgr[25%]
1.4.1.1.7	2.1.		DHHR and Stakeholders Conducts Review of Draft D015 Data Management Plan (including Governance and Quality)	5 days	Thu 2/18/21	Thu 2/25/21		220	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.4.1.1.8	2.1.		Walkthrough Client Deliverable Review Comments	0.25 days	Thu 2/25/21	Thu 2/25/21		221	Client Project Mgr,Client SME
1.4.1.1.9	2.1.		Revise D015 Data Management Plan (including Governance and Quality) based on Client Review	2 days	Thu 2/25/21	Mon 3/1/21		222	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.4.1.1.10	2.1.		Distribute Updated D015 Data Management Plan (including Governance and Quality) to Client for Approval	0.25 days	Mon 3/1/21	Mon 3/1/21		223	Account BA[25%]
1.4.1.1.11	2.1.		DHHR and Stakeholders Conducts Review of Revisions to D015 Data Management Plan (including Governance and Quality)	1 day	Tue 3/2/21	Tue 3/2/21		224	Account Quality Mgr[20%]
1.4.1.1.12	2.1.		Milestone - Client Approves D015 Data Management Plan (including Governance and Quality)	0 days	Tue 3/2/21	Tue 3/2/21		225	Client Project Mgr,Client SME
1.4.1.2	**2.2.**		**D016 Data Security, Privacy, and Confidentiality Plan**	**15 days**	**Tue 2/9/21**	**Tue 3/2/21**			
1.4.1.2.1	2.2.		Review D016 Data Security, Privacy, and Confidentiality Plan Requirements	0.25 days	Tue 2/9/21	Tue 2/9/21	291,304,317,330		Account BA
1.4.1.2.2	2.2.		Create Draft D016 Data Security, Privacy, and Confidentiality Plan	3 days	Tue 2/9/21	Fri 2/12/21		228	Account BA
1.4.1.2.3	2.2.		Conduct Internal Work Product Review of D016 Data Security, Privacy, and Confidentiality Plan	1 day	Fri 2/12/21	Tue 2/16/21		229	Account BA
1.4.1.2.4	2.2.		Revise Draft D016 Data Security, Privacy, and Confidentiality Plan based on Internal Review	2 days	Tue 2/16/21	Thu 2/18/21		230	Account BA,Account Quality Mgr
1.4.1.2.5	2.2.		[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]
1.4.1.2.6	2.2.		Conduct Work Product Review with Client of Draft D016 Data Security, Privacy, and Confidentiality Plan	0.25 days	Thu 2/18/21	Thu 2/18/21		232	Client Project Mgr[25%],Account Proj Mgr[25%]
1.4.1.2.7	2.2.		DHHR and Stakeholders Conducts Review of Draft D016 Data Security, Privacy, and Confidentiality Plan	5 days	Thu 2/18/21	Thu 2/25/21		233	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.4.1.2.8	2.2.		Walkthrough Client Deliverable Review Comments	0.25 days	Thu 2/25/21	Thu 2/25/21		234	Client Project Mgr,Client SME
1.4.1.2.9	2.2.		Revise D016 Data Security, Privacy, and Confidentiality Plan based on Client Review	2 days	Thu 2/25/21	Mon 3/1/21		235	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.4.1.2.10	2.2.		Distribute Updated D016 Data Security, Privacy, and Confidentiality Plan to Client for Approval	0.25 days	Mon 3/1/21	Mon 3/1/21		236	Account BA[25%]
1.4.1.2.11	2.2.		DHHR and Stakeholders Conducts Review of Revisions to D016 Data Security, Privacy, and Confidentiality Plan	1 day	Tue 3/2/21	Tue 3/2/21		237	Account Quality Mgr[20%]
1.4.1.2.12	2.2.		Milestone - Client Approves D016 Data Security, Privacy, and Confidentiality Plan	0 days	Tue 3/2/21	Tue 3/2/21		238	Client Project Mgr,Client SME
1.4.1.3	**2.3.**		**D017 Incident Management Plan**	**15 days**	**Tue 2/9/21**	**Tue 3/2/21**			
1.4.1.3.1	2.3.		Review D017 Incident Management Plan Requirements	0.25 days	Tue 2/9/21	Tue 2/9/21	291,304,317,330		Account BA
1.4.1.3.2	2.3.		Create Draft D017 Incident Management Plan	3 days	Tue 2/9/21	Fri 2/12/21		241	Account BA
1.4.1.3.3	2.3.		Conduct Internal Work Product Review of D017 Incident Management Plan	1 day	Fri 2/12/21	Tue 2/16/21		242	Account BA
1.4.1.3.4	2.3.		Revise Draft D017 Incident Management Plan based on Internal Review	2 days	Tue 2/16/21	Thu 2/18/21		243	Account BA,Account Quality Mgr
1.4.1.3.5	2.3.		[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]
1.4.1.3.6	2.3.		Conduct Work Product Review with Client of Draft D017 Incident Management Plan	0.25 days	Thu 2/18/21	Thu 2/18/21		245	Client Project Mgr[25%],Account Proj Mgr[25%]
1.4.1.3.7	2.3.		DHHR and Stakeholders Conducts Review of Draft D017 Incident Management Plan	5 days	Thu 2/18/21	Thu 2/25/21		246	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.4.1.3.8	2.3.		Walkthrough Client Deliverable Review Comments	0.25 days	Thu 2/25/21	Thu 2/25/21		247	Client Project Mgr,Client SME
1.4.1.3.9	2.3.		Revise D017 Incident Management Plan based on Client Review	2 days	Thu 2/25/21	Mon 3/1/21		248	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.4.1.3.10	2.3.		Distribute Updated D017 Incident Management Plan to Client for Approval	0.25 days	Mon 3/1/21	Mon 3/1/21		249	Account BA[25%]
1.4.1.3.11	2.3.		DHHR and Stakeholders Conducts Review of Revisions to D017 Incident Management Plan	1 day	Tue 3/2/21	Tue 3/2/21		250	Account Quality Mgr[20%]
1.4.1.3.12	2.3.		Milestone - Client Approves D017 Incident Management Plan	0 days	Tue 3/2/21	Tue 3/2/21		251	Client Project Mgr,Client SME
1.4.1.4	**2.4.**		**D018 Master Test Plan (Testing Management Plan)**	**15 days**	**Tue 2/9/21**	**Tue 3/2/21**			
1.4.1.4.1	2.4.		Review D018 Master Test Plan (Testing Management Plan) Requirements	0.25 days	Tue 2/9/21	Tue 2/9/21	291,304,317,330		Account BA
1.4.1.4.2	2.4.		Create Draft D018 Master Test Plan (Testing Management Plan)	3 days	Tue 2/9/21	Fri 2/12/21		254	Account BA
1.4.1.4.3	2.4.		Conduct Internal Work Product Review of D018 Master Test Plan (Testing Management Plan)	1 day	Fri 2/12/21	Tue 2/16/21		255	Account BA
1.4.1.4.4	2.4.		Revise Draft D018 Master Test Plan (Testing Management Plan) based on Internal Review	2 days	Tue 2/16/21	Thu 2/18/21		256	Account BA,Account Quality Mgr
1.4.1.4.5	2.4.		[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]
1.4.1.4.6	2.4.		Conduct Work Product Review with Client of Draft D018 Master Test Plan (Testing Management Plan)	0.25 days	Thu 2/18/21	Thu 2/18/21		258	Client Project Mgr[25%],Account Proj Mgr[25%]
1.4.1.4.7	2.4.		DHHR and Stakeholders Conducts Review of Draft D018 Master Test Plan (Testing Management Plan)	5 days	Thu 2/18/21	Thu 2/25/21		259	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.4.1.4.8	2.4.		Walkthrough Client Deliverable Review Comments	0.25 days	Thu 2/25/21	Thu 2/25/21		260	Client Project Mgr,Client SME

1.4.1.4.9	2.4.	Revise D018 Master Test Plan (Testing Management Plan) based on Client Review	2 days	Thu 2/25/21	Mon 3/1/21		261	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.4.1.4.10	2.4.	Distribute Updated D018 Master Test Plan (Testing Management Plan) to Client for Approval	0.25 days	Mon 3/1/21	Mon 3/1/21		262	Account BA[25%]
1.4.1.4.11	2.4.	DHHR and Stakeholders Conducts Review of Revisions to D018 Master Test Plan (Testing Management Plan)	1 day	Tue 3/2/21	Tue 3/2/21		263	Account Quality Mgr[20%]
1.4.1.4.12	2.4.	Milestone - Client Approves D018 Master Test Plan (Testing Manage	0 days	Tue 3/2/21	Tue 3/2/21		264	Client Project Mgr,Client SME
1.4.1.5	2.5.	**D019 Privacy Impact Analysis**	15 days	Tue 2/9/21	Tue 3/2/21			
1.4.1.5.1	2.5.	Review D019 Privacy Impact Analysis Requirements	0.25 days	Tue 2/9/21	Tue 2/9/21	291,304,317,330		Account BA
1.4.1.5.2	2.5.	Create Draft D019 Privacy Impact Analysis	3 days	Tue 2/9/21	Fri 2/12/21		267	Account BA
1.4.1.5.3	2.5.	Conduct Internal Work Product Review of D019 Privacy Impact Analysis	1 day	Fri 2/12/21	Tue 2/16/21		268	Account BA
1.4.1.5.4	2.5.	Revise Draft D019 Privacy Impact Analysis based on Internal Review	2 days	Tue 2/16/21	Thu 2/18/21		269	Account BA,Account Quality Mgr
1.4.1.5.5	2.5.	DELIVERABLE - D018 Master Test Plan (Testing Management Plan)	0 days	Thu 2/18/21	Thu 2/18/21		270	Account BA
1.4.1.5.6	2.5.	Conduct Work Product Review with Client of Draft D019 Privacy Impact Analysis	0.25 days	Thu 2/18/21	Thu 2/18/21		271	Client Project Mgr[25%],Account Proj Mgr[25%]
1.4.1.5.7	2.5.	DHHR and Stakeholders Conducts Review of Draft D019 Privacy Impact Analysis	5 days	Thu 2/18/21	Thu 2/25/21		272	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.4.1.5.8	2.5.	Walkthrough Client Deliverable Review Comments	0.25 days	Thu 2/25/21	Thu 2/25/21		273	Client Project Mgr,Client SME
1.4.1.5.9	2.5.	Revise D019 Privacy Impact Analysis based on Client Review	2 days	Thu 2/25/21	Mon 3/1/21		274	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.4.1.5.10	2.5.	Distribute Updated D019 Privacy Impact Analysis to Client for Approval	0.25 days	Mon 3/1/21	Mon 3/1/21		275	Account BA[25%]
1.4.1.5.11	2.5.	DHHR and Stakeholders Conducts Review of Revisions to D019 Privacy Impact Analysis	1 day	Tue 3/2/21	Tue 3/2/21		276	Account Quality Mgr[20%]
1.4.1.5.12	2.5.	Milestone - Client Approves D019 Privacy Impact Analysis	0 days	Tue 3/2/21	Tue 3/2/21		277	Client Project Mgr,Client SME
1.4.1.6	2.6.	**D020 Requirements Gap Analysis Document**	15 days	Mon 1/11/21	Mon 2/1/21			
1.4.1.6.1	2.6.	Review D020 Requirements Gap Analysis Document Requirements	0.25 days	Mon 1/11/21	Mon 1/11/21	3FS+5 days		Account BA
1.4.1.6.2	2.6.	Create Draft D020 Requirements Gap Analysis Document	3 days	Mon 1/11/21	Thu 1/14/21		280	Account BA
1.4.1.6.3	2.6.	Conduct Internal Work Product Review of D020 Requirements Gap Analysis Document	1 day	Thu 1/14/21	Fri 1/15/21		281	Account BA
1.4.1.6.4	2.6.	Revise Draft D020 Requirements Gap Analysis Document based on Internal Review	2 days	Fri 1/15/21	Wed 1/20/21		282	Account BA,Account Quality Mgr
1.4.1.6.5	2.6.	DELIVERABLE - D020 Requirements Gap Analysis Document - Draft Send Email to Client	0 days	Wed 1/20/21	Wed 1/20/21		283	Account BA
1.4.1.6.6	2.6.	Conduct Work Product Review with Client of Draft D020 Requirements Gap Analysis Document	0.25 days	Wed 1/20/21	Wed 1/20/21		284	Client Project Mgr[25%],Account Proj Mgr[25%]
1.4.1.6.7	2.6.	DHHR and Stakeholders Conducts Review of Draft D020 Requirements Gap Analysis Document	5 days	Wed 1/20/21	Wed 1/27/21		285	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.4.1.6.8	2.6.	Walkthrough Client Deliverable Review Comments	0.25 days	Wed 1/27/21	Wed 1/27/21		286	Client Project Mgr,Client SME
1.4.1.6.9	2.6.	Revise D020 Requirements Gap Analysis Document based on Client Review	2 days	Wed 1/27/21	Fri 1/29/21		287	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.4.1.6.10	2.6.	Distribute Updated D020 Requirements Gap Analysis Document to Client for Approval	0.25 days	Fri 1/29/21	Fri 1/29/21		288	Account BA[25%]
1.4.1.6.11	2.6.	DHHR and Stakeholders Conducts Review of Revisions to D020 Requirements Gap Analysis Document	1 day	Mon 2/1/21	Mon 2/1/21		289	Account Quality Mgr[20%]
1.4.1.6.12	2.6.	Milestone - Client Approves D020 Requirements Gap Analysis Docum	0 days	Mon 2/1/21	Mon 2/1/21		290	Client Project Mgr,Client SME
1.4.1.7	2.7.	**D021 Requirements Management Plan**	15 days	Mon 1/11/21	Mon 2/1/21			
1.4.1.7.1	2.7.	Review D021 Requirements Management Plan Requirements	0.25 days	Mon 1/11/21	Mon 1/11/21	3FS+5 days		Account BA
1.4.1.7.2	2.7.	Create Draft D021 Requirements Management Plan	3 days	Mon 1/11/21	Thu 1/14/21		293	Account BA
1.4.1.7.3	2.7.	Conduct Internal Work Product Review of D021 Requirements Management Plan	1 day	Thu 1/14/21	Fri 1/15/21		294	Account BA
1.4.1.7.4	2.7.	Revise Draft D021 Requirements Management Plan based on Internal Review	2 days	Fri 1/15/21	Wed 1/20/21		295	Account BA,Account Quality Mgr
1.4.1.7.5	2.7.	DELIVERABLE - D021 Requirements Management Plan - Draft Send Email to Client	0 days	Wed 1/20/21	Wed 1/20/21		296	Account BA
1.4.1.7.6	2.7.	Conduct Work Product Review with Client of Draft D021 Requirements Management Plan	0.25 days	Wed 1/20/21	Wed 1/20/21		297	Client Project Mgr[25%],Account Proj Mgr[25%]
1.4.1.7.7	2.7.	DHHR and Stakeholders Conducts Review of Draft D021 Requirements Management Plan	5 days	Wed 1/20/21	Wed 1/27/21		298	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.4.1.7.8	2.7.	Walkthrough Client Deliverable Review Comments	0.25 days	Wed 1/27/21	Wed 1/27/21		299	Client Project Mgr,Client SME
1.4.1.7.9	2.7.	Revise D021 Requirements Management Plan based on Client Review	2 days	Wed 1/27/21	Fri 1/29/21		300	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.4.1.7.10	2.7.	Distribute Updated D021 Requirements Management Plan to Client for Approval	0.25 days	Fri 1/29/21	Fri 1/29/21		301	Account BA[25%]
1.4.1.7.11	2.7.	DHHR and Stakeholders Conducts Review of Revisions to D021 Requirements Management Plan	1 day	Mon 2/1/21	Mon 2/1/21		302	Account Quality Mgr[20%]
1.4.1.7.12	2.7.	Milestone - Client Approves D021 Requirements Management Plan	0 days	Mon 2/1/21	Mon 2/1/21		303	Client Project Mgr,Client SME
1.4.1.8	2.8.	**D022 Requirements Specification Document (RSD)**	15 days	Tue 1/19/21	Mon 2/8/21			
1.4.1.8.1	2.8.	Review D022 Requirements Specification Document (RSD) Requirements	0.25 days	Tue 1/19/21	Tue 1/19/21	3FS+10 days		Account BA
1.4.1.8.2	2.8.	Create Draft D022 Requirements Specification Document (RSD)	3 days	Tue 1/19/21	Fri 1/22/21		306	Account BA
1.4.1.8.3	2.8.	Conduct Internal Work Product Review of D022 Requirements Specification Document (RSD)	1 day	Fri 1/22/21	Mon 1/25/21		307	Account BA
1.4.1.8.4	2.8.	Revise Draft D022 Requirements Specification Document (RSD) based on Internal Review	2 days	Mon 1/25/21	Wed 1/27/21		308	Account BA,Account Quality Mgr
1.4.1.8.5	2.8.	DELIVERABLE - D022 Requirements Specification Document (RSD) - Draft Send Email to Client	0 days	Wed 1/27/21	Wed 1/27/21		309	Account BA
1.4.1.8.6	2.8.	Conduct Work Product Review with Client of Draft D022 Requirements Specification Document (RSD)	0.25 days	Wed 1/27/21	Wed 1/27/21		310	Client Project Mgr[25%],Account Proj Mgr[25%]
1.4.1.8.7	2.8.	DHHR and Stakeholders Conducts Review of Draft D022 Requirements Specification Document (RSD)	5 days	Wed 1/27/21	Wed 2/3/21		311	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.4.1.8.8	2.8.	Walkthrough Client Deliverable Review Comments	0.25 days	Wed 2/3/21	Wed 2/3/21		312	Client Project Mgr,Client SME
1.4.1.8.9	2.8.	Revise D022 Requirements Specification Document (RSD) based on Client Review	2 days	Wed 2/3/21	Fri 2/5/21		313	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.4.1.8.10	2.8.	Distribute Updated D022 Requirements Specification Document (RSD) to Client for Approval	0.25 days	Fri 2/5/21	Fri 2/5/21		314	Account BA[25%]
1.4.1.8.11	2.8.	DHHR and Stakeholders Conducts Review of Revisions to D022 Requirements Specification Document (RSD)	1 day	Mon 2/8/21	Mon 2/8/21		315	Account Quality Mgr[20%]
1.4.1.8.12	2.8.	Milestone - Client Approves D022 Requirements Specification Docum	0 days	Mon 2/8/21	Mon 2/8/21		316	Client Project Mgr,Client SME
1.4.1.9	2.9.	**D023 Requirements Traceability Matrix (RTM)**	15 days	Mon 1/11/21	Mon 2/1/21			
1.4.1.9.1	2.9.	Review D023 Requirements Traceability Matrix (RTM) Requirements	0.25 days	Mon 1/11/21	Mon 1/11/21	3FS+5 days		Account BA
1.4.1.9.2	2.9.	Create Draft D023 Requirements Traceability Matrix (RTM)	3 days	Mon 1/11/21	Thu 1/14/21		319	Account BA
1.4.1.9.3	2.9.	Conduct Internal Work Product Review of D023 Requirements Traceability Matrix (RTM)	1 day	Thu 1/14/21	Fri 1/15/21		320	Account BA
1.4.1.9.4	2.9.	Revise Draft D023 Requirements Traceability Matrix (RTM) based on Internal Review	2 days	Fri 1/15/21	Wed 1/20/21		321	Account BA,Account Quality Mgr
1.4.1.9.5	2.9.	DELIVERABLE - D023 Requirements Traceability Matrix (RTM) - Draft Send Email to Client	0 days	Wed 1/20/21	Wed 1/20/21		322	Account BA
1.4.1.9.6	2.9.	Conduct Work Product Review with Client of Draft D023 Requirements Traceability Matrix (RTM)	0.25 days	Wed 1/20/21	Wed 1/20/21		323	Client Project Mgr[25%],Account Proj Mgr[25%]
1.4.1.9.7	2.9.	DHHR and Stakeholders Conducts Review of Draft D023 Requirements Traceability Matrix (RTM)	5 days	Wed 1/20/21	Wed 1/27/21		324	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.4.1.9.8	2.9.	Walkthrough Client Deliverable Review Comments	0.25 days	Wed 1/27/21	Wed 1/27/21		325	Client Project Mgr,Client SME
1.4.1.9.9	2.9.	Revise D023 Requirements Traceability Matrix (RTM) based on Client Review	2 days	Wed 1/27/21	Fri 1/29/21		326	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]

1.4.1.9.10	2.9.		Distribute Updated D023 Requirements Traceability Matrix (RTM) to Client for Approval	0.25 days	Fri 1/29/21	Fri 1/29/21		327	Account BA[25%]
1.4.1.9.11	2.9.		DHHR and Stakeholders Conducts Review of Revisions to D023 Requirements Traceability Matrix (RTM)	1 day	Mon 2/1/21	Mon 2/1/21		328	Account Quality Mgr[20%]
1.4.1.9.12	2.9.		Milestone - Client Approves D023 Requirements Traceability Matrix (RTM)	0 days	Mon 2/1/21	Mon 2/1/21		329	Client Project Mgr,Client SME
1.4.1.10	**2.10.**		**D024 Safeguard Procedures Report (SPR)**	**15 days**	**Tue 1/19/21**	**Mon 2/8/21**			
1.4.1.10.1	2.10.		Review D024 Safeguard Procedures Report (SPR) Requirements	0.25 days	Tue 1/19/21	Tue 1/19/21	3FS+10 days		Account BA
1.4.1.10.2	2.10.		Create Draft D024 Safeguard Procedures Report (SPR)	3 days	Tue 1/19/21	Fri 1/22/21		332	Account BA
1.4.1.10.3	2.10.		Conduct Internal Work Product Review of D024 Safeguard Procedures Report (SPR)	1 day	Fri 1/22/21	Mon 1/25/21		333	Account BA
1.4.1.10.4	2.10.		Revise Draft D024 Safeguard Procedures Report (SPR) based on Internal Review	2 days	Mon 1/25/21	Wed 1/27/21		334	Account BA,Account Quality Mgr
1.4.1.10.5	2.10.		[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]
1.4.1.10.6	2.10.		Conduct Work Product Review with Client of Draft D024 Safeguard Procedures Report (SPR)	0.25 days	Wed 1/27/21	Wed 1/27/21		336	Client Project Mgr[25%],Account Proj Mgr[25%]
1.4.1.10.7	2.10.		DHHR and Stakeholders Conducts Review of Draft D024 Safeguard Procedures Report (SPR)	5 days	Wed 1/27/21	Wed 2/3/21		337	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.4.1.10.8	2.10.		Walkthrough Client Deliverable Review Comments	0.25 days	Wed 2/3/21	Wed 2/3/21		338	Client Project Mgr,Client SME
1.4.1.10.9	2.10.		Revise D024 Safeguard Procedures Report (SPR) based on Client Review	2 days	Wed 2/3/21	Fri 2/5/21		339	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.4.1.10.10	2.10.		Distribute Updated D024 Safeguard Procedures Report (SPR) to Client for Approval	0.25 days	Fri 2/5/21	Fri 2/5/21		340	Account BA[25%]
1.4.1.10.11	2.10.		DHHR and Stakeholders Conducts Review of Revisions to D024 Safeguard Procedures Report (SPR)	1 day	Mon 2/8/21	Mon 2/8/21		341	Account Quality Mgr[20%]
1.4.1.10.12	2.10.		Milestone - Client Approves D024 Safeguard Procedures Report (SPR)	0 days	Mon 2/8/21	Mon 2/8/21		342	Client Project Mgr,Client SME
1.4.1.11	**2.11.**		**D025 Security Plan**	**15 days**	**Tue 1/19/21**	**Mon 2/8/21**			
1.4.1.11.1	2.11.		Review D025 Security Plan Requirements	0.25 days	Tue 1/19/21	Tue 1/19/21	3FS+10 days		Account BA
1.4.1.11.2	2.11.		Create Draft D025 Security Plan	3 days	Tue 1/19/21	Fri 1/22/21		345	Account BA
1.4.1.11.3	2.11.		Conduct Internal Work Product Review of D025 Security Plan	1 day	Fri 1/22/21	Mon 1/25/21		346	Account BA
1.4.1.11.4	2.11.		Revise Draft D025 Security Plan based on Internal Review	2 days	Mon 1/25/21	Wed 1/27/21		347	Account BA,Account Quality Mgr
1.4.1.11.5	2.11.		[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]
1.4.1.11.6	2.11.		Conduct Work Product Review with Client of Draft D025 Security Plan	0.25 days	Wed 1/27/21	Wed 1/27/21		349	Client Project Mgr[25%],Account Proj Mgr[25%]
1.4.1.11.7	2.11.		DHHR and Stakeholders Conducts Review of Draft D025 Security Plan	5 days	Wed 1/27/21	Wed 2/3/21		350	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.4.1.11.8	2.11.		Walkthrough Client Deliverable Review Comments	0.25 days	Wed 2/3/21	Wed 2/3/21		351	Client Project Mgr,Client SME
1.4.1.11.9	2.11.		Revise D025 Security Plan based on Client Review	2 days	Wed 2/3/21	Fri 2/5/21		352	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.4.1.11.10	2.11.		Distribute Updated D025 Security Plan to Client for Approval	0.25 days	Fri 2/5/21	Fri 2/5/21		353	Account BA[25%]
1.4.1.11.11	2.11.		DHHR and Stakeholders Conducts Review of Revisions to D025 Security Plan	1 day	Mon 2/8/21	Mon 2/8/21		354	Account Quality Mgr[20%]
1.4.1.11.12	2.11.		Milestone - Client Approves D025 Security Plan	0 days	Mon 2/8/21	Mon 2/8/21		355	Client Project Mgr,Client SME
1.4.1.12	**2.12.**		**D026 System Backup and Record Retention Plan**	**15 days**	**Mon 1/11/21**	**Mon 2/1/21**			
1.4.1.12.1	2.12.		Review D026 System Backup and Record Retention Plan Requirements	0.25 days	Mon 1/11/21	Mon 1/11/21	3FS+5 days		Account BA
1.4.1.12.2	2.12.		Create Draft D026 System Backup and Record Retention Plan	3 days	Mon 1/11/21	Thu 1/14/21		358	Account BA
1.4.1.12.3	2.12.		Conduct Internal Work Product Review of D026 System Backup and Record Retention Plan	1 day	Thu 1/14/21	Fri 1/15/21		359	Account BA
1.4.1.12.4	2.12.		Revise Draft D026 System Backup and Record Retention Plan based on Internal Review	2 days	Fri 1/15/21	Wed 1/20/21		360	Account BA,Account Quality Mgr
1.4.1.12.5	2.12.		[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]
1.4.1.12.6	2.12.		Conduct Work Product Review with Client of Draft D026 System Backup and Record Retention Plan	0.25 days	Wed 1/20/21	Wed 1/20/21		362	Client Project Mgr[25%],Account Proj Mgr[25%]
1.4.1.12.7	2.12.		DHHR and Stakeholders Conducts Review of Draft D026 System Backup and Record Retention Plan	5 days	Wed 1/20/21	Wed 1/27/21		363	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.4.1.12.8	2.12.		Walkthrough Client Deliverable Review Comments	0.25 days	Wed 1/27/21	Wed 1/27/21		364	Client Project Mgr,Client SME
1.4.1.12.9	2.12.		Revise D026 System Backup and Record Retention Plan based on Client Review	2 days	Wed 1/27/21	Fri 1/29/21		365	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.4.1.12.10	2.12.		Distribute Updated D026 System Backup and Record Retention Plan to Client for Approval	0.25 days	Fri 1/29/21	Fri 1/29/21		366	Account BA[25%]
1.4.1.12.11	2.12.		DHHR and Stakeholders Conducts Review of Revisions to D026 System Backup and Record Retention Plan	1 day	Mon 2/1/21	Mon 2/1/21		367	Account Quality Mgr[20%]
1.4.1.12.12	2.12.		Milestone - Client Approves D026 System Backup and Record Retention Plan	0 days	Mon 2/1/21	Mon 2/1/21		368	Client Project Mgr,Client SME
1.4.1.13	**2.13.**		**D027 System Requirement Document/Backlog of User Stories or Use Cases**	**15 days**	**Mon 1/11/21**	**Mon 2/1/21**			
1.4.1.13.1	2.13.		Review D027 System Requirement Document/Backlog of User Stories or Use Cases Requirements	0.25 days	Mon 1/11/21	Mon 1/11/21	3FS+5 days		Account BA
1.4.1.13.2	2.13.		Create Draft D027 System Requirement Document/Backlog of User Stories or Use Cases	3 days	Mon 1/11/21	Thu 1/14/21		371	Account BA
1.4.1.13.3	2.13.		Conduct Internal Work Product Review of D027 System Requirement Document/Backlog of User Stories or Use Cases	1 day	Thu 1/14/21	Fri 1/15/21		372	Account BA
1.4.1.13.4	2.13.		Revise Draft D027 System Requirement Document/Backlog of User Stories or Use Cases based on Internal Review	2 days	Fri 1/15/21	Wed 1/20/21		373	Account BA,Account Quality Mgr
1.4.1.13.5	2.13.		[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]
1.4.1.13.6	2.13.		Conduct Work Product Review with Client of Draft D027 System Requirement Document/Backlog of User Stories or Use Cases	0.25 days	Wed 1/20/21	Wed 1/20/21		375	Client Project Mgr[25%],Account Proj Mgr[25%]
1.4.1.13.7	2.13.		DHHR and Stakeholders Conducts Review of Draft D027 System Requirement Document/Backlog of User Stories or Use Cases	5 days	Wed 1/20/21	Wed 1/27/21		376	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.4.1.13.8	2.13.		Walkthrough Client Deliverable Review Comments	0.25 days	Wed 1/27/21	Wed 1/27/21		377	Client Project Mgr,Client SME
1.4.1.13.9	2.13.		Revise D027 System Requirement Document/Backlog of User Stories or Use Cases based on Client Review	2 days	Wed 1/27/21	Fri 1/29/21		378	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.4.1.13.10	2.13.		Distribute Updated D027 System Requirement Document/Backlog of User Stories or Use Cases to Client for Approval	0.25 days	Fri 1/29/21	Fri 1/29/21		379	Account BA[25%]
1.4.1.13.11	2.13.		DHHR and Stakeholders Conducts Review of Revisions to D027 System Requirement Document/Backlog of User Stories or Use Cases	1 day	Mon 2/1/21	Mon 2/1/21		380	Account Quality Mgr[20%]
1.4.1.13.12	2.13.		Milestone - Client Approves D027 System Requirement Document/Backlog of User Stories or Use Cases	0 days	Mon 2/1/21	Mon 2/1/21		381	Client Project Mgr,Client SME
1.4.1.14			Milestone -Task Group 2 - Deliverables Complete	0 days	Tue 3/2/21	Tue 3/2/21	##########		
1.4.2			**Requirement Analysis Preparation**	**3 days**	**Mon 1/11/21**	**Wed 1/13/21**			
1.4.2.1			Create Initial Requirements Specifications Document for Requirement Validation Sessions	3 days	Mon 1/11/21	Wed 1/13/21	3FS+5 days		HMS Business Analyst,Technical Lead
1.4.3			**Requirements Review Sessions**	**5 days**	**Thu 1/14/21**	**Thu 1/21/21**			
1.4.3.1		4.1	Conduct Requirements Review Session - Confirm Base + New Casualty-Trauma Recovery Requirements	1 day	Thu 1/14/21	Thu 1/14/21		385	HMS Business Analyst,Technical Lead
1.4.3.2		4.1	Conduct Requirements Review Session - Confirm Base + New Estate Recovery Requirements	1 day	Fri 1/15/21	Fri 1/15/21		387	HMS Business Analyst,Technical Lead
1.4.3.3		4.1	Conduct Requirements Review Session - Confirm Base + New Tri-Care, Medicare, and Commercial Recoveries Requirements	1 day	Tue 1/19/21	Tue 1/19/21		388	HMS Business Analyst,Technical Lead
1.4.3.4		4.1	Conduct Requirements Review Session - Confirm Base + New Credit Balance Audits Requirements	1 day	Wed 1/20/21	Wed 1/20/21		389	HMS Business Analyst,Technical Lead

1.4.3.5		4.1	Conduct Requirements Review Session - Confirm Base + New Third-Party Adds Requirements	1 day	Thu 1/21/21	Thu 1/21/21		390	HMS Business Analyst,Technical Lead
1.4.3.6			Milestone - Confirmation Requirement Validation Sessions Complete	0 days	Thu 1/21/21	Thu 1/21/21	##########		
1.4.4			Requirement Traceability Matrix (RTM) Update	9.25 days	Wed 1/20/21	Tue 2/2/21			
1.4.4.1			RTM) (Update)	9.25 days	Wed 1/20/21	Tue 2/2/21			
1.4.4.1.1			Review RTM (Update) Updates	0.25 days	Wed 1/20/21	Wed 1/20/21	392SS-2 days		HMS Business Analyst,Technical Lead
1.4.4.1.2			Review and Revise RTM (Update)	1 day	Wed 1/20/21	Thu 1/21/21		395	HMS Business Analyst,Technical Lead
1.4.4.1.3			Conduct Internal Work Product Review of RTM (Update)	1 day	Thu 1/21/21	Fri 1/22/21		396	HMS Business Analyst,Technical Lead
1.4.4.1.4			Revise Draft RTM (Update) based on Internal Review	1 day	Fri 1/22/21	Mon 1/25/21		397	HMS Business Analyst,Technical Lead
1.4.4.1.5			[illegible]	0 days	Mon 1/25/21	Mon 1/25/21		398	HMS Business Analyst,Technical Lead
1.4.4.1.6			Receive Acknowledgement for DHHR of Receipt of Deliverable	0.25 days	Mon 1/25/21	Mon 1/25/21		399	HMS Business Analyst,Technical Lead
1.4.4.1.7			Conduct Work Product Review with Client of Draft RTM (Update)	0.25 days	Mon 1/25/21	Mon 1/25/21		400	HMS Business Analyst,Technical Lead
1.4.4.1.8			DHHR and Stakeholders Conducts Review of Draft RTM (Update)	3 days	Mon 1/25/21	Thu 1/28/21		401	HMS Business Analyst,Technical Lead
1.4.4.1.9			Walkthrough Client Deliverable Review Comments	0.25 days	Thu 1/28/21	Thu 1/28/21		402	HMS Business Analyst,Technical Lead
1.4.4.1.10			Revise RTM (Update) based on Client Review	1 day	Fri 1/29/21	Fri 1/29/21		403	HMS Business Analyst,Technical Lead
1.4.4.1.11			Distribute Updated RTM (Update) to Client for Approval	0.25 days	Mon 2/1/21	Mon 2/1/21		404	HMS Business Analyst,Technical Lead
1.4.4.1.12			DHHR and Stakeholders Conducts Review of Revisions to RTM (Update)	1 day	Mon 2/1/21	Tue 2/2/21		405	HMS Business Analyst,Technical Lead
1.4.4.1.13			Milestone - Client Approves RTM (Update)	0 days	Tue 2/2/21	Tue 2/2/21	406		
1.4.4.2			Milestone - Requirements Review Complete	0 days	Tue 2/2/21	Tue 2/2/21	407		
1.4.5		2	Payment Milestone 2: Solution Planning 1 (Deliverables D015 through D021)	0 days	Tue 3/2/21	Tue 3/2/21	##########		
1.4.6		2	Payment Milestone 3: Solution Planning 2 (Deliverables D022 through D027)	0 days	Mon 2/8/21	Mon 2/8/21	##########		
1.5			Milestone - Task Group 2: Solution Planning Complete	0 days	Tue 3/2/21	Tue 3/2/21	583,408		
1.6		3	Task Group 3: Solution Design, Testing, and Operational Readiness	58.5 days	Mon 1/4/21	Mon 3/29/21			
1.6.1			Task Group 3 - Deliverables	35 days	Tue 2/2/21	Wed 3/24/21			
1.6.1.1	3.1.		D028 Capacity Plan	15 days	Wed 2/17/21	Wed 3/10/21			
1.6.1.1.1	3.1.		Review D028 Capacity Plan Requirements	0.25 days	Wed 2/17/21	Wed 2/17/21	407FS+10 days		Account BA
1.6.1.1.2	3.1.		Create Draft D028 Capacity Plan	3 days	Wed 2/17/21	Mon 2/22/21		415	Account BA
1.6.1.1.3	3.1.		Conduct Internal Work Product Review of D028 Capacity Plan	1 day	Mon 2/22/21	Tue 2/23/21		416	Account BA
1.6.1.1.4	3.1.		Revise Draft D028 Capacity Plan based on Internal Review	2 days	Tue 2/23/21	Thu 2/25/21		417	Account BA,Account Quality Mgr
1.6.1.1.5	3.1.		[illegible]	0 days	Thu 2/25/21	Thu 2/25/21		418	Account BA
1.6.1.1.6	3.1.		Conduct Work Product Review with Client of Draft D028 Capacity Plan	0.25 days	Thu 2/25/21	Thu 2/25/21		419	Client Project Mgr[25%],Account Proj Mgr[25%]
1.6.1.1.7	3.1.		DHHR and Stakeholders Conducts Review of Draft D028 Capacity Plan	5 days	Thu 2/25/21	Thu 3/4/21		420	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.6.1.1.8	3.1.		Walkthrough Client Deliverable Review Comments	0.25 days	Thu 3/4/21	Thu 3/4/21		421	Client Project Mgr,Client SME
1.6.1.1.9	3.1.		Revise D028 Capacity Plan based on Client Review	2 days	Fri 3/5/21	Mon 3/8/21		422	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.6.1.1.10	3.1.		Distribute Updated D028 Capacity Plan to Client for Approval	0.25 days	Tue 3/9/21	Tue 3/9/21		423	Account BA[25%]
1.6.1.1.11	3.1.		DHHR and Stakeholders Conducts Review of Revisions to D028 Capacity Plan	1 day	Tue 3/9/21	Wed 3/10/21		424	Account Quality Mgr[20%]
1.6.1.1.12	3.1.		Milestone - Client Approves D028 Capacity Plan	0 days	Wed 3/10/21	Wed 3/10/21		425	Client Project Mgr,Client SME
1.6.1.2	3.2.		D029 Configuration Management Plan	15 days	Wed 2/17/21	Wed 3/10/21			
1.6.1.2.1	3.2.		Review D029 Configuration Management Plan Requirements	0.25 days	Wed 2/17/21	Wed 2/17/21	407FS+10 days		Account BA
1.6.1.2.2	3.2.		Create Draft D029 Configuration Management Plan	3 days	Wed 2/17/21	Mon 2/22/21		428	Account BA
1.6.1.2.3	3.2.		Conduct Internal Work Product Review of D029 Configuration Management Plan	1 day	Mon 2/22/21	Tue 2/23/21		429	Account BA
1.6.1.2.4	3.2.		Revise Draft D029 Configuration Management Plan based on Internal Review	2 days	Tue 2/23/21	Thu 2/25/21		430	Account BA,Account Quality Mgr
1.6.1.2.5	3.2.		[illegible]	0 days	Thu 2/25/21	Thu 2/25/21		431	Account BA
1.6.1.2.6	3.2.		Conduct Work Product Review with Client of Draft D029 Configuration Management Plan	0.25 days	Thu 2/25/21	Thu 2/25/21		432	Client Project Mgr[25%],Account Proj Mgr[25%]
1.6.1.2.7	3.2.		DHHR and Stakeholders Conducts Review of Draft D029 Configuration Management Plan	5 days	Thu 2/25/21	Thu 3/4/21		433	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.6.1.2.8	3.2.		Walkthrough Client Deliverable Review Comments	0.25 days	Thu 3/4/21	Thu 3/4/21		434	Client Project Mgr,Client SME
1.6.1.2.9	3.2.		Revise D029 Configuration Management Plan based on Client Review	2 days	Fri 3/5/21	Mon 3/8/21		435	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.6.1.2.10	3.2.		Distribute Updated D029 Configuration Management Plan to Client for Approval	0.25 days	Tue 3/9/21	Tue 3/9/21		436	Account BA[25%]
1.6.1.2.11	3.2.		DHHR and Stakeholders Conducts Review of Revisions to D029 Configuration Management Plan	1 day	Tue 3/9/21	Wed 3/10/21		437	Account Quality Mgr[20%]
1.6.1.2.12	3.2.		Milestone - Client Approves D029 Configuration Management Plan	0 days	Wed 3/10/21	Wed 3/10/21		438	Client Project Mgr,Client SME
1.6.1.3	3.3.		D030 Data Conversion Plan (DCP)	15 days	Tue 2/2/21	Wed 2/24/21			
1.6.1.3.1	3.3.		Review D030 Data Conversion Plan (DCP) Requirements	0.25 days	Tue 2/2/21	Tue 2/2/21		407	Account BA
1.6.1.3.2	3.3.		Create Draft D030 Data Conversion Plan (DCP)	3 days	Tue 2/2/21	Fri 2/5/21		441	Account BA
1.6.1.3.3	3.3.		Conduct Internal Work Product Review of D030 Data Conversion Plan (DCP)	1 day	Fri 2/5/21	Mon 2/8/21		442	Account BA
1.6.1.3.4	3.3.		Revise Draft D030 Data Conversion Plan (DCP) based on Internal Review	2 days	Mon 2/8/21	Wed 2/10/21		443	Account BA,Account Quality Mgr
1.6.1.3.5	3.3.		[illegible]	0 days	Wed 2/10/21	Wed 2/10/21		444	Account BA
1.6.1.3.6	3.3.		Conduct Work Product Review with Client of Draft D030 Data Conversion Plan (DCP)	0.25 days	Wed 2/10/21	Wed 2/10/21		445	Client Project Mgr[25%],Account Proj Mgr[25%]
1.6.1.3.7	3.3.		DHHR and Stakeholders Conducts Review of Draft D030 Data Conversion Plan (DCP)	5 days	Wed 2/10/21	Thu 2/18/21		446	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.6.1.3.8	3.3.		Walkthrough Client Deliverable Review Comments	0.25 days	Thu 2/18/21	Thu 2/18/21		447	Client Project Mgr,Client SME
1.6.1.3.9	3.3.		Revise D030 Data Conversion Plan (DCP) based on Client Review	2 days	Fri 2/19/21	Mon 2/22/21		448	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.6.1.3.10	3.3.		Distribute Updated D030 Data Conversion Plan (DCP) to Client for Approval	0.25 days	Tue 2/23/21	Tue 2/23/21		449	Account BA[25%]
1.6.1.3.11	3.3.		DHHR and Stakeholders Conducts Review of Revisions to D030 Data Conversion Plan (DCP)	1 day	Tue 2/23/21	Wed 2/24/21		450	Account Quality Mgr[20%]
1.6.1.3.12	3.3.		Milestone - Client Approves D030 Data Conversion Plan (DCP)	0 days	Wed 2/24/21	Wed 2/24/21		451	Client Project Mgr,Client SME
1.6.1.4	3.4.		D031 Data Conversion Test Cases	15 days	Tue 2/2/21	Wed 2/24/21			
1.6.1.4.1	3.4.		Review D031 Data Conversion Test Cases Requirements	0.25 days	Tue 2/2/21	Tue 2/2/21		407	Account BA
1.6.1.4.2	3.4.		Create Draft D031 Data Conversion Test Cases	3 days	Tue 2/2/21	Fri 2/5/21		454	Account BA
1.6.1.4.3	3.4.		Conduct Internal Work Product Review of D031 Data Conversion Test Cases	1 day	Fri 2/5/21	Mon 2/8/21		455	Account BA
1.6.1.4.4	3.4.		Revise Draft D031 Data Conversion Test Cases based on Internal Review	2 days	Mon 2/8/21	Wed 2/10/21		456	Account BA,Account Quality Mgr
1.6.1.4.5	3.4.		[illegible]	0 days	Wed 2/10/21	Wed 2/10/21		457	Account BA
1.6.1.4.6	3.4.		Conduct Work Product Review with Client of Draft D031 Data Conversion Test Cases	0.25 days	Wed 2/10/21	Wed 2/10/21		458	Client Project Mgr[25%],Account Proj Mgr[25%]

1.6.1.4.7	3.4.	DHHR and Stakeholders Conducts Review of Draft D031 Data Conversion Test Cases	5 days	Wed 2/10/21	Thu 2/18/21		459	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.6.1.4.8	3.4.	Walkthrough Client Deliverable Review Comments	0.25 days	Thu 2/18/21	Thu 2/18/21		460	Client Project Mgr,Client SME
1.6.1.4.9	3.4.	Revise D031 Data Conversion Test Cases based on Client Review	2 days	Fri 2/19/21	Mon 2/22/21		461	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.6.1.4.10	3.4.	Distribute Updated D031 Data Conversion Test Cases to Client for Approval	0.25 days	Tue 2/23/21	Tue 2/23/21		462	Account BA[25%]
1.6.1.4.11	3.4.	DHHR and Stakeholders Conducts Review of Revisions to D031 Data Conversion Test Cases	1 day	Tue 2/23/21	Wed 2/24/21		463	Account Quality Mgr[20%]
1.6.1.4.12	3.4.	Milestone - Client Approves D031 Data Conversion Test Cases	0 days	Wed 2/24/21	Wed 2/24/21		464	Client Project Mgr,Client SME
1.6.1.5	**3.5.**	**D032 Data Conversion Test Results**	**15 days**	**Tue 2/2/21**	**Wed 2/24/21**			
1.6.1.5.1	3.5.	Review D032 Data Conversion Test Results Requirements	0.25 days	Tue 2/2/21	Tue 2/2/21		407	Account BA
1.6.1.5.2	3.5.	Create Draft D032 Data Conversion Test Results	3 days	Tue 2/2/21	Fri 2/5/21		467	Account BA
1.6.1.5.3	3.5.	Conduct Internal Work Product Review of D032 Data Conversion Test Results	1 day	Fri 2/5/21	Mon 2/8/21		468	Account BA
1.6.1.5.4	3.5.	Revise Draft D032 Data Conversion Test Results based on Internal Review	2 days	Mon 2/8/21	Wed 2/10/21		469	Account BA,Account Quality Mgr
1.6.1.5.5	3.5.	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	
1.6.1.5.6	3.5.	Conduct Work Product Review with Client of Draft D032 Data Conversion Test Results	0.25 days	Wed 2/10/21	Wed 2/10/21		471	Client Project Mgr[25%],Account Proj Mgr[25%]
1.6.1.5.7	3.5.	DHHR and Stakeholders Conducts Review of Draft D032 Data Conversion Test Results	5 days	Wed 2/10/21	Thu 2/18/21		472	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.6.1.5.8	3.5.	Walkthrough Client Deliverable Review Comments	0.25 days	Thu 2/18/21	Thu 2/18/21		473	Client Project Mgr,Client SME
1.6.1.5.9	3.5.	Revise D032 Data Conversion Test Results based on Client Review	2 days	Fri 2/19/21	Mon 2/22/21		474	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.6.1.5.10	3.5.	Distribute Updated D032 Data Conversion Test Results to Client for Approval	0.25 days	Tue 2/23/21	Tue 2/23/21		475	Account BA[25%]
1.6.1.5.11	3.5.	DHHR and Stakeholders Conducts Review of Revisions to D032 Data Conversion Test Results	1 day	Tue 2/23/21	Wed 2/24/21		476	Account Quality Mgr[20%]
1.6.1.5.12	3.5.	Milestone - Client Approves D032 Data Conversion Test Results	0 days	Wed 2/24/21	Wed 2/24/21		477	Client Project Mgr,Client SME
1.6.1.6	**3.6.**	**D033 Database Design Document and Data Models**	**15 days**	**Tue 2/2/21**	**Wed 2/24/21**			
1.6.1.6.1	3.6.	Review D033 Database Design Document and Data Models Requirements	0.25 days	Tue 2/2/21	Tue 2/2/21		407	Account BA
1.6.1.6.2	3.6.	Create Draft D033 Database Design Document and Data Models	3 days	Tue 2/2/21	Fri 2/5/21		480	Account BA
1.6.1.6.3	3.6.	Conduct Internal Work Product Review of D033 Database Design Document and Data Models	1 day	Fri 2/5/21	Mon 2/8/21		481	Account BA
1.6.1.6.4	3.6.	Revise Draft D033 Database Design Document and Data Models based on Internal Review	2 days	Mon 2/8/21	Wed 2/10/21		482	Account BA,Account Quality Mgr
1.6.1.6.5	3.6.	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	
1.6.1.6.6	3.6.	Conduct Work Product Review with Client of Draft D033 Database Design Document and Data Models	0.25 days	Wed 2/10/21	Wed 2/10/21		484	Client Project Mgr[25%],Account Proj Mgr[25%]
1.6.1.6.7	3.6.	DHHR and Stakeholders Conducts Review of Draft D033 Database Design Document and Data Models	5 days	Wed 2/10/21	Thu 2/18/21		485	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.6.1.6.8	3.6.	Walkthrough Client Deliverable Review Comments	0.25 days	Thu 2/18/21	Thu 2/18/21		486	Client Project Mgr,Client SME
1.6.1.6.9	3.6.	Revise D033 Database Design Document and Data Models based on Client Review	2 days	Fri 2/19/21	Mon 2/22/21		487	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.6.1.6.10	3.6.	Distribute Updated D033 Database Design Document and Data Models to Client for Approval	0.25 days	Tue 2/23/21	Tue 2/23/21		488	Account BA[25%]
1.6.1.6.11	3.6.	DHHR and Stakeholders Conducts Review of Revisions to D033 Database Design Document and Data Models	1 day	Tue 2/23/21	Wed 2/24/21		489	Account Quality Mgr[20%]
1.6.1.6.12	3.6.	Milestone - Client Approves D033 Database Design Document and Data Models	0 days	Wed 2/24/21	Wed 2/24/21		490	Client Project Mgr,Client SME
1.6.1.7	**3.7.**	**D034 Detailed System Design (DSD) Document**	**15 days**	**Tue 2/2/21**	**Wed 2/24/21**			
1.6.1.7.1	3.7.	Review D034 Detailed System Design (DSD) Document Requirements	0.25 days	Tue 2/2/21	Tue 2/2/21		407	Account BA
1.6.1.7.2	3.7.	Create Draft D034 Detailed System Design (DSD) Document	3 days	Tue 2/2/21	Fri 2/5/21		493	Account BA
1.6.1.7.3	3.7.	Conduct Internal Work Product Review of D034 Detailed System Design (DSD) Document	1 day	Fri 2/5/21	Mon 2/8/21		494	Account BA
1.6.1.7.4	3.7.	Revise Draft D034 Detailed System Design (DSD) Document based on Internal Review	2 days	Mon 2/8/21	Wed 2/10/21		495	Account BA,Account Quality Mgr
1.6.1.7.5	3.7.	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	
1.6.1.7.6	3.7.	Conduct Work Product Review with Client of Draft D034 Detailed System Design (DSD) Document	0.25 days	Wed 2/10/21	Wed 2/10/21		497	Client Project Mgr[25%],Account Proj Mgr[25%]
1.6.1.7.7	3.7.	DHHR and Stakeholders Conducts Review of Draft D034 Detailed System Design (DSD) Document	5 days	Wed 2/10/21	Thu 2/18/21		498	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.6.1.7.8	3.7.	Walkthrough Client Deliverable Review Comments	0.25 days	Thu 2/18/21	Thu 2/18/21		499	Client Project Mgr,Client SME
1.6.1.7.9	3.7.	Revise D034 Detailed System Design (DSD) Document based on Client Review	2 days	Fri 2/19/21	Mon 2/22/21		500	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.6.1.7.10	3.7.	Distribute Updated D034 Detailed System Design (DSD) Document to Client for Approval	0.25 days	Tue 2/23/21	Tue 2/23/21		501	Account BA[25%]
1.6.1.7.11	3.7.	DHHR and Stakeholders Conducts Review of Revisions to D034 Detailed System Design (DSD) Document	1 day	Tue 2/23/21	Wed 2/24/21		502	Account Quality Mgr[20%]
1.6.1.7.12	3.7.	Milestone - Client Approves D034 Detailed System Design (DSD) Document	0 days	Wed 2/24/21	Wed 2/24/21		503	Client Project Mgr,Client SME
1.6.1.8	**3.8.**	**D035 Disaster Recovery and Business Continuity Plan**	**15 days**	**Tue 2/2/21**	**Wed 2/24/21**			
1.6.1.8.1	3.8.	Review D035 Disaster Recovery and Business Continuity Plan Requirements	0.25 days	Tue 2/2/21	Tue 2/2/21		407	Account BA
1.6.1.8.2	3.8.	Create Draft D035 Disaster Recovery and Business Continuity Plan	3 days	Tue 2/2/21	Fri 2/5/21		506	Account BA
1.6.1.8.3	3.8.	Conduct Internal Work Product Review of D035 Disaster Recovery and Business Continuity Plan	1 day	Fri 2/5/21	Mon 2/8/21		507	Account BA
1.6.1.8.4	3.8.	Revise Draft D035 Disaster Recovery and Business Continuity Plan based on Internal Review	2 days	Mon 2/8/21	Wed 2/10/21		508	Account BA,Account Quality Mgr
1.6.1.8.5	3.8.	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	
1.6.1.8.6	3.8.	Conduct Work Product Review with Client of Draft D035 Disaster Recovery and Business Continuity Plan	0.25 days	Wed 2/10/21	Wed 2/10/21		510	Client Project Mgr[25%],Account Proj Mgr[25%]
1.6.1.8.7	3.8.	DHHR and Stakeholders Conducts Review of Draft D035 Disaster Recovery and Business Continuity Plan	5 days	Wed 2/10/21	Thu 2/18/21		511	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.6.1.8.8	3.8.	Walkthrough Client Deliverable Review Comments	0.25 days	Thu 2/18/21	Thu 2/18/21		512	Client Project Mgr,Client SME
1.6.1.8.9	3.8.	Revise D035 Disaster Recovery and Business Continuity Plan based on Client Review	2 days	Fri 2/19/21	Mon 2/22/21		513	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.6.1.8.10	3.8.	Distribute Updated D035 Disaster Recovery and Business Continuity Plan to Client for Approval	0.25 days	Tue 2/23/21	Tue 2/23/21		514	Account BA[25%]
1.6.1.8.11	3.8.	DHHR and Stakeholders Conducts Review of Revisions to D035 Disaster Recovery and Business Continuity Plan	1 day	Tue 2/23/21	Wed 2/24/21		515	Account Quality Mgr[20%]
1.6.1.8.12	3.8.	Milestone - Client Approves D035 Disaster Recovery and Business Continuity Plan	0 days	Wed 2/24/21	Wed 2/24/21		516	Client Project Mgr,Client SME
1.6.1.9	**3.9.**	**D036 Federal Certification and Review Management Plan**	**15 days**	**Wed 2/24/21**	**Wed 3/17/21**			
1.6.1.9.1	3.9.	Review D036 Federal Certification and Review Management Plan Requirements	0.25 days	Wed 2/24/21	Wed 2/24/21	407FS+15 days		Account BA
1.6.1.9.2	3.9.	Create Draft D036 Federal Certification and Review Management Plan	3 days	Wed 2/24/21	Mon 3/1/21		519	Account BA
1.6.1.9.3	3.9.	Conduct Internal Work Product Review of D036 Federal Certification and Review Management Plan	1 day	Mon 3/1/21	Tue 3/2/21		520	Account BA
1.6.1.9.4	3.9.	Revise Draft D036 Federal Certification and Review Management Plan based on Internal Review	2 days	Tue 3/2/21	Thu 3/4/21		521	Account BA,Account Quality Mgr
1.6.1.9.5	3.9.	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	
1.6.1.9.6	3.9.	Conduct Work Product Review with Client of Draft D036 Federal Certification and Review Management Plan	0.25 days	Thu 3/4/21	Thu 3/4/21		523	Client Project Mgr[25%],Account Proj Mgr[25%]
1.6.1.9.7	3.9.	DHHR and Stakeholders Conducts Review of Draft D036 Federal Certification and Review Management Plan	5 days	Thu 3/4/21	Thu 3/11/21		524	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.6.1.9.8	3.9.	Walkthrough Client Deliverable Review Comments	0.25 days	Thu 3/11/21	Thu 3/11/21		525	Client Project Mgr,Client SME

1.6.1.9.9	3.9.	Revise D036 Federal Certification and Review Management Plan based on Client Review	2 days	Fri 3/12/21	Mon 3/15/21	526	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.6.1.9.10	3.9.	Distribute Updated D036 Federal Certification and Review Management Plan to Client for Approval	0.25 days	Tue 3/16/21	Tue 3/16/21	527	Account BA[25%]
1.6.1.9.11	3.9.	DHHR and Stakeholders Conducts Review of Revisions to D036 Federal Certification and Review Management Plan	1 day	Tue 3/16/21	Wed 3/17/21	528	Account Quality Mgr[20%]
1.6.1.9.12	3.9.	Milestone - Client Approves D036 Federal Certification and Review Management Plan					
1.6.1.10	3.10.	D037 Interface Inventory	15 days	Wed 2/24/21	Wed 3/17/21		
1.6.1.10.1	3.10.	Review D037 Interface Inventory Requirements	0.25 days	Wed 2/24/21	Wed 2/24/21	407FS+15 days	Account BA
1.6.1.10.2	3.10.	Create Draft D037 Interface Inventory	3 days	Wed 2/24/21	Mon 3/1/21	532	Account BA
1.6.1.10.3	3.10.	Conduct Internal Work Product Review of D037 Interface Inventory	1 day	Mon 3/1/21	Tue 3/2/21	533	Account BA
1.6.1.10.4	3.10.	Revise Draft D037 Interface Inventory based on Internal Review	2 days	Tue 3/2/21	Thu 3/4/21	534	Account BA,Account Quality Mgr
1.6.1.10.5	3.10.						
1.6.1.10.6	3.10.	Conduct Work Product Review with Client of Draft D037 Interface Inventory	0.25 days	Thu 3/4/21	Thu 3/4/21	536	Client Project Mgr[25%],Account Proj Mgr[25%]
1.6.1.10.7	3.10.	DHHR and Stakeholders Conducts Review of Draft D037 Interface Inventory	5 days	Thu 3/4/21	Thu 3/11/21	537	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.6.1.10.8	3.10.	Walkthrough Client Deliverable Review Comments	0.25 days	Thu 3/11/21	Thu 3/11/21	538	Client Project Mgr,Client SME
1.6.1.10.9	3.10.	Revise D037 Interface Inventory based on Client Review	2 days	Fri 3/12/21	Mon 3/15/21	539	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.6.1.10.10	3.10.	Distribute Updated D037 Interface Inventory to Client for Approval	0.25 days	Tue 3/16/21	Tue 3/16/21	540	Account BA[25%]
1.6.1.10.11	3.10.	DHHR and Stakeholders Conducts Review of Revisions to D037 Interface Inventory	1 day	Tue 3/16/21	Wed 3/17/21	541	Account Quality Mgr[20%]
1.6.1.10.12	3.10.	Milestone - Client Approves D037 Interface Inventory					
1.6.1.11	3.11.	D038 Load and Stress Test Cases	15 days	Wed 2/24/21	Wed 3/17/21		
1.6.1.11.1	3.11.	Review D038 Load and Stress Test Cases Requirements	0.25 days	Wed 2/24/21	Wed 2/24/21	407FS+15 days	Account BA
1.6.1.11.2	3.11.	Create Draft D038 Load and Stress Test Cases	3 days	Wed 2/24/21	Mon 3/1/21	545	Account BA
1.6.1.11.3	3.11.	Conduct Internal Work Product Review of D038 Load and Stress Test Cases	1 day	Mon 3/1/21	Tue 3/2/21	546	Account BA
1.6.1.11.4	3.11.	Revise Draft D038 Load and Stress Test Cases based on Internal Review	2 days	Tue 3/2/21	Thu 3/4/21	547	Account BA,Account Quality Mgr
1.6.1.11.5	3.11.						
1.6.1.11.6	3.11.	Conduct Work Product Review with Client of Draft D038 Load and Stress Test Cases	0.25 days	Thu 3/4/21	Thu 3/4/21	549	Client Project Mgr[25%],Account Proj Mgr[25%]
1.6.1.11.7	3.11.	DHHR and Stakeholders Conducts Review of Draft D038 Load and Stress Test Cases	5 days	Thu 3/4/21	Thu 3/11/21	550	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.6.1.11.8	3.11.	Walkthrough Client Deliverable Review Comments	0.25 days	Thu 3/11/21	Thu 3/11/21	551	Client Project Mgr,Client SME
1.6.1.11.9	3.11.	Revise D038 Load and Stress Test Cases based on Client Review	2 days	Fri 3/12/21	Mon 3/15/21	552	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.6.1.11.10	3.11.	Distribute Updated D038 Load and Stress Test Cases to Client for Approval	0.25 days	Tue 3/16/21	Tue 3/16/21	553	Account BA[25%]
1.6.1.11.11	3.11.	DHHR and Stakeholders Conducts Review of Revisions to D038 Load and Stress Test Cases	1 day	Tue 3/16/21	Wed 3/17/21	554	Account Quality Mgr[20%]
1.6.1.11.12	3.11.	Milestone - Client Approves D038 Load and Stress Test Cases					
1.6.1.12	3.12.	D039 Load and Stress Test Results	15 days	Wed 2/24/21	Wed 3/17/21		
1.6.1.12.1	3.12.	Review D039 Load and Stress Test Results Requirements	0.25 days	Wed 2/24/21	Wed 2/24/21	407FS+15 days	Account BA
1.6.1.12.2	3.12.	Create Draft D039 Load and Stress Test Results	3 days	Wed 2/24/21	Mon 3/1/21	558	Account BA
1.6.1.12.3	3.12.	Conduct Internal Work Product Review of D039 Load and Stress Test Results	1 day	Mon 3/1/21	Tue 3/2/21	559	Account BA
1.6.1.12.4	3.12.	Revise Draft D039 Load and Stress Test Results based on Internal Review	2 days	Tue 3/2/21	Thu 3/4/21	560	Account BA,Account Quality Mgr
1.6.1.12.5	3.12.						
1.6.1.12.6	3.12.	Conduct Work Product Review with Client of Draft D039 Load and Stress Test Results	0.25 days	Thu 3/4/21	Thu 3/4/21	562	Client Project Mgr[25%],Account Proj Mgr[25%]
1.6.1.12.7	3.12.	DHHR and Stakeholders Conducts Review of Draft D039 Load and Stress Test Results	5 days	Thu 3/4/21	Thu 3/11/21	563	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.6.1.12.8	3.12.	Walkthrough Client Deliverable Review Comments	0.25 days	Thu 3/11/21	Thu 3/11/21	564	Client Project Mgr,Client SME
1.6.1.12.9	3.12.	Revise D039 Load and Stress Test Results based on Client Review	2 days	Fri 3/12/21	Mon 3/15/21	565	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.6.1.12.10	3.12.	Distribute Updated D039 Load and Stress Test Results to Client for Approval	0.25 days	Tue 3/16/21	Tue 3/16/21	566	Account BA[25%]
1.6.1.12.11	3.12.	DHHR and Stakeholders Conducts Review of Revisions to D039 Load and Stress Test Results	1 day	Tue 3/16/21	Wed 3/17/21	567	Account Quality Mgr[20%]
1.6.1.12.12	3.12.	Milestone - Client Approves D039 Load and Stress Test Results					
1.6.1.13	3.13.	D040 Operational Readiness Plan (OPR)	15 days	Wed 2/24/21	Wed 3/17/21		
1.6.1.13.1	3.13.	Review D040 Operational Readiness Plan (OPR) Requirements	0.25 days	Wed 2/24/21	Wed 2/24/21	407FS+15 days	Account BA
1.6.1.13.2	3.13.	Create Draft D040 Operational Readiness Plan (OPR)	3 days	Wed 2/24/21	Mon 3/1/21	571	Account BA
1.6.1.13.3	3.13.	Conduct Internal Work Product Review of D040 Operational Readiness Plan (OPR)	1 day	Mon 3/1/21	Tue 3/2/21	572	Account BA
1.6.1.13.4	3.13.	Revise Draft D040 Operational Readiness Plan (OPR) based on Internal Review	2 days	Tue 3/2/21	Thu 3/4/21	573	Account BA,Account Quality Mgr
1.6.1.13.5	3.13.						
1.6.1.13.6	3.13.	Conduct Work Product Review with Client of Draft D040 Operational Readiness Plan (OPR)	0.25 days	Thu 3/4/21	Thu 3/4/21	575	Client Project Mgr[25%],Account Proj Mgr[25%]
1.6.1.13.7	3.13.	DHHR and Stakeholders Conducts Review of Draft D040 Operational Readiness Plan (OPR)	5 days	Thu 3/4/21	Thu 3/11/21	576	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.6.1.13.8	3.13.	Walkthrough Client Deliverable Review Comments	0.25 days	Thu 3/11/21	Thu 3/11/21	577	Client Project Mgr,Client SME
1.6.1.13.9	3.13.	Revise D040 Operational Readiness Plan (OPR) based on Client Review	2 days	Fri 3/12/21	Mon 3/15/21	578	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.6.1.13.10	3.13.	Distribute Updated D040 Operational Readiness Plan (OPR) to Client for Approval	0.25 days	Tue 3/16/21	Tue 3/16/21	579	Account BA[25%]
1.6.1.13.11	3.13.	DHHR and Stakeholders Conducts Review of Revisions to D040 Operational Readiness Plan (OPR)	1 day	Tue 3/16/21	Wed 3/17/21	580	Account Quality Mgr[20%]
1.6.1.13.12	3.13.	Milestone - Client Approves D040 Operational Readiness Plan (OPR)					
1.6.1.14	3.14.	D041 Operational Readiness Test Scripts	15 days	Wed 2/24/21	Wed 3/17/21		
1.6.1.14.1	3.14.	Review D041 Operational Readiness Test Scripts Requirements	0.25 days	Wed 2/24/21	Wed 2/24/21	407FS+15 days	Account BA
1.6.1.14.2	3.14.	Create Draft D041 Operational Readiness Test Scripts	3 days	Wed 2/24/21	Mon 3/1/21	584	Account BA
1.6.1.14.3	3.14.	Conduct Internal Work Product Review of D041 Operational Readiness Test Scripts	1 day	Mon 3/1/21	Tue 3/2/21	585	Account BA
1.6.1.14.4	3.14.	Revise Draft D041 Operational Readiness Test Scripts based on Internal Review	2 days	Tue 3/2/21	Thu 3/4/21	586	Account BA,Account Quality Mgr
1.6.1.14.5	3.14.						
1.6.1.14.6	3.14.	Conduct Work Product Review with Client of Draft D041 Operational Readiness Test Scripts	0.25 days	Thu 3/4/21	Thu 3/4/21	588	Client Project Mgr[25%],Account Proj Mgr[25%]
1.6.1.14.7	3.14.	DHHR and Stakeholders Conducts Review of Draft D041 Operational Readiness Test Scripts	5 days	Thu 3/4/21	Thu 3/11/21	589	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.6.1.14.8	3.14.	Walkthrough Client Deliverable Review Comments	0.25 days	Thu 3/11/21	Thu 3/11/21	590	Client Project Mgr,Client SME
1.6.1.14.9	3.14.	Revise D041 Operational Readiness Test Scripts based on Client Review	2 days	Fri 3/12/21	Mon 3/15/21	591	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]

1.6.1.14.10	3.14.	Distribute Updated D041 Operational Readiness Test Scripts to Client for Approval	0.25 days	Tue 3/16/21	Tue 3/16/21		592	Account BA[25%]
1.6.1.14.11	3.14.	DHHR and Stakeholders Conducts Review of Revisions to D041 Operational Readiness Test Scripts	1 day	Tue 3/16/21	Wed 3/17/21		593	Account Quality Mgr[20%]
1.6.1.14.12	3.14.	Milestone - Client Approves D041 Operational Readiness Test Scripts	0 days	Wed 3/17/21	Wed 3/17/21		594	Client Project Mgr,Client SME
1.6.1.15	**3.15.**	**D042 Operational Readiness Test Results**	**15 days**	**Wed 2/24/21**	**Wed 3/17/21**			
1.6.1.15.1	3.15.	Review D042 Operational Readiness Test Results Requirements	0.25 days	Wed 2/24/21	Wed 2/24/21	407FS+15 days		Account BA
1.6.1.15.2	3.15.	Create Draft D042 Operational Readiness Test Results	3 days	Wed 2/24/21	Mon 3/1/21		597	Account BA
1.6.1.15.3	3.15.	Conduct Internal Work Product Review of D042 Operational Readiness Test Results	1 day	Mon 3/1/21	Tue 3/2/21		598	Account BA
1.6.1.15.4	3.15.	Revise Draft D042 Operational Readiness Test Results based on Internal Review	2 days	Tue 3/2/21	Thu 3/4/21		599	Account BA,Account Quality Mgr
1.6.1.15.5	3.15.	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]
1.6.1.15.6	3.15.	Conduct Work Product Review with Client of Draft D042 Operational Readiness Test Results	0.25 days	Thu 3/4/21	Thu 3/4/21		601	Client Project Mgr[25%],Account Proj Mgr[25%]
1.6.1.15.7	3.15.	DHHR and Stakeholders Conducts Review of Draft D042 Operational Readiness Test Results	5 days	Thu 3/4/21	Thu 3/11/21		602	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.6.1.15.8	3.15.	Walkthrough Client Deliverable Review Comments	0.25 days	Thu 3/11/21	Thu 3/11/21		603	Client Project Mgr,Client SME
1.6.1.15.9	3.15.	Revise D042 Operational Readiness Test Results based on Client Review	2 days	Fri 3/12/21	Mon 3/15/21		604	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.6.1.15.10	3.15.	Distribute Updated D042 Operational Readiness Test Results to Client for Approval	0.25 days	Tue 3/16/21	Tue 3/16/21		605	Account BA[25%]
1.6.1.15.11	3.15.	DHHR and Stakeholders Conducts Review of Revisions to D042 Operational Readiness Test Results	1 day	Tue 3/16/21	Wed 3/17/21		606	Account Quality Mgr[20%]
1.6.1.15.12	3.15.	Milestone - Client Approves D042 Operational Readiness Test Results	0 days	Wed 3/17/21	Wed 3/17/21		607	Client Project Mgr,Client SME
1.6.1.16	**3.16.**	**D043 Regression Test Cases**	**15 days**	**Wed 3/3/21**	**Wed 3/24/21**			
1.6.1.16.1	3.16.	Review D043 Regression Test Cases Requirements	0.25 days	Wed 3/3/21	Wed 3/3/21	407FS+20 days		Account BA
1.6.1.16.2	3.16.	Create Draft D043 Regression Test Cases	3 days	Wed 3/3/21	Mon 3/8/21		610	Account BA
1.6.1.16.3	3.16.	Conduct Internal Work Product Review of D043 Regression Test Cases	1 day	Mon 3/8/21	Tue 3/9/21		611	Account BA
1.6.1.16.4	3.16.	Revise Draft D043 Regression Test Cases based on Internal Review	2 days	Tue 3/9/21	Thu 3/11/21		612	Account BA,Account Quality Mgr
1.6.1.16.5	3.16.	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]
1.6.1.16.6	3.16.	Conduct Work Product Review with Client of Draft D043 Regression Test Cases	0.25 days	Thu 3/11/21	Thu 3/11/21		614	Client Project Mgr[25%],Account Proj Mgr[25%]
1.6.1.16.7	3.16.	DHHR and Stakeholders Conducts Review of Draft D043 Regression Test Cases	5 days	Thu 3/11/21	Thu 3/18/21		615	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.6.1.16.8	3.16.	Walkthrough Client Deliverable Review Comments	0.25 days	Thu 3/18/21	Thu 3/18/21		616	Client Project Mgr,Client SME
1.6.1.16.9	3.16.	Revise D043 Regression Test Cases based on Client Review	2 days	Fri 3/19/21	Mon 3/22/21		617	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.6.1.16.10	3.16.	Distribute Updated D043 Regression Test Cases to Client for Approval	0.25 days	Tue 3/23/21	Tue 3/23/21		618	Account BA[25%]
1.6.1.16.11	3.16.	DHHR and Stakeholders Conducts Review of Revisions to D043 Regression Test Cases	1 day	Tue 3/23/21	Wed 3/24/21		619	Account Quality Mgr[20%]
1.6.1.16.12	3.16.	Milestone - Client Approves D043 Regression Test Cases	0 days	Wed 3/24/21	Wed 3/24/21		620	Client Project Mgr,Client SME
1.6.1.17	**3.17.**	**D044 Regression Test Results**	**15 days**	**Wed 3/3/21**	**Wed 3/24/21**			
1.6.1.17.1	3.17.	Review D044 Regression Test Results Requirements	0.25 days	Wed 3/3/21	Wed 3/3/21	407FS+20 days		Account BA
1.6.1.17.2	3.17.	Create Draft D044 Regression Test Results	3 days	Wed 3/3/21	Mon 3/8/21		623	Account BA
1.6.1.17.3	3.17.	Conduct Internal Work Product Review of D044 Regression Test Results	1 day	Mon 3/8/21	Tue 3/9/21		624	Account BA
1.6.1.17.4	3.17.	Revise Draft D044 Regression Test Results based on Internal Review	2 days	Tue 3/9/21	Thu 3/11/21		625	Account BA,Account Quality Mgr
1.6.1.17.5	3.17.	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]
1.6.1.17.6	3.17.	Conduct Work Product Review with Client of Draft D044 Regression Test Results	0.25 days	Thu 3/11/21	Thu 3/11/21		627	Client Project Mgr[25%],Account Proj Mgr[25%]
1.6.1.17.7	3.17.	DHHR and Stakeholders Conducts Review of Draft D044 Regression Test Results	5 days	Thu 3/11/21	Thu 3/18/21		628	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.6.1.17.8	3.17.	Walkthrough Client Deliverable Review Comments	0.25 days	Thu 3/18/21	Thu 3/18/21		629	Client Project Mgr,Client SME
1.6.1.17.9	3.17.	Revise D044 Regression Test Results based on Client Review	2 days	Fri 3/19/21	Mon 3/22/21		630	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.6.1.17.10	3.17.	Distribute Updated D044 Regression Test Results to Client for Approval	0.25 days	Tue 3/23/21	Tue 3/23/21		631	Account BA[25%]
1.6.1.17.11	3.17.	DHHR and Stakeholders Conducts Review of Revisions to D044 Regression Test Results	1 day	Tue 3/23/21	Wed 3/24/21		632	Account Quality Mgr[20%]
1.6.1.17.12	3.17.	Milestone - Client Approves D044 Regression Test Results	0 days	Wed 3/24/21	Wed 3/24/21		633	Client Project Mgr,Client SME
1.6.1.18	**3.18.**	**D045 Reports and Forms Inventory**	**15 days**	**Wed 3/3/21**	**Wed 3/24/21**			
1.6.1.18.1	3.18.	Review D045 Reports and Forms Inventory Requirements	0.25 days	Wed 3/3/21	Wed 3/3/21	407FS+20 days		Account BA
1.6.1.18.2	3.18.	Create Draft D045 Reports and Forms Inventory	3 days	Wed 3/3/21	Mon 3/8/21		636	Account BA
1.6.1.18.3	3.18.	Conduct Internal Work Product Review of D045 Reports and Forms Inventory	1 day	Mon 3/8/21	Tue 3/9/21		637	Account BA
1.6.1.18.4	3.18.	Revise Draft D045 Reports and Forms Inventory based on Internal Review	2 days	Tue 3/9/21	Thu 3/11/21		638	Account BA,Account Quality Mgr
1.6.1.18.5	3.18.	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]
1.6.1.18.6	3.18.	Conduct Work Product Review with Client of Draft D045 Reports and Forms Inventory	0.25 days	Thu 3/11/21	Thu 3/11/21		640	Client Project Mgr[25%],Account Proj Mgr[25%]
1.6.1.18.7	3.18.	DHHR and Stakeholders Conducts Review of Draft D045 Reports and Forms Inventory	5 days	Thu 3/11/21	Thu 3/18/21		641	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.6.1.18.8	3.18.	Walkthrough Client Deliverable Review Comments	0.25 days	Thu 3/18/21	Thu 3/18/21		642	Client Project Mgr,Client SME
1.6.1.18.9	3.18.	Revise D045 Reports and Forms Inventory based on Client Review	2 days	Fri 3/19/21	Mon 3/22/21		643	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.6.1.18.10	3.18.	Distribute Updated D045 Reports and Forms Inventory to Client for Approval	0.25 days	Tue 3/23/21	Tue 3/23/21		644	Account BA[25%]
1.6.1.18.11	3.18.	DHHR and Stakeholders Conducts Review of Revisions to D045 Reports and Forms Inventory	1 day	Tue 3/23/21	Wed 3/24/21		645	Account Quality Mgr[20%]
1.6.1.18.12	3.18.	Milestone - Client Approves D045 Reports and Forms Inventory	0 days	Wed 3/24/21	Wed 3/24/21		646	Client Project Mgr,Client SME
1.6.1.19	**3.19.**	**D046 System Integration Plan**	**15 days**	**Wed 3/3/21**	**Wed 3/24/21**			
1.6.1.19.1	3.19.	Review D046 System Integration Plan Requirements	0.25 days	Wed 3/3/21	Wed 3/3/21	407FS+20 days		Account BA
1.6.1.19.2	3.19.	Create Draft D046 System Integration Plan	3 days	Wed 3/3/21	Mon 3/8/21		649	Account BA
1.6.1.19.3	3.19.	Conduct Internal Work Product Review of D046 System Integration Plan	1 day	Mon 3/8/21	Tue 3/9/21		650	Account BA
1.6.1.19.4	3.19.	Revise Draft D046 System Integration Plan based on Internal Review	2 days	Tue 3/9/21	Thu 3/11/21		651	Account BA,Account Quality Mgr
1.6.1.19.5	3.19.	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]
1.6.1.19.6	3.19.	Conduct Work Product Review with Client of Draft D046 System Integration Plan	0.25 days	Thu 3/11/21	Thu 3/11/21		653	Client Project Mgr[25%],Account Proj Mgr[25%]
1.6.1.19.7	3.19.	DHHR and Stakeholders Conducts Review of Draft D046 System Integration Plan	5 days	Thu 3/11/21	Thu 3/18/21		654	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.6.1.19.8	3.19.	Walkthrough Client Deliverable Review Comments	0.25 days	Thu 3/18/21	Thu 3/18/21		655	Client Project Mgr,Client SME
1.6.1.19.9	3.19.	Revise D046 System Integration Plan based on Client Review	2 days	Fri 3/19/21	Mon 3/22/21		656	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.6.1.19.10	3.19.	Distribute Updated D046 System Integration Plan to Client for Approval	0.25 days	Tue 3/23/21	Tue 3/23/21		657	Account BA[25%]
1.6.1.19.11	3.19.	DHHR and Stakeholders Conducts Review of Revisions to D046 System Integration Plan	1 day	Tue 3/23/21	Wed 3/24/21		658	Account Quality Mgr[20%]

1.6.1.19.12		[illegible]stone - Client Approves D046 System Integration Plan	[illegible]	[illegible]	[illegible]			[illegible]
1.6.1.20	3.20.	D047 System Integration Test Cases	15 days	Wed 3/3/21	Wed 3/24/21			
1.6.1.20.1	3.20.	Review D047 System Integration Test Cases Requirements	0.25 days	Wed 3/3/21	Wed 3/3/21	407FS+20 days		Account BA
1.6.1.20.2	3.20.	Create Draft D047 System Integration Test Cases	3 days	Wed 3/3/21	Mon 3/8/21		662	Account BA
1.6.1.20.3	3.20.	Conduct Internal Work Product Review of D047 System Integration Test Cases	1 day	Mon 3/8/21	Tue 3/9/21		663	Account BA
1.6.1.20.4	3.20.	Revise Draft D047 System Integration Test Cases based on Internal Review	2 days	Tue 3/9/21	Thu 3/11/21		664	Account BA,Account Quality Mgr
1.6.1.20.5	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
1.6.1.20.6	3.20.	Conduct Work Product Review with Client of Draft D047 System Integration Test Cases	0.25 days	Thu 3/11/21	Thu 3/11/21		666	Client Project Mgr[25%],Account Proj Mgr[25%]
1.6.1.20.7	3.20.	DHHR and Stakeholders Conducts Review of Draft D047 System Integration Test Cases	5 days	Thu 3/11/21	Thu 3/18/21		667	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.6.1.20.8	3.20.	Walkthrough Client Deliverable Review Comments	0.25 days	Thu 3/18/21	Thu 3/18/21		668	Client Project Mgr,Client SME
1.6.1.20.9	3.20.	Revise D047 System Integration Test Cases based on Client Review	2 days	Fri 3/19/21	Mon 3/22/21		669	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.6.1.20.10	3.20.	Distribute Updated D047 System Integration Test Cases to Client for Approval	0.25 days	Tue 3/23/21	Tue 3/23/21		670	Account BA[25%]
1.6.1.20.11	3.20.	DHHR and Stakeholders Conducts Review of Revisions to D047 System Integration Test Cases	1 day	Tue 3/23/21	Wed 3/24/21		671	Account Quality Mgr[20%]
1.6.1.20.12	[illegible]	[illegible]tone - Client Approves D047 System Integration Test Cases	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
1.6.1.21	3.21.	D048 System Integration Test Results	15 days	Wed 3/3/21	Wed 3/24/21			
1.6.1.21.1	3.21.	Review D048 System Integration Test Results Requirements	0.25 days	Wed 3/3/21	Wed 3/3/21	407FS+20 days		Account BA
1.6.1.21.2	3.21.	Create Draft D048 System Integration Test Results	3 days	Wed 3/3/21	Mon 3/8/21		675	Account BA
1.6.1.21.3	3.21.	Conduct Internal Work Product Review of D048 System Integration Test Results	1 day	Mon 3/8/21	Tue 3/9/21		676	Account BA
1.6.1.21.4	3.21.	Revise Draft D048 System Integration Test Results based on Internal Review	2 days	Tue 3/9/21	Thu 3/11/21		677	Account BA,Account Quality Mgr
1.6.1.21.5	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
1.6.1.21.6	3.21.	Conduct Work Product Review with Client of Draft D048 System Integration Test Results	0.25 days	Thu 3/11/21	Thu 3/11/21		679	Client Project Mgr[25%],Account Proj Mgr[25%]
1.6.1.21.7	3.21.	DHHR and Stakeholders Conducts Review of Draft D048 System Integration Test Results	5 days	Thu 3/11/21	Thu 3/18/21		680	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.6.1.21.8	3.21.	Walkthrough Client Deliverable Review Comments	0.25 days	Thu 3/18/21	Thu 3/18/21		681	Client Project Mgr,Client SME
1.6.1.21.9	3.21.	Revise D048 System Integration Test Results based on Client Review	2 days	Fri 3/19/21	Mon 3/22/21		682	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.6.1.21.10	3.21.	Distribute Updated D048 System Integration Test Results to Client for Approval	0.25 days	Tue 3/23/21	Tue 3/23/21		683	Account BA[25%]
1.6.1.21.11	3.21.	DHHR and Stakeholders Conducts Review of Revisions to D048 System Integration Test Results	1 day	Tue 3/23/21	Wed 3/24/21		684	Account Quality Mgr[20%]
1.6.1.21.12	[illegible]	[illegible]tone - Client Approves D048 System Integration Test Results	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
1.6.1.22	3.22.	D049 Training Management Plan	15 days	Wed 3/3/21	Wed 3/24/21			
1.6.1.22.1	3.22.	Review D049 Training Management Plan Requirements	0.25 days	Wed 3/3/21	Wed 3/3/21	407FS+20 days		Account BA
1.6.1.22.2	3.22.	Create Draft D049 Training Management Plan	3 days	Wed 3/3/21	Mon 3/8/21		688	Account BA
1.6.1.22.3	3.22.	Conduct Internal Work Product Review of D049 Training Management Plan	1 day	Mon 3/8/21	Tue 3/9/21		689	Account BA
1.6.1.22.4	3.22.	Revise Draft D049 Training Management Plan based on Internal Review	2 days	Tue 3/9/21	Thu 3/11/21		690	Account BA,Accoun: Quality Mgr
1.6.1.22.5	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
1.6.1.22.6	3.22.	Conduct Work Product Review with Client of Draft D049 Training Management Plan	0.25 days	Thu 3/11/21	Thu 3/11/21		692	Client Project Mgr[25%],Account Proj Mgr[25%]
1.6.1.22.7	3.22.	DHHR and Stakeholders Conducts Review of Draft D049 Training Management Plan	5 days	Thu 3/11/21	Thu 3/18/21		693	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.6.1.22.8	3.22.	Walkthrough Client Deliverable Review Comments	0.25 days	Thu 3/18/21	Thu 3/18/21		694	Client Project Mgr,Client SME
1.6.1.22.9	3.22.	Revise D049 Training Management Plan based on Client Review	2 days	Fri 3/19/21	Mon 3/22/21		695	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.6.1.22.10	3.22.	Distribute Updated D049 Training Management Plan to Client for Approval	0.25 days	Tue 3/23/21	Tue 3/23/21		696	Account BA[25%]
1.6.1.22.11	3.22.	DHHR and Stakeholders Conducts Review of Revisions to D049 Training Management Plan	1 day	Tue 3/23/21	Wed 3/24/21		697	Account Quality Mgr[20%]
1.6.1.22.12	[illegible]	[illegible]one - Client Approves D049 Training Management Plan	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
1.6.1.23	3.23.	D050 User Acceptance Test (UAT) Cases	15 days	Wed 3/3/21	Wed 3/24/21			
1.6.1.23.1	3.23.	Review D050 User Acceptance Test (UAT) Cases Requirements	0.25 days	Wed 3/3/21	Wed 3/3/21	407FS+20 days		Account BA
1.6.1.23.2	3.23.	Create Draft D050 User Acceptance Test (UAT) Cases	3 days	Wed 3/3/21	Mon 3/8/21		701	Account BA
1.6.1.23.3	3.23.	Conduct Internal Work Product Review of D050 User Acceptance Test (UAT) Cases	1 day	Mon 3/8/21	Tue 3/9/21		702	Account BA
1.6.1.23.4	3.23.	Revise Draft D050 User Acceptance Test (UAT) Cases based on Internal Review	2 days	Tue 3/9/21	Thu 3/11/21		703	Account BA,Account Quality Mgr
1.6.1.23.5	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
1.6.1.23.6	3.23.	Conduct Work Product Review with Client of Draft D050 User Acceptance Test (UAT) Cases	0.25 days	Thu 3/11/21	Thu 3/11/21		705	Client Project Mgr[25%],Account Proj Mgr[25%]
1.6.1.23.7	3.23.	DHHR and Stakeholders Conducts Review of Draft D050 User Acceptance Test (UAT) Cases	5 days	Thu 3/11/21	Thu 3/18/21		706	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.6.1.23.8	3.23.	Walkthrough Client Deliverable Review Comments	0.25 days	Thu 3/18/21	Thu 3/18/21		707	Client Project Mgr,Client SME
1.6.1.23.9	3.23.	Revise D050 User Acceptance Test (UAT) Cases based on Client Review	2 days	Fri 3/19/21	Mon 3/22/21		708	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.6.1.23.10	3.23.	Distribute Updated D050 User Acceptance Test (UAT) Cases to Client for Approval	0.25 days	Tue 3/23/21	Tue 3/23/21		709	Account BA[25%]
1.6.1.23.11	3.23.	DHHR and Stakeholders Conducts Review of Revisions to D050 User Acceptance Test (UAT) Cases	1 day	Tue 3/23/21	Wed 3/24/21		710	Account Quality Mgr[20%]
1.6.1.23.12	[illegible]	[illegible]one - Client Approves D050 User Acceptance Test (UAT) Cases	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
1.6.1.24	3.24.	D051 UAT Results and Letter of Completion	15 days	Wed 3/3/21	Wed 3/24/21			
1.6.1.24.1	3.24.	Review D051 UAT Results and Letter of Completion Requirements	0.25 days	Wed 3/3/21	Wed 3/3/21	407FS+20 days		Account BA
1.6.1.24.2	3.24.	Create Draft D051 UAT Results and Letter of Completion	3 days	Wed 3/3/21	Mon 3/8/21		714	Account BA
1.6.1.24.3	3.24.	Conduct Internal Work Product Review of D051 UAT Results and Letter of Completion	1 day	Mon 3/8/21	Tue 3/9/21		715	Account BA
1.6.1.24.4	3.24.	Revise Draft D051 UAT Results and Letter of Completion based on Internal Review	2 days	Tue 3/9/21	Thu 3/11/21		716	Account BA,Account Quality Mgr
1.6.1.24.5	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
1.6.1.24.6	3.24.	Conduct Work Product Review with Client of Draft D051 UAT Results and Letter of Completion	0.25 days	Thu 3/11/21	Thu 3/11/21		718	Client Project Mgr[25%],Account Proj Mgr[25%]
1.6.1.24.7	3.24.	DHHR and Stakeholders Conducts Review of Draft D051 UAT Results and Letter of Completion	5 days	Thu 3/11/21	Thu 3/18/21		719	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.6.1.24.8	3.24.	Walkthrough Client Deliverable Review Comments	0.25 days	Thu 3/18/21	Thu 3/18/21		720	Client Project Mgr,Client SME
1.6.1.24.9	3.24.	Revise D051 UAT Results and Letter of Completion based on Client Review	2 days	Fri 3/19/21	Mon 3/22/21		721	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.6.1.24.10	3.24.	Distribute Updated D051 UAT Results and Letter of Completion to Client for Approval	0.25 days	Tue 3/23/21	Tue 3/23/21		722	Account BA[25%]
1.6.1.24.11	3.24.	DHHR and Stakeholders Conducts Review of Revisions to D051 UAT Results and Letter of Completion	1 day	Tue 3/23/21	Wed 3/24/21		723	Account Quality Mgr[20%]
1.6.1.24.12	[illegible]	[illegible]one - Client Approves D051 UAT Results and Letter of Complet[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
1.6.2	[illegible]	[illegible]-Task Group 3 - Deliverables Complete	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

1.6.3	**Solution Configuration Design**	8 days	Fri 1/15/21	Wed 1/27/21			
1.6.3.1	Conduct Config Analysis / Design - Trauma Recovery (Existing + New Functionality)	2 days	Fri 1/15/21	Tue 1/19/21		387	HMS Business Analyst,Technical Lead
1.6.3.2	Conduct Config Analysis / Design - Estate Recovery (Existing + New Functionality)	2 days	Tue 1/19/21	Wed 1/20/21		388	HMS Business Analyst,Technical Lead
1.6.3.3	Conduct Config Analysis / Design - Tri-Care, Medicare, and Commercial Recoveries (Existing + New Functionality)	2 days	Wed 1/20/21	Thu 1/21/21		389	HMS Business Analyst,Technical Lead
1.6.3.4	Conduct Config Analysis / Design - Credit Balance Audits (Existing + New Functionality)	2 days	Thu 1/21/21	Fri 1/22/21		390	HMS Business Analyst,Technical Lead
1.6.3.5	Conduct Config Analysis / Design - Third-Party Adds (Existing + New Functionality)	2 days	Fri 1/22/21	Mon 1/25/21		391	HMS Business Analyst,Technical Lead
1.6.3.6	Milestone - Configuration Design Phase Complete	2 days	Tue 1/26/21	Wed 1/27/21	##########		
1.6.4	**Solution Development Phase**	**7 days**	**Wed 1/20/21**	**Thu 1/28/21**			
1.6.4.1	**Solution Configuration/Development**	**7 days**	**Wed 1/20/21**	**Thu 1/28/21**			
1.6.4.1.1	Configure/Develop/Unit Test - Casualty-Trauma Recovery Module Functionality	3 days	Wed 1/20/21	Fri 1/22/21		728	HMS Business Analyst,Technical Lead
1.6.4.1.2	Configure/Develop/Unit Test - Estate Recovery Module Functionality	3 days	Thu 1/21/21	Mon 1/25/21		729	HMS Business Analyst,Technical Lead
1.6.4.1.3	Configure/Develop/Unit Test - Tri-Care, Medicare, and Commercial Recoveries Module Functionality	3 days	Fri 1/22/21	Tue 1/26/21		730	HMS Business Analyst,Technical Lead
1.6.4.1.4	Configure/Develop/Unit Test - Credit Balance Audits Module Functionality	3 days	Mon 1/25/21	Wed 1/27/21		731	HMS Business Analyst,Technical Lead
1.6.4.1.5	Configure/Develop/Unit Test - Third-Party Adds Module Functionality	3 days	Tue 1/26/21	Thu 1/28/21		732	HMS Business Analyst,Technical Lead
1.6.4.1.6	Milestone - Configuration/Development and Unit Test Complete	0 days	Thu 1/28/21	Thu 1/28/21	##########		
1.6.5	**Training**	**10 days**	**Wed 1/27/21**	**Wed 2/10/21**			
1.6.5.1	**Training Material/ Manuals**	**10 days**	**Wed 1/27/21**	**Wed 2/10/21**			
1.6.5.1.1	Review RFP Training Materials Requirements	0.5 days	Thu 1/28/21	Thu 1/28/21		733	Trainer,Training Mgr[20%]
1.6.5.1.2	Create Training Materials	10 days	Thu 1/28/21	Wed 2/10/21		733	Trainer,Training Mgr[20%]
1.6.5.1.3	Review & Revise Training Materials	1 day	Thu 1/28/21	Thu 1/28/21		733	Trainer,Training Mgr[20%]
1.6.5.1.4	Produce Training Materials	2 days	Thu 1/28/21	Fri 1/29/21		733	Trainer,Training Mgr[20%]
1.6.5.1.5	Milestone - Training Materials Complete	0 days	Wed 1/27/21	Wed 1/27/21	733		
1.6.6	**Data Conversion**	**22 days**	**Mon 1/4/21**	**Wed 2/3/21**			
1.6.6.1	**Conversion Specifications & Detailed Data Mapping**	7 days	**Mon 1/4/21**	**Tue 1/12/21**			
1.6.6.1.1	Request Source Data	1 day	Mon 1/4/21	Mon 1/4/21	387FS-9 days		Conv Business Analyst
1.6.6.1.2	Prepare and Upload Source Data	2 days	Tue 1/5/21	Wed 1/6/21		751	Conv Developer
1.6.6.1.3	Profile Source Data	2 days	Thu 1/7/21	Fri 1/8/21		752	Conv Business Analyst[15%],Conv Developer[50%],BMS Integrator
1.6.6.1.4	Develop Detailed Data Mapping	2 days	Mon 1/11/21	Tue 1/12/21		753	Conv Business Analyst[15%],Conv Developer[50%],BMS Integrator
1.6.6.1.5	Milestone - Conversion Specifications & Detailed Data Mapping Complete	0 days	Tue 1/12/21	Tue 1/12/21	754		
1.6.6.1.6	Milestone - Conversion Design Activities Complete	0 days	Tue 1/12/21	Tue 1/12/21	755		
1.6.6.2	**Program Development and Unit Testing**	**5 days**	**Wed 1/13/21**	**Wed 1/20/21**			
1.6.6.2.1	Develop and Unit Test Conversion Solution	5 days	Wed 1/13/21	Wed 1/20/21		756	Conv Developer
1.6.6.2.2	Milestone - Conversion Development and Unit Testing Complete	0 days	Wed 1/20/21	Wed 1/20/21	756		
1.6.6.3	**Conversion Testing**	**5 days**	**Wed 1/13/21**	**Wed 1/20/21**			
1.6.6.3.1	**Conversion & Reconciliation Test Cases/Scripts**	**5 days**	**Wed 1/13/21**	**Wed 1/20/21**			
1.6.6.3.1.1	Identify Test Cases/Scripts for Data Conversion	2 days	Wed 1/13/21	Thu 1/14/21		756	Conv Business Analyst[20%],Conv Developer[20%],HMS Conv Testing Team,Conv Mgr[10%]
1.6.6.3.1.2	Define Test Results for Data Conversion	2 days	Wed 1/13/21	Thu 1/14/21	762SS		Conv Business Analyst[20%],Conv Developer[20%],HMS Conv Testing Team,Conv Mgr[10%]
1.6.6.3.1.3	Prepare Test Results for Data Conversion	1 day	Fri 1/15/21	Fri 1/15/21		763	Conv Business Analyst[20%],Conv Developer[20%],HMS Conv Testing Team,Conv Mgr[10%]
1.6.6.3.1.4	Conduct Internal Review of Test Results Data Conversion	1 day	Tue 1/19/21	Tue 1/19/21		764	Conv Business Analyst[20%],Conv Developer[20%],Conv Mgr[10%],HMS Conv Testing Team
1.6.6.3.1.5	Revise Test Results Data Conversion based on Internal Review	1 day	Wed 1/20/21	Wed 1/20/21		765	Conv Business Analyst[20%],Conv Developer[20%],HMS Conv Testing Team,Conv Mgr[10%]
1.6.6.3.1.6	Milestone - Conversion & Reconciliation Test Cases/Scripts Complete	0 days	Wed 1/20/21	Wed 1/20/21	765		
1.6.6.4	**Conversion System Integration Testing**	**2 days**	**Thu 1/21/21**	**Fri 1/22/21**			
1.6.6.4.1	Execute Conversion Testing	2 days	Thu 1/21/21	Fri 1/22/21		766	HMS Conv Testing Team
1.6.6.5	**Review Conversion Results**	**4 days**	**Mon 1/25/21**	**Thu 1/28/21**			
1.6.6.5.1	Create and Review Conversion Test Results Reports	1 day	Mon 1/25/21	Mon 1/25/21		769	HMS Conv Testing Team,BMS Integrator
1.6.6.5.2	Revise Conversion Programs	2 days	Tue 1/26/21	Wed 1/27/21		771	Conv Business Analyst[25%],Conv Developer[25%],HMS Conv Testing Team
1.6.6.5.3	Re-Execute Conversion System Test	1 day	Thu 1/28/21	Thu 1/28/21		772	Conv Business Analyst[25%],Conv Developer[25%]
1.6.6.5.4	Milestone - Data Conversion System Testing for Preliminary Conversion Complete	0 days	Thu 1/28/21	Thu 1/28/21	773		
1.6.6.5.5	Milestone - Conversion Data Ready for Testing	0 days	Thu 1/28/21	Thu 1/28/21	774		
1.6.6.6	**Load Converted Data**	**2 days**	**Fri 1/29/21**	**Mon 2/1/21**			
1.6.6.6.1	Review & Revise Plan to Load Converted Data	1 day	Fri 1/29/21	Fri 1/29/21		773	Conv Business Analyst[25%],Conv Developer[50%]
1.6.6.6.2	Load Converted Data	1 day	Mon 2/1/21	Mon 2/1/21		777	Conv Business Analyst[25%],Conv Developer[50%]
1.6.6.6.3	Milestone - Conversion Data Load to Test Environment Complete	0 days	Mon 2/1/21	Mon 2/1/21	778		
1.6.6.7	**Conversion Researches and Resolves Conversion Findings**	**2 days**	**Tue 2/2/21**	**Wed 2/3/21**			
1.6.6.7.1	Apply Conversion Data Base Changes	2 days	Tue 2/2/21	Wed 2/3/21		779	HMS DBA[30%],Conv Mgr[20%]
1.6.6.7.2	Apply Corrections to Preliminary Conversion Results	2 days	Tue 2/2/21	Wed 2/3/21		779	Conv Mgr[30%]
1.6.6.7.3	Milestone - Conversion Data Ready for Testing Efforts	0 days	Wed 2/3/21	Wed 2/3/21	782		
1.6.6.7.4	Milestone - Preliminary Data Conversion Complete	0 days	Wed 2/3/21	Wed 2/3/21	783		
1.6.7	**Integration Testing**	15.25 days	**Fri 1/29/21**	**Mon 2/22/21**			
1.6.7.1	**Integration Test Data Preparation**	2 days	**Fri 1/29/21**	**Mon 2/1/21**			
1.6.7.1.1	Populate Integration Test Environment	1 day	Fri 1/29/21	Fri 1/29/21		775	Account Developer
1.6.7.1.2	Validate Integration Test Environment	1 day	Mon 2/1/21	Mon 2/1/21		787	Account Developer
1.6.7.2	**Integration Tests Execution**	4 days	**Tue 2/2/21**	**Fri 2/5/21**			
1.6.7.2.1	Migrate Code as Necessary for Integration Testing	1 day	Tue 2/2/21	Tue 2/2/21		788	Acct Business Lead - SME[10%]

1.6.7.2.2		Conduct Integration Tests	3 days	Wed 2/3/21	Fri 2/5/21		790	HMS Integration Test Team[30%]
1.6.7.3		Integration Tests Results	5.25 days	Mon 2/8/21	Mon 2/22/21		789	
1.6.7.3.1		Compile Integration Testing Results	2 days	Mon 2/8/21	Tue 2/9/21			Account Business Analyst[40%],HMS Integration Test Team[25%]
1.6.7.3.2		[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	
1.6.7.3.3		Compile Integration Testing Report and Deliver to DHHR	1 day	Wed 2/10/21	Wed 2/10/21		794	Account Business Analyst,HMS System Test Team[50%]
1.6.7.3.4		Conduct Walkthrough with DHHR of Final Integration Testing Test Results	1 day	Thu 2/11/21	Thu 2/11/21		795	HMS Testing Mgr[50%],BMS Tester
1.6.7.3.5		DHHR Conducts Review of Integration Testing Test Results	2 days	Fri 2/12/21	Tue 2/16/21		796	BMS Tester[50%]
1.6.7.3.6		Walkthrough DHHR Deliverable Review Comments	0.25 days	Wed 2/17/21	Wed 2/17/21		797	BMS PMO Project Manager[50%],BMS Tester
1.6.7.3.7		Revise Integration Testing Test Results based on DHHR Review	1 day	Wed 2/17/21	Thu 2/18/21		798	Account Business Analyst[40%],HMS Integration Test Team[25%]
1.6.7.3.8		DHHR Conduct Final Review and Approval of Integration Testing Test Results	2 days	Thu 2/18/21	Mon 2/22/21		799	BMS Tester[13%],BMS PMO Project Manager[13%]
1.6.7.3.9		[illegible]one - Completion and DHHR Approval of Solution Integration Testing Results (SIT)	0 days	Mon 2/22/21	Mon 2/22/21		800	
1.6.8		Performance/ Stress Test (Capacity Test)	11.5 days	Fri 1/29/21	Tue 2/16/21			
1.6.8.1		Performance/ Stress Test Execution and Rework	5 days	Fri 1/29/21	Thu 2/4/21			
1.6.8.1.1		Migrate Code as Necessary for Performance/ Stress Testing	1 day	Fri 1/29/21	Fri 1/29/21		775	Acct Business Lead - SME[10%]
1.6.8.1.2		Conduct Performance/ Stress Testing	3 days	Mon 2/1/21	Wed 2/3/21		804	HMS Performance Test Team[125%],HMS Performance Test Lead[200%]
1.6.8.1.3		Rework& Support Performance/ Stress Testing	3 days	Tue 2/2/21	Thu 2/4/21	805SS+1 day		HMS Performance Test Team[40%],HMS Performance Test Lead[41%]
1.6.8.2		Performance/ Stress Testing Results	6.5 days	Fri 2/5/21	Tue 2/16/21		803	
1.6.8.2.1		Compile Performance/ Stress Testing Results	1 day	Fri 2/5/21	Fri 2/5/21			Account Business Analyst[50%],HMS Performance Test Team[200%],HMS Performance Test Lead[75%]
1.6.8.2.2		[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	
1.6.8.2.3		Compile Performance/ Stress Testing Report and Deliver to DHHR	1 day	Mon 2/8/21	Mon 2/8/21		809	Account Business Analyst,HMS System Test Team[50%]
1.6.8.2.4		Conduct Work Product Review with DHHR of Final Capacity Results	0.25 days	Tue 2/9/21	Tue 2/9/21		810	HMS Testing Mgr[20%],BMS Tester,HMS Performance Test Lead
1.6.8.2.5		DHHR Conducts Review of Final Capacity Results	2 days	Tue 2/9/21	Thu 2/11/21		811	BMS Tester
1.6.8.2.6		Walkthrough DHHR Feedback Review Comments	0.25 days	Thu 2/11/21	Thu 2/11/21		812	BMS Performance Test Lead[75%],BMS Tester,BMS PMO Project Manager[50%]
1.6.8.2.7		Revise Final Network Capacity Results based on DHHR Review	1 day	Thu 2/11/21	Fri 2/12/21		813	Account Business Analyst[21%],HMS Performance Test Team,HMS Performance Test Lead
1.6.8.2.8		DHHR Conduct Final Review of Final Capacity Results	1 day	Fri 2/12/21	Tue 2/16/21		814	HMS Testing Mgr[10%],BMS Tester
1.6.8.2.9		[illegible]one - DHHR Completes Performance/ Stress Testing Results Review	0 days	Tue 2/16/21	Tue 2/16/21		815	
1.6.9		User Acceptance Testing (UAT)	20.25 days	Mon 2/22/21	Mon 3/22/21			
1.6.9.1		UAT Training	5 days	Mon 2/22/21	Thu 2/25/21			
1.6.9.1.1		UAT Training Prep	2 days	Mon 2/22/21	Wed 2/24/21			
1.6.9.1.1.1		Verify Target Audience for UAT Training	1 day	Mon 2/22/21	Tue 2/23/21		801	Instructional Design/Trainer[30%],BMS UAT Test Lead[30%],Training Mgr[10%],HMS Testing Mgr[10%]
1.6.9.1.1.2		Confirm UAT Training Schedule	1 day	Mon 2/22/21	Tue 2/23/21	820SS		Instructional Design/Trainer[30%],BMS UAT Test Lead[30%],Training Mgr[10%],HMS Testing Mgr[10%]
1.6.9.1.1.3		Confirm Classrooms and Training Sites	1 day	Mon 2/22/21	Tue 2/23/21	821SS		Instructional Design/Trainer[30%],BMS UAT Test Lead[30%],Training Mgr[10%],HMS Testing Mgr[10%]
1.6.9.1.1.4		Verify Training Environment Tasks are Complete	1 day	Mon 2/22/21	Tue 2/23/21	822SS		Instructional Design/Trainer,BMS UAT Test Lead[10%]
1.6.9.1.1.5		Conduct Overview of UAT	1 day	Tue 2/23/21	Wed 2/24/21		823	BMS PMO Project Manager[33%],BMS UAT Test Lead[33%]
1.6.9.1.1.6		Describe the System Changes that were Made & How to Test	1 day	Tue 2/23/21	Wed 2/24/21	824SS		Acct Business Lead - SME[25%]
1.6.9.1.2		Conduct UAT Training Sessions	1 day	Wed 2/24/21	Thu 2/25/21			
1.6.9.1.2.1		Document UAT Training Participants	1 day	Wed 2/24/21	Thu 2/25/21		824	Training Mgr[20%],Instructional Design/Trainer[10%]
1.6.9.1.2.2		Conduct UAT Training Session	1 day	Wed 2/24/21	Thu 2/25/21	827SS		Instructional Design/Trainer,Training Mgr[11%],BMS UAT Tester[55%]
1.6.9.2		UAT Test Data	2 days	Wed 2/24/21	Fri 2/26/21			
1.6.9.2.1		Load UAT Environment with Converted Data/Files	1 day	Wed 2/24/21	Thu 2/25/21		824	Conv Developer
1.6.9.2.2		Validate UAT Environment with Converted Data/Files	1 day	Thu 2/25/21	Fri 2/26/21		830	Conv Business Analyst,Conv Developer,Conv Mgr
1.6.9.3		UAT Execution	8 days	Thu 2/25/21	Tue 3/9/21			
1.6.9.3.1		Migrate Code Necessary for User Acceptance Testing	1 day	Thu 2/25/21	Fri 2/26/21		830	Acct Business Lead - SME[10%]
1.6.9.3.2		Execute User Acceptance Test Cycles End-To-End Tests	2 days	Fri 2/26/21	Tue 3/2/21		833	BMS UAT Test Lead,BMS UAT Tester[30%]
1.6.9.3.3		Execute User Acceptance Test Cycles Adhoc Tests	1 day	Tue 3/2/21	Wed 3/3/21		834	BMS UAT Test Lead,BMS UAT Tester[30%]
1.6.9.3.4		Execute User Acceptance Test Cycles & Review Results	2 days	Wed 3/3/21	Fri 3/5/21		835	BMS UAT Test Lead,BMS UAT Tester[30%]
1.6.9.3.5		Update Test Case Tracking System with Results	2 days	Fri 3/5/21	Tue 3/9/21		836	BMS UAT Test Lead[50%],BMS UAT Tester[30%]
1.6.9.4		UAT Support and Retest	8 days	Fri 2/26/21	Wed 3/10/21			
1.6.9.4.1		Provide UAT Support and Retest	8 days	Fri 2/26/21	Wed 3/10/21	834SS		HMS UAT Test Team 18%]
1.6.9.5		UAT Test Results	8.25 days	Wed 3/10/21	Mon 3/22/21			
1.6.9.5.1		Compile UAT Test Results	1 day	Wed 3/10/21	Thu 3/11/21		839	Account Business Analyst[17%],BMS UAT Test Lead[20%],BMS UAT Tester[30%]
1.6.9.5.2		[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	
1.6.9.5.3		Compile User Acceptance Testing Report and Deliver to DHHR	1 day	Thu 3/11/21	Fri 3/12/21		842	Account Business Analyst,BMS System Test Team[50%]
1.6.9.5.4		Conduct Work Product Review with The DHHR of UAT Test Results	0.25 days	Fri 3/12/21	Fri 3/12/21		843	HMS Testing Mgr[8%],BMS UAT Test Lead[38%],BMS PMO Project Manager
1.6.9.5.5		DHHR Conducts Review of UAT Test Results	2 days	Fri 3/12/21	Tue 3/16/21		844	BMS PMO Project Manager,BMS Imp Planning SME[25%]
1.6.9.5.6		Walkthrough DHHR Deliverable Review Comments	0.25 days	Tue 3/16/21	Tue 3/16/21		845	HMS Testing Mgr[50%],BMS PMO Project Manager[50%]
1.6.9.5.7		Revise UAT Test Results based on DHHR Review	1 day	Tue 3/16/21	Wed 3/17/21		846	Account Business Analyst[130%]
1.6.9.5.8		Distribute UAT Test Results to DHHR for 2nd Review	0.25 days	Wed 3/17/21	Wed 3/17/21		847	Account Business Analyst[30%]

1.6.9.5.9			DHHR Performs 2nd Review of UAT Test Results	1 day	Thu 3/18/21	Thu 3/18/21		848	BMS PMO Project Manager[50%],BMS Imp Planning SME[25%]
1.6.9.5.10			Walkthrough DHHR Deliverable Review Comments	0.25 days	Fri 3/19/21	Fri 3/19/21		849	HMS Testing Mgr[50%],BMS PMO Project Manager[50%]
1.6.9.5.11			Revise UAT Test Results based on 2nd Review Feedback	1 day	Fri 3/19/21	Mon 3/22/21		850	HMS Testing Mgr[20%]
1.6.9.5.12			Distribute UAT Test Results to DHHR for Approval	0.25 days	Mon 3/22/21	Mon 3/22/21		851	Account Business Analyst[30%]
1.6.9.5.13			Milestone - DHHR Approves UAT Test Results	0 days	Mon 3/22/21	Mon 3/22/21		852	
1.6.10			Operational Readiness Testing	12.25 days	Thu 3/11/21	Mon 3/29/21			
1.6.10.1			Operational Readiness Test Prep - Load Data	2 days	Thu 3/11/21	Mon 3/15/21			
1.6.10.1.1			Load Data for Operational Readiness Test	1 day	Thu 3/11/21	Fri 3/12/21		841	HMS Operational Test Team[200%]
1.6.10.1.2			Validate Loaded Data for Operational Readiness Test	1 day	Fri 3/12/21	Mon 3/15/21		856	HMS Operational Test Team[200%],HMS Operational Test Leads
1.6.10.2			Operational Readiness Test Execution and Rework	4 days	Fri 3/12/21	Thu 3/18/21			
1.6.10.2.1			Migrate Code as Necessary for Operational Readiness Testing	2 days	Fri 3/12/21	Tue 3/16/21	857SS		Acct Business Lead - SME[10%]
1.6.10.2.2			Conduct Operational Readiness Testing Cycles	2 days	Tue 3/16/21	Thu 3/18/21		859	HMS Operational Test Team[200%],HMS Operational Test Leads[10%]
1.6.10.2.3			Operational Readiness Test Support & Rework	2 days	Fri 3/12/21	Tue 3/16/21	859SS		HMS Operational Test Team[200%],HMS Operational Test Leads[50%]
1.6.10.2.4			Milestone - Completion of Operational Readiness Testing Execution	0 days	Tue 3/16/21	Tue 3/16/21		861	
1.6.10.3			Operational Readiness Testing Results	7.25 days	Thu 3/18/21	Mon 3/29/21		858	
1.6.10.3.1			Compile Operational Readiness Testing Results	1 day	Thu 3/18/21	Fri 3/19/21			Account Business Analyst[50%],HMS Operational Test Team[200%],HMS Operational Test Leads
1.6.10.3.2			[illegible]	[illegible]	[illegible]	[illegible]		864	
1.6.10.3.3			Compile Operational Readiness Testing Report and Deliver to DHHR	1 day	Fri 3/19/21	Mon 3/22/21	865SS		Account Business Analyst,BMS System Test Team[50%]
1.6.10.3.4			Conduct Walkthrough with DHHR of Final Operational Readiness Testing Test Results	1 day	Mon 3/22/21	Tue 3/23/21		866	BMS Tester,HMS Operational Test Team,HMS Operational Test Leads
1.6.10.3.5			DHHR Conducts Review of Operational Readiness Testing Test Results	2 days	Tue 3/23/21	Thu 3/25/21		867	BMS Tester
1.6.10.3.6			Walkthrough DHHR Deliverable Review Comments	0.25 days	Thu 3/25/21	Thu 3/25/21		868	BMS PMO Project Manager[50%],BMS Lead[50%],BMS Tester,HMS Operational Test Team,HMS Operational Test Leads
1.6.10.3.7			Revise Operational Readiness Testing Test Results based on DHHR Review	1 day	Thu 3/25/21	Fri 3/26/21		869	Account Business Analyst[40%],HMS Operational Test Team,HMS Operational Test Leads
1.6.10.3.8			DHHR Conduct Final Review and Approval of Operational Readiness Testing Test Results	1 day	Fri 3/26/21	Mon 3/29/21		870	BMS PMO Project Manager[13%],BMS Lead[13%],BMS Tester[13%]
1.6.10.3.9			Milestone - Completion and DHHR Approval of Operational Readiness Testing	0 days	Mon 3/29/21	Mon 3/29/21		871	
1.6.11		3	Payment Milestone 4: Solution Design, Testing, and Operational Readiness 1 (deliverables D028 through D035)	0 days	Wed 3/10/21	Wed 3/10/21	[illegible]		
1.6.12		3	Payment Milestone 5: Solution Design, Testing, and Operational Readiness 2 (deliverables D036 through D042)	0 days	Wed 3/17/21	Wed 3/17/21	[illegible]		
1.6.13		3	Payment Milestone 6: Solution Design, Testing, and Operational Readiness 3 (deliverables D043 through D051)	0 days	Wed 3/24/21	Wed 3/24/21	[illegible]		
1.7			Milestone - Task Group 3: Solution Design, Testing, and Operational Readiness Complete	0 days	Wed 3/24/21	Wed 3/24/21	726,733,741		
1.8		4	Task Group 4: Solution Deployment	23.25 days	Wed 3/3/21	Mon 4/5/21			
1.8.1			Task Group 4 - Deliverables	15 days	Wed 3/3/21	Wed 3/24/21			
1.8.1.1	4.1.		D052 Cutover Play Book	15 days	Wed 3/3/21	Wed 3/24/21			
1.8.1.1.1	4.1.		Review D052 Cutover Play Book Requirements	0.25 days	Wed 3/3/21	Wed 3/3/21	876FS-15 days		Account BA
1.8.1.1.2	4.1.		Create Draft D052 Cutover Play Book	3 days	Wed 3/3/21	Mon 3/8/21		880	Account BA
1.8.1.1.3	4.1.		Conduct Internal Work Product Review of D052 Cutover Play Book	1 day	Mon 3/8/21	Tue 3/9/21		881	Account BA
1.8.1.1.4	4.1.		Revise Draft D052 Cutover Play Book based on Internal Review	2 days	Tue 3/9/21	Thu 3/11/21		882	Account BA,Account Quality Mgr
1.8.1.1.5	4.1.		[illegible]	[illegible]	[illegible]	[illegible]		883	[illegible]
1.8.1.1.6	4.1.		Conduct Work Product Review with Client of Draft D052 Cutover Play Book	0.25 days	Thu 3/11/21	Thu 3/11/21		884	Client Project Mgr[25%],Account Proj Mgr[25%]
1.8.1.1.7	4.1.		DHHR and Stakeholders Conducts Review of Draft D052 Cutover Play Book	5 days	Thu 3/11/21	Thu 3/18/21		885	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.8.1.1.8	4.1.		Walkthrough Client Deliverable Review Comments	0.25 days	Thu 3/18/21	Thu 3/18/21		886	Client Project Mgr,Client SME
1.8.1.1.9	4.1.		Revise D052 Cutover Play Book based on Client Review	2 days	Fri 3/19/21	Mon 3/22/21		887	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.8.1.1.10	4.1.		Distribute Updated D052 Cutover Play Book to Client for Approval	0.25 days	Tue 3/23/21	Tue 3/23/21		888	Account BA[25%]
1.8.1.1.11	4.1.		DHHR and Stakeholders Conducts Review of Revisions to D052 Cutover Play Book	1 day	Tue 3/23/21	Wed 3/24/21		889	Account Quality Mgr[20%]
1.8.1.1.12	4.1.		Milestone - Client Approves D052 Cutover Play Book	0 days	Wed 3/24/21	Wed 3/24/21		890	Client Project Mgr,Client SME
1.8.1.2	4.2.		D053 Federal Review Supporting Documentation	15 days	Wed 3/3/21	Wed 3/24/21			
1.8.1.2.1	4.2.		Review D053 Federal Review Supporting Documentation Requirements	0.25 days	Wed 3/3/21	Wed 3/3/21	876FS-15 days		Account BA
1.8.1.2.2	4.2.		Create Draft D053 Federal Review Supporting Documentation	3 days	Wed 3/3/21	Mon 3/8/21		893	Account BA
1.8.1.2.3	4.2.		Conduct Internal Work Product Review of D053 Federal Review Supporting Documentation	1 day	Mon 3/8/21	Tue 3/9/21		894	Account BA
1.8.1.2.4	4.2.		Revise Draft D053 Federal Review Supporting Documentation based on Internal Review	2 days	Tue 3/9/21	Thu 3/11/21		895	Account BA,Account Quality Mgr
1.8.1.2.5	4.2.		[illegible]	[illegible]	[illegible]	[illegible]		896	[illegible]
1.8.1.2.6	4.2.		Conduct Work Product Review with Client of Draft D053 Federal Review Supporting Documentation	0.25 days	Thu 3/11/21	Thu 3/11/21		897	Client Project Mgr[25%],Account Proj Mgr[25%]
1.8.1.2.7	4.2.		DHHR and Stakeholders Conducts Review of Draft D053 Federal Review Supporting Documentation	5 days	Thu 3/11/21	Thu 3/18/21		898	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.8.1.2.8	4.2.		Walkthrough Client Deliverable Review Comments	0.25 days	Thu 3/18/21	Thu 3/18/21		899	Client Project Mgr,Client SME
1.8.1.2.9	4.2.		Revise D053 Federal Review Supporting Documentation based on Client Review	2 days	Fri 3/19/21	Mon 3/22/21		900	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.8.1.2.10	4.2.		Distribute Updated D053 Federal Review Supporting Documentation to Client for Approval	0.25 days	Tue 3/23/21	Tue 3/23/21		901	Account BA[25%]
1.8.1.2.11	4.2.		DHHR and Stakeholders Conducts Review of Revisions to D053 Federal Review Supporting Documentation	1 day	Tue 3/23/21	Wed 3/24/21		902	Account Quality Mgr[20%]
1.8.1.2.12	4.2.		Milestone - Client Approves D053 Federal Review Supporting Documentation	0 days	Wed 3/24/21	Wed 3/24/21		903	Client Project Mgr,Client SME
1.8.1.3	4.3.		D054 Implementation Certification Letter	15 days	Wed 3/3/21	Wed 3/24/21			
1.8.1.3.1	4.3.		Review D054 Implementation Certification Letter Requirements	0.25 days	Wed 3/3/21	Wed 3/3/21	876FS-15 days		Account BA
1.8.1.3.2	4.3.		Create Draft D054 Implementation Certification Letter	3 days	Wed 3/3/21	Mon 3/8/21		906	Account BA
1.8.1.3.3	4.3.		Conduct Internal Work Product Review of D054 Implementation Certification Letter	1 day	Mon 3/8/21	Tue 3/9/21		907	Account BA
1.8.1.3.4	4.3.		Revise Draft D054 Implementation Certification Letter based on Internal Review	2 days	Tue 3/9/21	Thu 3/11/21		908	Account BA,Account Quality Mgr

1.8.1.3.5	4.3.	[illegible]						
1.8.1.3.6	4.3.	Conduct Work Product Review with Client of Draft D054 Implementation Certification Letter	0.25 days	Thu 3/11/21	Thu 3/11/21		910	Client Project Mgr[25%],Account Proj Mgr[25%]
1.8.1.3.7	4.3.	DHHR and Stakeholders Conducts Review of Draft D054 Implementation Certification Letter	5 days	Thu 3/11/21	Thu 3/18/21		911	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.8.1.3.8	4.3.	Walkthrough Client Deliverable Review Comments	0.25 days	Thu 3/18/21	Thu 3/18/21		912	Client Project Mgr,Client SME
1.8.1.3.9	4.3.	Revise D054 Implementation Certification Letter based on Client Review	2 days	Fri 3/19/21	Mon 3/22/21		913	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.8.1.3.10	4.3.	Distribute Updated D054 Implementation Certification Letter to Client for Approval	0.25 days	Tue 3/23/21	Tue 3/23/21		914	Account BA[25%]
1.8.1.3.11	4.3.	DHHR and Stakeholders Conducts Review of Revisions to D054 Implementation Certification Letter	1 day	Tue 3/23/21	Wed 3/24/21		915	Account Quality Mgr[20%]
1.8.1.3.12	4.3.	Milestone - Client Approves D054 Implementation Certification Lett	0 days	[illegible]	[illegible]		[illegible]	
1.8.1.4	**4.4.**	**D055 Implementation Plan (Rollout Plan)**	**15 days**	**Wed 3/3/21**	**Wed 3/24/21**			
1.8.1.4.1	4.4.	Review D055 Implementation Plan (Rollout Plan) Requirements	0.25 days	Wed 3/3/21	Wed 3/3/21	876FS-15 days		Account BA
1.8.1.4.2	4.4.	Create Draft D055 Implementation Plan (Rollout Plan)	3 days	Wed 3/3/21	Mon 3/8/21		919	Account BA
1.8.1.4.3	4.4.	Conduct Internal Work Product Review of D055 Implementation Plan (Rollout Plan)	1 day	Mon 3/8/21	Tue 3/9/21		920	Account BA
1.8.1.4.4	4.4.	Revise Draft D055 Implementation Plan (Rollout Plan) based on Internal Review	2 days	Tue 3/9/21	Thu 3/11/21		921	Account BA,Account Quality Mgr
1.8.1.4.5	4.4.	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	
1.8.1.4.6	4.4.	Conduct Work Product Review with Client of Draft D055 Implementation Plan (Rollout Plan)	0.25 days	Thu 3/11/21	Thu 3/11/21		923	Client Project Mgr[25%],Account Proj Mgr[25%]
1.8.1.4.7	4.4.	DHHR and Stakeholders Conducts Review of Draft D055 Implementation Plan (Rollout Plan)	5 days	Thu 3/11/21	Thu 3/18/21		924	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.8.1.4.8	4.4.	Walkthrough Client Deliverable Review Comments	0.25 days	Thu 3/18/21	Thu 3/18/21		925	Client Project Mgr,Client SME
1.8.1.4.9	4.4.	Revise D055 Implementation Plan (Rollout Plan) based on Client Review	2 days	Fri 3/19/21	Mon 3/22/21		926	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.8.1.4.10	4.4.	Distribute Updated D055 Implementation Plan (Rollout Plan) to Client for Approval	0.25 days	Tue 3/23/21	Tue 3/23/21		927	Account BA[25%]
1.8.1.4.11	4.4.	DHHR and Stakeholders Conducts Review of Revisions to D055 Implementation Plan (Rollout Plan)	1 day	Tue 3/23/21	Wed 3/24/21		928	Account Quality Mgr[20%]
1.8.1.4.12	4.4.	Milestone - Client Approves D055 Implementation Plan (Rollout Plar	0 days	[illegible]	[illegible]		[illegible]	
1.8.1.5	**4.5.**	**D056 Operations Change Management Plan**	**15 days**	**Wed 3/3/21**	**Wed 3/24/21**			
1.8.1.5.1	4.5.	Review D056 Operations Change Management Plan Requirements	0.25 days	Wed 3/3/21	Wed 3/3/21	876FS-15 days		Account BA
1.8.1.5.2	4.5.	Create Draft D056 Operations Change Management Plan	3 days	Wed 3/3/21	Mon 3/8/21		932	Account BA
1.8.1.5.3	4.5.	Conduct Internal Work Product Review of D056 Operations Change Management Plan	1 day	Mon 3/8/21	Tue 3/9/21		933	Account BA
1.8.1.5.4	4.5.	Revise Draft D056 Operations Change Management Plan based on Internal Review	2 days	Tue 3/9/21	Thu 3/11/21		934	Account BA,Account Quality Mgr
1.8.1.5.5	4.5.	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	
1.8.1.5.6	4.5.	Conduct Work Product Review with Client of Draft D056 Operations Change Management Plan	0.25 days	Thu 3/11/21	Thu 3/11/21		936	Client Project Mgr[25%],Account Proj Mgr[25%]
1.8.1.5.7	4.5.	DHHR and Stakeholders Conducts Review of Draft D056 Operations Change Management Plan	5 days	Thu 3/11/21	Thu 3/18/21		937	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.8.1.5.8	4.5.	Walkthrough Client Deliverable Review Comments	0.25 days	Thu 3/18/21	Thu 3/18/21		938	Client Project Mgr,Client SME
1.8.1.5.9	4.5.	Revise D056 Operations Change Management Plan based on Client Review	2 days	Fri 3/19/21	Mon 3/22/21		939	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.8.1.5.10	4.5.	Distribute Updated D056 Operations Change Management Plan to Client for Approval	0.25 days	Tue 3/23/21	Tue 3/23/21		940	Account BA[25%]
1.8.1.5.11	4.5.	DHHR and Stakeholders Conducts Review of Revisions to D056 Operations Change Management Plan	1 day	Tue 3/23/21	Wed 3/24/21		941	Account Quality Mgr[20%]
1.8.1.5.12	4.5.	Milestone - Client Approves D056 Operations Change Management P	0 days	[illegible]	[illegible]		[illegible]	
1.8.1.6	**4.6.**	**D057 Operational Milestone Review (OMR)**	**15 days**	**Wed 3/3/21**	**Wed 3/24/21**			
1.8.1.6.1	4.6.	Review D057 Operational Milestone Review (OMR) Requirements	0.25 days	Wed 3/3/21	Wed 3/3/21	876FS-15 days		Account BA
1.8.1.6.2	4.6.	Create Draft D057 Operational Milestone Review (OMR)	3 days	Wed 3/3/21	Mon 3/8/21		945	Account BA
1.8.1.6.3	4.6.	Conduct Internal Work Product Review of D057 Operational Milestone Review (OMR)	1 day	Mon 3/8/21	Tue 3/9/21		946	Account BA
1.8.1.6.4	4.6.	Revise Draft D057 Operational Milestone Review (OMR) based on Internal Review	2 days	Tue 3/9/21	Thu 3/11/21		947	Account BA,Account Quality Mgr
1.8.1.6.5	4.6.	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	
1.8.1.6.6	4.6.	Conduct Work Product Review with Client of Draft D057 Operational Milestone Review (OMR)	0.25 days	Thu 3/11/21	Thu 3/11/21		949	Client Project Mgr[25%],Account Proj Mgr[25%]
1.8.1.6.7	4.6.	DHHR and Stakeholders Conducts Review of Draft D057 Operational Milestone Review (OMR)	5 days	Thu 3/11/21	Thu 3/18/21		950	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.8.1.6.8	4.6.	Walkthrough Client Deliverable Review Comments	0.25 days	Thu 3/18/21	Thu 3/18/21		951	Client Project Mgr,Client SME
1.8.1.6.9	4.6.	Revise D057 Operational Milestone Review (OMR) based on Client Review	2 days	Fri 3/19/21	Mon 3/22/21		952	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.8.1.6.10	4.6.	Distribute Updated D057 Operational Milestone Review (OMR) to Client for Approval	0.25 days	Tue 3/23/21	Tue 3/23/21		953	Account BA[25%]
1.8.1.6.11	4.6.	DHHR and Stakeholders Conducts Review of Revisions to D057 Operational Milestone Review (OMR)	1 day	Tue 3/23/21	Wed 3/24/21		954	Account Quality Mgr[20%]
1.8.1.6.12	4.6.	Milestone - Client Approves D057 Operational Milestone Review (OM	0 days	[illegible]	[illegible]		[illegible]	
1.8.1.7	**4.7.**	**D058 Production Screenshots, Reports, and Data for Certification**	**15 days**	**Wed 3/3/21**	**Wed 3/24/21**			
1.8.1.7.1	4.7.	Review D058 Production Screenshots, Reports, and Data for Certification Requirements	0.25 days	Wed 3/3/21	Wed 3/3/21	876FS-15 days		Account BA
1.8.1.7.2	4.7.	Create Draft D058 Production Screenshots, Reports, and Data for Certification	3 days	Wed 3/3/21	Mon 3/8/21		958	Account BA
1.8.1.7.3	4.7.	Conduct Internal Work Product Review of D058 Production Screenshots, Reports, and Data for Certification	1 day	Mon 3/8/21	Tue 3/9/21		959	Account BA
1.8.1.7.4	4.7.	Revise Draft D058 Production Screenshots, Reports, and Data for Certification based on Internal Review	2 days	Tue 3/9/21	Thu 3/11/21		960	Account BA,Account Quality Mgr
1.8.1.7.5	4.7.	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	
1.8.1.7.6	4.7.	Conduct Work Product Review with Client of Draft D058 Production Screenshots, Reports, and Data for Certification	0.25 days	Thu 3/11/21	Thu 3/11/21		962	Client Project Mgr[25%],Account Proj Mgr[25%]
1.8.1.7.7	4.7.	DHHR and Stakeholders Conducts Review of Draft D058 Production Screenshots, Reports, and Data for Certification	5 days	Thu 3/11/21	Thu 3/18/21		963	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.8.1.7.8	4.7.	Walkthrough Client Deliverable Review Comments	0.25 days	Thu 3/18/21	Thu 3/18/21		964	Client Project Mgr,Client SME
1.8.1.7.9	4.7.	Revise D058 Production Screenshots, Reports, and Data for Certification based on Client Review	2 days	Fri 3/19/21	Mon 3/22/21		965	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.8.1.7.10	4.7.	Distribute Updated D058 Production Screenshots, Reports, and Data for Certification to Client for Approval	0.25 days	Tue 3/23/21	Tue 3/23/21		966	Account BA[25%]
1.8.1.7.11	4.7.	DHHR and Stakeholders Conducts Review of Revisions to D058 Production Screenshots, Reports, and Data for Certification	1 day	Tue 3/23/21	Wed 3/24/21		967	Account Quality Mgr[20%]
1.8.1.7.12	4.7.	Milestone - Client Approves D058 Production Screenshots, Reports, a	0 days	[illegible]	[illegible]		[illegible]	
1.8.1.8	**4.8.**	**D059 Report Distribution Schedule**	**15 days**	**Wed 3/3/21**	**Wed 3/24/21**			
1.8.1.8.1	4.8.	Review D059 Report Distribution Schedule Requirements	0.25 days	Wed 3/3/21	Wed 3/3/21	876FS-15 days		Account BA
1.8.1.8.2	4.8.	Create Draft D059 Report Distribution Schedule	3 days	Wed 3/3/21	Mon 3/8/21		971	Account BA
1.8.1.8.3	4.8.	Conduct Internal Work Product Review of D059 Report Distribution Schedule	1 day	Mon 3/8/21	Tue 3/9/21		972	Account BA
1.8.1.8.4	4.8.	Revise Draft D059 Report Distribution Schedule based on Internal Review	2 days	Tue 3/9/21	Thu 3/11/21		973	Account BA,Account Quality Mgr
1.8.1.8.5	4.8.	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	

1.8.1.8.6	4.8.	Conduct Work Product Review with Client of Draft D059 Report Distribution Schedule	0.25 days	Thu 3/11/21	Thu 3/11/21		975	Client Project Mgr[25%],Account Proj Mgr[25%]
1.8.1.8.7	4.8.	DHHR and Stakeholders Conducts Review of Draft D059 Report Distribution Schedule	5 days	Thu 3/11/21	Thu 3/18/21		976	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.8.1.8.8	4.8.	Walkthrough Client Deliverable Review Comments	0.25 days	Thu 3/18/21	Thu 3/18/21		977	Client Project Mgr,Client SME
1.8.1.8.9	4.8.	Revise D059 Report Distribution Schedule based on Client Review	2 days	Fri 3/19/21	Mon 3/22/21		978	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.8.1.8.10	4.8.	Distribute Updated D059 Report Distribution Schedule to Client for Approval	0.25 days	Tue 3/23/21	Tue 3/23/21		979	Account BA[25%]
1.8.1.8.11	4.8.	DHHR and Stakeholders Conducts Review of Revisions to D059 Report Distribution Schedule	1 day	Tue 3/23/21	Wed 3/24/21		980	Account Quality Mgr[20%]
1.8.1.8.12	4.8.	Milestone - Client Approves D059 Report Distribution Schedule	0 days	Wed 3/24/21	Wed 3/24/21		981	Client Project Mgr,Client SME
1.8.1.9	**4.9.**	**D060 Solution Health Monitoring Plan**	**15 days**	**Wed 3/3/21**	**Wed 3/24/21**			
1.8.1.9.1	4.9.	Review D060 Solution Health Monitoring Plan Requirements	0.25 days	Wed 3/3/21	Wed 3/3/21	876FS-15 days		Account BA
1.8.1.9.2	4.9.	Create Draft D060 Solution Health Monitoring Plan	3 days	Wed 3/3/21	Mon 3/8/21		984	Account BA
1.8.1.9.3	4.9.	Conduct Internal Work Product Review of D060 Solution Health Monitoring Plan	1 day	Mon 3/8/21	Tue 3/9/21		985	Account BA
1.8.1.9.4	4.9.	Revise Draft D060 Solution Health Monitoring Plan based on Internal Review	2 days	Tue 3/9/21	Thu 3/11/21		986	Account BA,Account Quality Mgr
1.8.1.9.5	4.9.	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]
1.8.1.9.6	4.9.	Conduct Work Product Review with Client of Draft D060 Solution Health Monitoring Plan	0.25 days	Thu 3/11/21	Thu 3/11/21		988	Client Project Mgr[25%],Account Proj Mgr[25%]
1.8.1.9.7	4.9.	DHHR and Stakeholders Conducts Review of Draft D060 Solution Health Monitoring Plan	5 days	Thu 3/11/21	Thu 3/18/21		989	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.8.1.9.8	4.9.	Walkthrough Client Deliverable Review Comments	0.25 days	Thu 3/18/21	Thu 3/18/21		990	Client Project Mgr,Client SME
1.8.1.9.9	4.9.	Revise D060 Solution Health Monitoring Plan based on Client Review	2 days	Fri 3/19/21	Mon 3/22/21		991	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.8.1.9.10	4.9.	Distribute Updated D060 Solution Health Monitoring Plan to Client for Approval	0.25 days	Tue 3/23/21	Tue 3/23/21		992	Account BA[25%]
1.8.1.9.11	4.9.	DHHR and Stakeholders Conducts Review of Revisions to D060 Solution Health Monitoring Plan	1 day	Tue 3/23/21	Wed 3/24/21		993	Account Quality Mgr[20%]
1.8.1.9.12	4.9.	Milestone - Client Approves D060 Solution Health Monitoring Plan	0 days	Wed 3/24/21	Wed 3/24/21		994	Client Project Mgr,Client SME
1.8.1.10	**4.10.**	**D061 System Operations Plan**	**15 days**	**Wed 3/3/21**	**Wed 3/24/21**			
1.8.1.10.1	4.10.	Review D061 System Operations Plan Requirements	0.25 days	Wed 3/3/21	Wed 3/3/21	876FS-15 days		Account BA
1.8.1.10.2	4.10.	Create Draft D061 System Operations Plan	3 days	Wed 3/3/21	Mon 3/8/21		997	Account BA
1.8.1.10.3	4.10.	Conduct Internal Work Product Review of D061 System Operations Plan	1 day	Mon 3/8/21	Tue 3/9/21		998	Account BA
1.8.1.10.4	4.10.	Revise Draft D061 System Operations Plan based on Internal Review	2 days	Tue 3/9/21	Thu 3/11/21		999	Account BA,Account Quality Mgr
1.8.1.10.5	4.10.	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]
1.8.1.10.6	4.10.	Conduct Work Product Review with Client of Draft D061 System Operations Plan	0.25 days	Thu 3/11/21	Thu 3/11/21		1001	Client Project Mgr[25%],Account Proj Mgr[25%]
1.8.1.10.7	4.10.	DHHR and Stakeholders Conducts Review of Draft D061 System Operations Plan	5 days	Thu 3/11/21	Thu 3/18/21		1002	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.8.1.10.8	4.10.	Walkthrough Client Deliverable Review Comments	0.25 days	Thu 3/18/21	Thu 3/18/21		1003	Client Project Mgr,Client SME
1.8.1.10.9	4.10.	Revise D061 System Operations Plan based on Client Review	2 days	Fri 3/19/21	Mon 3/22/21		1004	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.8.1.10.10	4.10.	Distribute Updated D061 System Operations Plan to Client for Approval	0.25 days	Tue 3/23/21	Tue 3/23/21		1005	Account BA[25%]
1.8.1.10.11	4.10.	DHHR and Stakeholders Conducts Review of Revisions to D061 System Operations Plan	1 day	Tue 3/23/21	Wed 3/24/21		1006	Account Quality Mgr[20%]
1.8.1.10.12	4.10.	Milestone - Client Approves D061 System Operations Plan	0 days	Wed 3/24/21	Wed 3/24/21		1007	Client Project Mgr,Client SME
1.8.1.11	**4.11.**	**D062 System and User Documentation**	**15 days**	**Wed 3/3/21**	**Wed 3/24/21**			
1.8.1.11.1	4.11.	Review D062 System and User Documentation Requirements	0.25 days	Wed 3/3/21	Wed 3/3/21	876FS-15 days		Account BA
1.8.1.11.2	4.11.	Create Draft D062 System and User Documentation	3 days	Wed 3/3/21	Mon 3/8/21		1010	Account BA
1.8.1.11.3	4.11.	Conduct Internal Work Product Review of D062 System and User Documentation	1 day	Mon 3/8/21	Tue 3/9/21		1011	Account BA
1.8.1.11.4	4.11.	Revise Draft D062 System and User Documentation based on Internal Review	2 days	Tue 3/9/21	Thu 3/11/21		1012	Account BA,Account Quality Mgr
1.8.1.11.5	4.11.	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]
1.8.1.11.6	4.11.	Conduct Work Product Review with Client of Draft D062 System and User Documentation	0.25 days	Thu 3/11/21	Thu 3/11/21		1014	Client Project Mgr[25%],Account Proj Mgr[25%]
1.8.1.11.7	4.11.	DHHR and Stakeholders Conducts Review of Draft D062 System and User Documentation	5 days	Thu 3/11/21	Thu 3/18/21		1015	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.8.1.11.8	4.11.	Walkthrough Client Deliverable Review Comments	0.25 days	Thu 3/18/21	Thu 3/18/21		1016	Client Project Mgr,Client SME
1.8.1.11.9	4.11.	Revise D062 System and User Documentation based on Client Review	2 days	Fri 3/19/21	Mon 3/22/21		1017	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.8.1.11.10	4.11.	Distribute Updated D062 System and User Documentation to Client for Approval	0.25 days	Tue 3/23/21	Tue 3/23/21		1018	Account BA[25%]
1.8.1.11.11	4.11.	DHHR and Stakeholders Conducts Review of Revisions to D062 System and User Documentation	1 day	Tue 3/23/21	Wed 3/24/21		1019	Account Quality Mgr[20%]
1.8.1.11.12	4.11.	Milestone - Client Approves D062 System and User Documentation	0 days	Wed 3/24/21	Wed 3/24/21		1020	Client Project Mgr,Client SME
1.8.1.12	**4.12.**	**D063 Training Materials**	**15 days**	**Wed 3/3/21**	**Wed 3/24/21**			
1.8.1.12.1	4.12.	Review D063 Training Materials Requirements	0.25 days	Wed 3/3/21	Wed 3/3/21	876FS-15 days		Account BA
1.8.1.12.2	4.12.	Create Draft D063 Training Materials	3 days	Wed 3/3/21	Mon 3/8/21		1023	Account BA
1.8.1.12.3	4.12.	Conduct Internal Work Product Review of D063 Training Materials	1 day	Mon 3/8/21	Tue 3/9/21		1024	Account BA
1.8.1.12.4	4.12.	Revise Draft D063 Training Materials based on Internal Review	2 days	Tue 3/9/21	Thu 3/11/21		1025	Account BA,Account Quality Mgr
1.8.1.12.5	4.12.	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]
1.8.1.12.6	4.12.	Conduct Work Product Review with Client of Draft D063 Training Materials	0.25 days	Thu 3/11/21	Thu 3/11/21		1027	Client Project Mgr[25%],Account Proj Mgr[25%]
1.8.1.12.7	4.12.	DHHR and Stakeholders Conducts Review of Draft D063 Training Materials	5 days	Thu 3/11/21	Thu 3/18/21		1028	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.8.1.12.8	4.12.	Walkthrough Client Deliverable Review Comments	0.25 days	Thu 3/18/21	Thu 3/18/21		1029	Client Project Mgr,Client SME
1.8.1.12.9	4.12.	Revise D063 Training Materials based on Client Review	2 days	Fri 3/19/21	Mon 3/22/21		1030	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.8.1.12.10	4.12.	Distribute Updated D063 Training Materials to Client for Approval	0.25 days	Tue 3/23/21	Tue 3/23/21		1031	Account BA[25%]
1.8.1.12.11	4.12.	DHHR and Stakeholders Conducts Review of Revisions to D063 Training Materials	1 day	Tue 3/23/21	Wed 3/24/21		1032	Account Quality Mgr[20%]
1.8.1.12.12	4.12.	Milestone - Client Approves D063 Training Materials	0 days	Wed 3/24/21	Wed 3/24/21		1033	Client Project Mgr,Client SME
1.8.1.13	**4.13.**	**D064 Training Report**	**15 days**	**Wed 3/3/21**	**Wed 3/24/21**			
1.8.1.13.1	4.13.	Review D064 Training Report Requirements	0.25 days	Wed 3/3/21	Wed 3/3/21	876FS-15 days		Account BA
1.8.1.13.2	4.13.	Create Draft D064 Training Report	3 days	Wed 3/3/21	Mon 3/8/21		1036	Account BA
1.8.1.13.3	4.13.	Conduct Internal Work Product Review of D064 Training Report	1 day	Mon 3/8/21	Tue 3/9/21		1037	Account BA
1.8.1.13.4	4.13.	Revise Draft D064 Training Report based on Internal Review	2 days	Tue 3/9/21	Thu 3/11/21		1038	Account BA,Account Quality Mgr
1.8.1.13.5	4.13.	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]
1.8.1.13.6	4.13.	Conduct Work Product Review with Client of Draft D064 Training Report	0.25 days	Thu 3/11/21	Thu 3/11/21		1040	Client Project Mgr[25%],Account Proj Mgr[25%]
1.8.1.13.7	4.13.	DHHR and Stakeholders Conducts Review of Draft D064 Training Report	5 days	Thu 3/11/21	Thu 3/18/21		1041	Account BA,Account Quality Mgr,Client Project Mgr,Client SME

1.8.1.13.8	4.13.	Walkthrough Client Deliverable Review Comments	0.25 days	Thu 3/18/21	Thu 3/18/21		1042	Client Project Mgr,Client SME
1.8.1.13.9	4.13.	Revise D064 Training Report based on Client Review	2 days	Fri 3/19/21	Mon 3/22/21		1043	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.8.1.13.10	4.13.	Distribute Updated D064 Training Report to Client for Approval	0.25 days	Tue 3/23/21	Tue 3/23/21		1044	Account BA[25%]
1.8.1.13.11	4.13.	DHHR and Stakeholders Conducts Review of Revisions to D064 Training Report	1 day	Tue 3/23/21	Wed 3/24/21		1045	Account Quality Mgr[20%]
1.8.1.13.12	4.13.	Milestone - Client Approves D064 Training Report	0 days	Wed 3/24/21	Wed 3/24/21		1046	Client Project Mgr,Client SME
1.8.1.14	4.14.	D065 Training Schedule	15 days	Wed 3/3/21	Wed 3/24/21			
1.8.1.14.1	4.14.	Review D065 Training Schedule Requirements	0.25 days	Wed 3/3/21	Wed 3/3/21	876FS-15 days		Account BA
1.8.1.14.2	4.14.	Create Draft D065 Training Schedule	3 days	Wed 3/3/21	Mon 3/8/21		1049	Account BA
1.8.1.14.3	4.14.	Conduct Internal Work Product Review of D065 Training Schedule	1 day	Mon 3/8/21	Tue 3/9/21		1050	Account BA
1.8.1.14.4	4.14.	Revise Draft D065 Training Schedule based on Internal Review	2 days	Tue 3/9/21	Thu 3/11/21		1051	Account BA,Account Quality Mgr
1.8.1.14.5	4.14.	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]
1.8.1.14.6	4.14.	Conduct Work Product Review with Client of Draft D065 Training Schedule	0.25 days	Thu 3/11/21	Thu 3/11/21		1053	Client Project Mgr[25%],Account Proj Mgr[25%]
1.8.1.14.7	4.14.	DHHR and Stakeholders Conducts Review of Draft D065 Training Schedule	5 days	Thu 3/11/21	Thu 3/18/21		1054	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.8.1.14.8	4.14.	Walkthrough Client Deliverable Review Comments	0.25 days	Thu 3/18/21	Thu 3/18/21		1055	Client Project Mgr,Client SME
1.8.1.14.9	4.14.	Revise D065 Training Schedule based on Client Review	2 days	Fri 3/19/21	Mon 3/22/21		1056	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.8.1.14.10	4.14.	Distribute Updated D065 Training Schedule to Client for Approval	0.25 days	Tue 3/23/21	Tue 3/23/21		1057	Account BA[25%]
1.8.1.14.11	4.14.	DHHR and Stakeholders Conducts Review of Revisions to D065 Training Schedule	1 day	Tue 3/23/21	Wed 3/24/21		1058	Account Quality Mgr[20%]
1.8.1.14.12	4.14.	Milestone - Client Approves D065 Training Schedule	0 days	Wed 3/24/21	Wed 3/24/21		1059	Client Project Mgr,Client SME
1.8.1.15	4.15.	D066 Turnover and Closeout Management Plan	15 days	Wed 3/3/21	Wed 3/24/21			
1.8.1.15.1	4.15.	Review D066 Turnover and Closeout Management Plan Requirements	0.25 days	Wed 3/3/21	Wed 3/3/21	876FS-15 days		Account BA
1.8.1.15.2	4.15.	Create Draft D066 Turnover and Closeout Management Plan	3 days	Wed 3/3/21	Mon 3/8/21		1062	Account BA
1.8.1.15.3	4.15.	Conduct Internal Work Product Review of D066 Turnover and Closeout Management Plan	1 day	Mon 3/8/21	Tue 3/9/21		1063	Account BA
1.8.1.15.4	4.15.	Revise Draft D066 Turnover and Closeout Management Plan based on Internal Review	2 days	Tue 3/9/21	Thu 3/11/21		1064	Account BA,Account Quality Mgr
1.8.1.15.5	4.15.	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]
1.8.1.15.6	4.15.	Conduct Work Product Review with Client of Draft D066 Turnover and Closeout Management Plan	0.25 days	Thu 3/11/21	Thu 3/11/21		1066	Client Project Mgr[25%],Account Proj Mgr[25%]
1.8.1.15.7	4.15.	DHHR and Stakeholders Conducts Review of Draft D066 Turnover and Closeout Management Plan	5 days	Thu 3/11/21	Thu 3/18/21		1067	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.8.1.15.8	4.15.	Walkthrough Client Deliverable Review Comments	0.25 days	Thu 3/18/21	Thu 3/18/21		1068	Client Project Mgr,Client SME
1.8.1.15.9	4.15.	Revise D066 Turnover and Closeout Management Plan based on Client Review	2 days	Fri 3/19/21	Mon 3/22/21		1069	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.8.1.15.10	4.15.	Distribute Updated D066 Turnover and Closeout Management Plan to Client for Approval	0.25 days	Tue 3/23/21	Tue 3/23/21		1070	Account BA[25%]
1.8.1.15.11	4.15.	DHHR and Stakeholders Conducts Review of Revisions to D066 Turnover and Closeout Management Plan	1 day	Tue 3/23/21	Wed 3/24/21		1071	Account Quality Mgr[20%]
1.8.1.15.12	4.15.	Milestone - Client Approves D066 Turnover and Closeout Management Plan	0 days	Wed 3/24/21	Wed 3/24/21		1072	Client Project Mgr,Client SME
1.8.2		Milestone -Task Group 3 - Deliverables Complete	0 days	Wed 3/24/21	Wed 3/24/21	##########		
1.8.3		Solution Deployment	8.25 days	Wed 3/24/21	Mon 4/5/21			
1.8.3.1		Implementation - Execution	5 days	Mon 3/29/21	Mon 4/5/21			
1.8.3.1.1		Implementation Prep	1 day	Mon 3/29/21	Tue 3/30/21			
1.8.3.1.1.1		Promote Code and Maps from UAT to PROD	1 day	Mon 3/29/21	Tue 3/30/21		872	HMS Developer
1.8.3.1.1.2		Validate PROD Environment	1 day	Mon 3/29/21	Tue 3/30/21		872	Acct Business Lead - SME,HMS Business Lead
1.8.3.1.2		Implementation Execute	5 days	Mon 3/29/21	Mon 4/5/21			
1.8.3.1.2.1		Execute Implementation Plan	5 days	Mon 3/29/21	Mon 4/5/21		872	HMS Project Mgr,Account Manager,Account Developer,Acct Business Lead - SME,Account Ops Mgr,HMS Business Analyst
1.8.3.1.3		Final Data Conversion - Pre Go Live Cutoff	5 days	Mon 3/29/21	Mon 4/5/21			
1.8.3.1.3.1		Final Conversion Preparation	1 day	Mon 3/29/21	Tue 3/30/21			
1.8.3.1.3.1.1		Conduct Final Conversion Preparation and Maintenance	1 day	Mon 3/29/21	Tue 3/30/21		872	Conv Business Analyst,Conv Developer
1.8.3.1.3.2		Acquire and Backup Current Data	2 days	Tue 3/30/21	Thu 4/1/21			
1.8.3.1.3.2.1		Acquire and Load Current Data From DHHR	2 days	Tue 3/30/21	Thu 4/1/21		1084	Conv Business Analyst[30%],Conv Developer[30%]
1.8.3.1.3.2.2		Acquire and Store Backup of Archive Data	2 days	Tue 3/30/21	Thu 4/1/21	1086SS		Conv Business Analyst[30%],Conv Developer[30%]
1.8.3.1.3.3		Execute Final Conversions	2 days	Thu 4/1/21	Mon 4/5/21			
1.8.3.1.3.3.1		Execute Final Data Conversions	1 day	Thu 4/1/21	Fri 4/2/21		1087	Conv Business Analyst[30%],Conv Developer[30%]
1.8.3.1.3.3.2		Balance Data	1 day	Fri 4/2/21	Mon 4/5/21		1089	Conv Business Analyst[30%],Conv Developer[30%]
1.8.3.1.3.4		Post Conversion Results	1 day	Fri 4/2/21	Mon 4/5/21			
1.8.3.1.3.4.1		Assemble Final Conversion Results	1 day	Fri 4/2/21	Mon 4/5/21	1090SS		Conv Business Analyst[30%],Conv Developer[30%]
1.8.3.2		DHHR Sign-off	0 days	Mon 4/5/21	Mon 4/5/21			
1.8.3.2.1		Produce and Deliver Implementation Certification Letter	0 days	Mon 4/5/21	Mon 4/5/21		1092	Technical Lead[21%]
1.8.3.3		MILESTONE - West Virginia TPL Services Go-Live	0 days	Mon 4/5/21	Mon 4/5/21		1092	
1.8.3.4	6	Payment Milestone 7: Deployment 1 (Deliverables D052 through D056)	0 days	Wed 3/24/21	Wed 3/24/21	##########		
1.8.3.5	6	Payment Milestone 8: Deployment 2 (Deliverables D057 through D061)	0 days	Wed 3/24/21	Wed 3/24/21	##########		
1.8.3.6	6	Payment Milestone 9: Deployment 3 (Deliverables D062 through D066)	0 days	Wed 3/24/21	Wed 3/24/21	##########		
1.9		Milestone - Task Group 4: Solution Deployment Completed	0 days	Mon 4/5/21	Mon 4/5/21	10,741,095		
1.10	5	Task Group 5: Project Monitor and Control (Recurring Deliverables)	1506 days	Mon 1/4/21	Mon 1/4/27			
1.10.1		Task Group 5 - Deliverables	1506 days	Mon 1/4/21	Mon 1/4/27			
1.10.1.1	5.1.	D067 Project Schedule	1501 days	Mon 1/11/21	Mon 1/4/27			
1.10.1.1.1		Update and Submit Project Schedule Changes	1501 days	Mon 1/11/21	Mon 1/4/27			
1.10.1.1.1.1		Update and Submit Project Schedule Changes 1	1 day	Mon 1/11/21	Mon 1/11/21			
1.10.1.1.1.2		Update and Submit Project Schedule Changes 3	1 day	Mon 1/25/21	Mon 1/25/21			
1.10.1.1.1.3		Update and Submit Project Schedule Changes 5	1 day	Mon 2/8/21	Mon 2/8/21			
1.10.1.1.1.4		Update and Submit Project Schedule Changes 7	1 day	Mon 2/22/21	Mon 2/22/21			
1.10.1.1.1.5		Update and Submit Project Schedule Changes 9	1 day	Mon 3/8/21	Mon 3/8/21			
1.10.1.1.1.6		Update and Submit Project Schedule Changes 11	1 day	Mon 3/22/21	Mon 3/22/21			
1.10.1.1.1.7		Update and Submit Project Schedule Changes 13	1 day	Mon 4/5/21	Mon 4/5/21			

1.10.1.1.1.8		Update and Submit Project Schedule Changes 15		1 day	Mon 4/19/21	Mon 4/19/21	
1.10.1.1.1.9		Update and Submit Project Schedule Changes 17		1 day	Mon 5/3/21	Mon 5/3/21	
1.10.1.1.1.10		Update and Submit Project Schedule Changes 19		1 day	Mon 5/17/21	Mon 5/17/21	
1.10.1.1.1.11		Update and Submit Project Schedule Changes 21		1 day	Tue 6/1/21	Tue 6/1/21	
1.10.1.1.1.12		Update and Submit Project Schedule Changes 23		1 day	Mon 6/14/21	Mon 6/14/21	
1.10.1.1.1.13		Update and Submit Project Schedule Changes 25		1 day	Mon 6/28/21	Mon 6/28/21	
1.10.1.1.1.14		Update and Submit Project Schedule Changes 27		1 day	Mon 7/12/21	Mon 7/12/21	
1.10.1.1.1.15		Update and Submit Project Schedule Changes 29		1 day	Mon 7/26/21	Mon 7/26/21	
1.10.1.1.1.16		Update and Submit Project Schedule Changes 31		1 day	Mon 8/9/21	Mon 8/9/21	
1.10.1.1.1.17		Update and Submit Project Schedule Changes 33		1 day	Mon 8/23/21	Mon 8/23/21	
1.10.1.1.1.18		Update and Submit Project Schedule Changes 35		1 day	Tue 9/7/21	Tue 9/7/21	
1.10.1.1.1.19		Update and Submit Project Schedule Changes 37		1 day	Mon 9/20/21	Mon 9/20/21	
1.10.1.1.1.20		Update and Submit Project Schedule Changes 39		1 day	Mon 10/4/21	Mon 10/4/21	
1.10.1.1.1.21		Update and Submit Project Schedule Changes 41		1 day	Mon 10/18/21	Mon 10/18/21	
1.10.1.1.1.22		Update and Submit Project Schedule Changes 43		1 day	Mon 11/1/21	Mon 11/1/21	
1.10.1.1.1.23		Update and Submit Project Schedule Changes 45		1 day	Mon 11/15/21	Mon 11/15/21	
1.10.1.1.1.24		Update and Submit Project Schedule Changes 47		1 day	Mon 11/29/21	Mon 11/29/21	
1.10.1.1.1.25		Update and Submit Project Schedule Changes 49		1 day	Mon 12/13/21	Mon 12/13/21	
1.10.1.1.1.26		Update and Submit Project Schedule Changes 51		1 day	Mon 12/27/21	Mon 12/27/21	
1.10.1.1.1.27		Update and Submit Project Schedule Changes 53		1 day	Mon 1/10/22	Mon 1/10/22	
1.10.1.1.1.28		Update and Submit Project Schedule Changes 55		1 day	Mon 1/24/22	Mon 1/24/22	
1.10.1.1.1.29		Update and Submit Project Schedule Changes 57		1 day	Mon 2/7/22	Mon 2/7/22	
1.10.1.1.1.30		Update and Submit Project Schedule Changes 59		1 day	Tue 2/22/22	Tue 2/22/22	
1.10.1.1.1.31		Update and Submit Project Schedule Changes 61		1 day	Mon 3/7/22	Mon 3/7/22	
1.10.1.1.1.32		Update and Submit Project Schedule Changes 63		1 day	Mon 3/21/22	Mon 3/21/22	
1.10.1.1.1.33		Update and Submit Project Schedule Changes 65		1 day	Mon 4/4/22	Mon 4/4/22	
1.10.1.1.1.34		Update and Submit Project Schedule Changes 67		1 day	Mon 4/18/22	Mon 4/18/22	
1.10.1.1.1.35		Update and Submit Project Schedule Changes 69		1 day	Mon 5/2/22	Mon 5/2/22	
1.10.1.1.1.36		Update and Submit Project Schedule Changes 71		1 day	Mon 5/16/22	Mon 5/16/22	
1.10.1.1.1.37		Update and Submit Project Schedule Changes 73		1 day	Tue 5/31/22	Tue 5/31/22	
1.10.1.1.1.38		Update and Submit Project Schedule Changes 74		1 day	Mon 6/6/22	Mon 6/6/22	
1.10.1.1.1.39		Update and Submit Project Schedule Changes 75		1 day	Mon 6/13/22	Mon 6/13/22	
1.10.1.1.1.40		Update and Submit Project Schedule Changes 77		1 day	Mon 6/27/22	Mon 6/27/22	
1.10.1.1.1.41		Update and Submit Project Schedule Changes 79		1 day	Mon 7/11/22	Mon 7/11/22	
1.10.1.1.1.42		Update and Submit Project Schedule Changes 81		1 day	Mon 7/25/22	Mon 7/25/22	
1.10.1.1.1.43		Update and Submit Project Schedule Changes 83		1 day	Mon 8/8/22	Mon 8/8/22	
1.10.1.1.1.44		Update and Submit Project Schedule Changes 85		1 day	Mon 8/22/22	Mon 8/22/22	
1.10.1.1.1.45		Update and Submit Project Schedule Changes 87		1 day	Tue 9/6/22	Tue 9/6/22	
1.10.1.1.1.46		Update and Submit Project Schedule Changes 89		1 day	Mon 9/19/22	Mon 9/19/22	
1.10.1.1.1.47		Update and Submit Project Schedule Changes 91		1 day	Mon 10/3/22	Mon 10/3/22	
1.10.1.1.1.48		Update and Submit Project Schedule Changes 93		1 day	Mon 10/17/22	Mon 10/17/22	
1.10.1.1.1.49		Update and Submit Project Schedule Changes 95		1 day	Mon 10/31/22	Mon 10/31/22	
1.10.1.1.1.50		Update and Submit Project Schedule Changes 97		1 day	Mon 11/14/22	Mon 11/14/22	
1.10.1.1.1.51		Update and Submit Project Schedule Changes 99		1 day	Mon 11/28/22	Mon 11/28/22	
1.10.1.1.1.52		Update and Submit Project Schedule Changes 101		1 day	Mon 12/12/22	Mon 12/12/22	
1.10.1.1.1.53		Update and Submit Project Schedule Changes 103		1 day	Mon 12/26/22	Mon 12/26/22	
1.10.1.1.1.54		Update and Submit Project Schedule Changes 105		1 day	Mon 1/9/23	Mon 1/9/23	
1.10.1.1.1.55		Update and Submit Project Schedule Changes 107		1 day	Mon 1/23/23	Mon 1/23/23	
1.10.1.1.1.56		Update and Submit Project Schedule Changes 109		1 day	Mon 2/6/23	Mon 2/6/23	
1.10.1.1.1.57		Update and Submit Project Schedule Changes 111		1 day	Tue 2/21/23	Tue 2/21/23	
1.10.1.1.1.58		Update and Submit Project Schedule Changes 113		1 day	Mon 3/6/23	Mon 3/6/23	
1.10.1.1.1.59		Update and Submit Project Schedule Changes 115		1 day	Mon 3/20/23	Mon 3/20/23	
1.10.1.1.1.60		Update and Submit Project Schedule Changes 117		1 day	Mon 4/3/23	Mon 4/3/23	
1.10.1.1.1.61		Update and Submit Project Schedule Changes 119		1 day	Mon 4/17/23	Mon 4/17/23	
1.10.1.1.1.62		Update and Submit Project Schedule Changes 121		1 day	Mon 5/1/23	Mon 5/1/23	
1.10.1.1.1.63		Update and Submit Project Schedule Changes 123		1 day	Mon 5/15/23	Mon 5/15/23	
1.10.1.1.1.64		Update and Submit Project Schedule Changes 125		1 day	Tue 5/30/23	Tue 5/30/23	
1.10.1.1.1.65		Update and Submit Project Schedule Changes 127		1 day	Mon 6/12/23	Mon 6/12/23	
1.10.1.1.1.66		Update and Submit Project Schedule Changes 129		1 day	Mon 6/26/23	Mon 6/26/23	
1.10.1.1.1.67		Update and Submit Project Schedule Changes 131		1 day	Mon 7/10/23	Mon 7/10/23	
1.10.1.1.1.68		Update and Submit Project Schedule Changes 133		1 day	Mon 7/24/23	Mon 7/24/23	
1.10.1.1.1.69		Update and Submit Project Schedule Changes 135		1 day	Mon 8/7/23	Mon 8/7/23	
1.10.1.1.1.70		Update and Submit Project Schedule Changes 137		1 day	Mon 8/21/23	Mon 8/21/23	
1.10.1.1.1.71		Update and Submit Project Schedule Changes 139		1 day	Tue 9/5/23	Tue 9/5/23	
1.10.1.1.1.72		Update and Submit Project Schedule Changes 141		1 day	Mon 9/18/23	Mon 9/18/23	
1.10.1.1.1.73		Update and Submit Project Schedule Changes 143		1 day	Mon 10/2/23	Mon 10/2/23	
1.10.1.1.1.74		Update and Submit Project Schedule Changes 145		1 day	Mon 10/16/23	Mon 10/16/23	
1.10.1.1.1.75		Update and Submit Project Schedule Changes 147		1 day	Mon 10/30/23	Mon 10/30/23	
1.10.1.1.1.76		Update and Submit Project Schedule Changes 149		1 day	Mon 11/13/23	Mon 11/13/23	
1.10.1.1.1.77		Update and Submit Project Schedule Changes 151		1 day	Mon 11/27/23	Mon 11/27/23	
1.10.1.1.1.78		Update and Submit Project Schedule Changes 153		1 day	Mon 12/11/23	Mon 12/11/23	
1.10.1.1.1.79		Update and Submit Project Schedule Changes 155		1 day	Tue 12/26/23	Tue 12/26/23	

1.10.1.1.1.80		Update and Submit Project Schedule Changes 157			1 day	Mon 1/8/24	Mon 1/8/24	
1.10.1.1.1.81		Update and Submit Project Schedule Changes 159			1 day	Mon 1/22/24	Mon 1/22/24	
1.10.1.1.1.82		Update and Submit Project Schedule Changes 161			1 day	Mon 2/5/24	Mon 2/5/24	
1.10.1.1.1.83		Update and Submit Project Schedule Changes 163			1 day	Tue 2/20/24	Tue 2/20/24	
1.10.1.1.1.84		Update and Submit Project Schedule Changes 165			1 day	Mon 3/4/24	Mon 3/4/24	
1.10.1.1.1.85		Update and Submit Project Schedule Changes 167			1 day	Mon 3/18/24	Mon 3/18/24	
1.10.1.1.1.86		Update and Submit Project Schedule Changes 169			1 day	Mon 4/1/24	Mon 4/1/24	
1.10.1.1.1.87		Update and Submit Project Schedule Changes 171			1 day	Mon 4/15/24	Mon 4/15/24	
1.10.1.1.1.88		Update and Submit Project Schedule Changes 173			1 day	Mon 4/29/24	Mon 4/29/24	
1.10.1.1.1.89		Update and Submit Project Schedule Changes 175			1 day	Mon 5/13/24	Mon 5/13/24	
1.10.1.1.1.90		Update and Submit Project Schedule Changes 177			1 day	Tue 5/28/24	Tue 5/28/24	
1.10.1.1.1.91		Update and Submit Project Schedule Changes 179			1 day	Mon 6/10/24	Mon 6/10/24	
1.10.1.1.1.92		Update and Submit Project Schedule Changes 181			1 day	Mon 6/24/24	Mon 6/24/24	
1.10.1.1.1.93		Update and Submit Project Schedule Changes 183			1 day	Mon 7/8/24	Mon 7/8/24	
1.10.1.1.1.94		Update and Submit Project Schedule Changes 185			1 day	Mon 7/22/24	Mon 7/22/24	
1.10.1.1.1.95		Update and Submit Project Schedule Changes 187			1 day	Mon 8/5/24	Mon 8/5/24	
1.10.1.1.1.96		Update and Submit Project Schedule Changes 189			1 day	Mon 8/19/24	Mon 8/19/24	
1.10.1.1.1.97		Update and Submit Project Schedule Changes 191			1 day	Tue 9/3/24	Tue 9/3/24	
1.10.1.1.1.98		Update and Submit Project Schedule Changes 193			1 day	Mon 9/16/24	Mon 9/16/24	
1.10.1.1.1.99		Update and Submit Project Schedule Changes 195			1 day	Mon 9/30/24	Mon 9/30/24	
1.10.1.1.1.100		Update and Submit Project Schedule Changes 197			1 day	Mon 10/14/24	Mon 10/14/24	
1.10.1.1.1.101		Update and Submit Project Schedule Changes 199			1 day	Mon 10/28/24	Mon 10/28/24	
1.10.1.1.1.102		Update and Submit Project Schedule Changes 201			1 day	Mon 11/11/24	Mon 11/11/24	
1.10.1.1.1.103		Update and Submit Project Schedule Changes 203			1 day	Mon 11/25/24	Mon 11/25/24	
1.10.1.1.1.104		Update and Submit Project Schedule Changes 205			1 day	Mon 12/9/24	Mon 12/9/24	
1.10.1.1.1.105		Update and Submit Project Schedule Changes 207			1 day	Mon 12/23/24	Mon 12/23/24	
1.10.1.1.1.106		Update and Submit Project Schedule Changes 209			1 day	Mon 1/6/25	Mon 1/6/25	
1.10.1.1.1.107		Update and Submit Project Schedule Changes 211			1 day	Tue 1/21/25	Tue 1/21/25	
1.10.1.1.1.108		Update and Submit Project Schedule Changes 213			1 day	Mon 2/3/25	Mon 2/3/25	
1.10.1.1.1.109		Update and Submit Project Schedule Changes 215			1 day	Tue 2/18/25	Tue 2/18/25	
1.10.1.1.1.110		Update and Submit Project Schedule Changes 217			1 day	Mon 3/3/25	Mon 3/3/25	
1.10.1.1.1.111		Update and Submit Project Schedule Changes 219			1 day	Mon 3/17/25	Mon 3/17/25	
1.10.1.1.1.112		Update and Submit Project Schedule Changes 221			1 day	Mon 3/31/25	Mon 3/31/25	
1.10.1.1.1.113		Update and Submit Project Schedule Changes 223			1 day	Mon 4/14/25	Mon 4/14/25	
1.10.1.1.1.114		Update and Submit Project Schedule Changes 225			1 day	Mon 4/28/25	Mon 4/28/25	
1.10.1.1.1.115		Update and Submit Project Schedule Changes 227			1 day	Mon 5/12/25	Mon 5/12/25	
1.10.1.1.1.116		Update and Submit Project Schedule Changes 229			1 day	Tue 5/27/25	Tue 5/27/25	
1.10.1.1.1.117		Update and Submit Project Schedule Changes 231			1 day	Mon 6/9/25	Mon 6/9/25	
1.10.1.1.1.118		Update and Submit Project Schedule Changes 233			1 day	Mon 6/23/25	Mon 6/23/25	
1.10.1.1.1.119		Update and Submit Project Schedule Changes 235			1 day	Mon 7/7/25	Mon 7/7/25	
1.10.1.1.1.120		Update and Submit Project Schedule Changes 237			1 day	Mon 7/21/25	Mon 7/21/25	
1.10.1.1.1.121		Update and Submit Project Schedule Changes 239			1 day	Mon 8/4/25	Mon 8/4/25	
1.10.1.1.1.122		Update and Submit Project Schedule Changes 241			1 day	Mon 8/18/25	Mon 8/18/25	
1.10.1.1.1.123		Update and Submit Project Schedule Changes 243			1 day	Tue 9/2/25	Tue 9/2/25	
1.10.1.1.1.124		Update and Submit Project Schedule Changes 245			1 day	Mon 9/15/25	Mon 9/15/25	
1.10.1.1.1.125		Update and Submit Project Schedule Changes 247			1 day	Mon 9/29/25	Mon 9/29/25	
1.10.1.1.1.126		Update and Submit Project Schedule Changes 249			1 day	Mon 10/13/25	Mon 10/13/25	
1.10.1.1.1.127		Update and Submit Project Schedule Changes 251			1 day	Mon 10/27/25	Mon 10/27/25	
1.10.1.1.1.128		Update and Submit Project Schedule Changes 253			1 day	Mon 11/10/25	Mon 11/10/25	
1.10.1.1.1.129		Update and Submit Project Schedule Changes 255			1 day	Mon 11/24/25	Mon 11/24/25	
1.10.1.1.1.130		Update and Submit Project Schedule Changes 257			1 day	Mon 12/8/25	Mon 12/8/25	
1.10.1.1.1.131		Update and Submit Project Schedule Changes 259			1 day	Mon 12/22/25	Mon 12/22/25	
1.10.1.1.1.132		Update and Submit Project Schedule Changes 261			1 day	Mon 1/5/26	Mon 1/5/26	
1.10.1.1.1.133		Update and Submit Project Schedule Changes 263			1 day	Tue 1/20/26	Tue 1/20/26	
1.10.1.1.1.134		Update and Submit Project Schedule Changes 265			1 day	Mon 2/2/26	Mon 2/2/26	
1.10.1.1.1.135		Update and Submit Project Schedule Changes 267			1 day	Tue 2/17/26	Tue 2/17/26	
1.10.1.1.1.136		Update and Submit Project Schedule Changes 269			1 day	Mon 3/2/26	Mon 3/2/26	
1.10.1.1.1.137		Update and Submit Project Schedule Changes 271			1 day	Mon 3/16/26	Mon 3/16/26	
1.10.1.1.1.138		Update and Submit Project Schedule Changes 273			1 day	Mon 3/30/26	Mon 3/30/26	
1.10.1.1.1.139		Update and Submit Project Schedule Changes 275			1 day	Mon 4/13/26	Mon 4/13/26	
1.10.1.1.1.140		Update and Submit Project Schedule Changes 277			1 day	Mon 4/27/26	Mon 4/27/26	
1.10.1.1.1.141		Update and Submit Project Schedule Changes 279			1 day	Mon 5/11/26	Mon 5/11/26	
1.10.1.1.1.142		Update and Submit Project Schedule Changes 281			1 day	Tue 5/26/26	Tue 5/26/26	
1.10.1.1.1.143		Update and Submit Project Schedule Changes 283			1 day	Mon 6/8/26	Mon 6/8/26	
1.10.1.1.1.144		Update and Submit Project Schedule Changes 285			1 day	Mon 6/22/26	Mon 6/22/26	
1.10.1.1.1.145		Update and Submit Project Schedule Changes 287			1 day	Mon 7/6/26	Mon 7/6/26	
1.10.1.1.1.146		Update and Submit Project Schedule Changes 289			1 day	Mon 7/20/26	Mon 7/20/26	
1.10.1.1.1.147		Update and Submit Project Schedule Changes 291			1 day	Mon 8/3/26	Mon 8/3/26	
1.10.1.1.1.148		Update and Submit Project Schedule Changes 293			1 day	Mon 8/17/26	Mon 8/17/26	
1.10.1.1.1.149		Update and Submit Project Schedule Changes 295			1 day	Mon 8/31/26	Mon 8/31/26	
1.10.1.1.1.150		Update and Submit Project Schedule Changes 297			1 day	Mon 9/14/26	Mon 9/14/26	
1.10.1.1.1.151		Update and Submit Project Schedule Changes 299			1 day	Mon 9/28/26	Mon 9/28/26	

1.10.1.1.1.152		Update and Submit Project Schedule Changes 301	1 day	Mon 10/12/26	Mon 10/12/26
1.10.1.1.1.153		Update and Submit Project Schedule Changes 303	1 day	Mon 10/26/26	Mon 10/26/26
1.10.1.1.1.154		Update and Submit Project Schedule Changes 305	1 day	Mon 11/9/26	Mon 11/9/26
1.10.1.1.1.155		Update and Submit Project Schedule Changes 307	1 day	Mon 11/23/26	Mon 11/23/26
1.10.1.1.1.156		Update and Submit Project Schedule Changes 309	1 day	Mon 12/7/26	Mon 12/7/26
1.10.1.1.1.157		Update and Submit Project Schedule Changes 311	1 day	Mon 12/21/26	Mon 12/21/26
1.10.1.1.1.158		Update and Submit Project Schedule Changes 313	1 day	Mon 1/4/27	Mon 1/4/27
1.10.1.2	**5.2.**	**D068 Project Status Reporting (Weekly and Monthly)**	**1500 days**	**Tue 1/12/21**	**Mon 1/4/27**
1.10.1.2.1		**Weekly Project Status Reporting**	**1498 days**	**Tue 1/12/21**	**Tue 12/29/26**
1.10.1.2.1.1		Weekly Project Status Reporting 1	1 day	Tue 1/12/21	Tue 1/12/21
1.10.1.2.1.2		Weekly Project Status Reporting 2	1 day	Tue 1/19/21	Tue 1/19/21
1.10.1.2.1.3		Weekly Project Status Reporting 3	1 day	Tue 1/26/21	Tue 1/26/21
1.10.1.2.1.4		Weekly Project Status Reporting 4	1 day	Tue 2/2/21	Tue 2/2/21
1.10.1.2.1.5		Weekly Project Status Reporting 5	1 day	Tue 2/9/21	Tue 2/9/21
1.10.1.2.1.6		Weekly Project Status Reporting 6	1 day	Tue 2/16/21	Tue 2/16/21
1.10.1.2.1.7		Weekly Project Status Reporting 7	1 day	Tue 2/23/21	Tue 2/23/21
1.10.1.2.1.8		Weekly Project Status Reporting 8	1 day	Tue 3/2/21	Tue 3/2/21
1.10.1.2.1.9		Weekly Project Status Reporting 9	1 day	Tue 3/9/21	Tue 3/9/21
1.10.1.2.1.10		Weekly Project Status Reporting 10	1 day	Tue 3/16/21	Tue 3/16/21
1.10.1.2.1.11		Weekly Project Status Reporting 11	1 day	Tue 3/23/21	Tue 3/23/21
1.10.1.2.1.12		Weekly Project Status Reporting 12	1 day	Tue 3/30/21	Tue 3/30/21
1.10.1.2.1.13		Weekly Project Status Reporting 13	1 day	Tue 4/6/21	Tue 4/6/21
1.10.1.2.1.14		Weekly Project Status Reporting 14	1 day	Tue 4/13/21	Tue 4/13/21
1.10.1.2.1.15		Weekly Project Status Reporting 15	1 day	Tue 4/20/21	Tue 4/20/21
1.10.1.2.1.16		Weekly Project Status Reporting 16	1 day	Tue 4/27/21	Tue 4/27/21
1.10.1.2.1.17		Weekly Project Status Reporting 17	1 day	Tue 5/4/21	Tue 5/4/21
1.10.1.2.1.18		Weekly Project Status Reporting 18	1 day	Tue 5/11/21	Tue 5/11/21
1.10.1.2.1.19		Weekly Project Status Reporting 19	1 day	Tue 5/18/21	Tue 5/18/21
1.10.1.2.1.20		Weekly Project Status Reporting 20	1 day	Tue 5/25/21	Tue 5/25/21
1.10.1.2.1.21		Weekly Project Status Reporting 21	1 day	Tue 6/1/21	Tue 6/1/21
1.10.1.2.1.22		Weekly Project Status Reporting 22	1 day	Tue 6/8/21	Tue 6/8/21
1.10.1.2.1.23		Weekly Project Status Reporting 23	1 day	Tue 6/15/21	Tue 6/15/21
1.10.1.2.1.24		Weekly Project Status Reporting 24	1 day	Tue 6/22/21	Tue 6/22/21
1.10.1.2.1.25		Weekly Project Status Reporting 25	1 day	Tue 6/29/21	Tue 6/29/21
1.10.1.2.1.26		Weekly Project Status Reporting 26	1 day	Tue 7/6/21	Tue 7/6/21
1.10.1.2.1.27		Weekly Project Status Reporting 27	1 day	Tue 7/13/21	Tue 7/13/21
1.10.1.2.1.28		Weekly Project Status Reporting 28	1 day	Tue 7/20/21	Tue 7/20/21
1.10.1.2.1.29		Weekly Project Status Reporting 29	1 day	Tue 7/27/21	Tue 7/27/21
1.10.1.2.1.30		Weekly Project Status Reporting 30	1 day	Tue 8/3/21	Tue 8/3/21
1.10.1.2.1.31		Weekly Project Status Reporting 31	1 day	Tue 8/10/21	Tue 8/10/21
1.10.1.2.1.32		Weekly Project Status Reporting 32	1 day	Tue 8/17/21	Tue 8/17/21
1.10.1.2.1.33		Weekly Project Status Reporting 33	1 day	Tue 8/24/21	Tue 8/24/21
1.10.1.2.1.34		Weekly Project Status Reporting 34	1 day	Tue 8/31/21	Tue 8/31/21
1.10.1.2.1.35		Weekly Project Status Reporting 35	1 day	Tue 9/7/21	Tue 9/7/21
1.10.1.2.1.36		Weekly Project Status Reporting 36	1 day	Tue 9/14/21	Tue 9/14/21
1.10.1.2.1.37		Weekly Project Status Reporting 37	1 day	Tue 9/21/21	Tue 9/21/21
1.10.1.2.1.38		Weekly Project Status Reporting 38	1 day	Tue 9/28/21	Tue 9/28/21
1.10.1.2.1.39		Weekly Project Status Reporting 39	1 day	Tue 10/5/21	Tue 10/5/21
1.10.1.2.1.40		Weekly Project Status Reporting 40	1 day	Tue 10/12/21	Tue 10/12/21
1.10.1.2.1.41		Weekly Project Status Reporting 41	1 day	Tue 10/19/21	Tue 10/19/21
1.10.1.2.1.42		Weekly Project Status Reporting 42	1 day	Tue 10/26/21	Tue 10/26/21
1.10.1.2.1.43		Weekly Project Status Reporting 43	1 day	Tue 11/2/21	Tue 11/2/21
1.10.1.2.1.44		Weekly Project Status Reporting 44	1 day	Tue 11/9/21	Tue 11/9/21
1.10.1.2.1.45		Weekly Project Status Reporting 45	1 day	Tue 11/16/21	Tue 11/16/21
1.10.1.2.1.46		Weekly Project Status Reporting 46	1 day	Tue 11/23/21	Tue 11/23/21
1.10.1.2.1.47		Weekly Project Status Reporting 47	1 day	Tue 11/30/21	Tue 11/30/21
1.10.1.2.1.48		Weekly Project Status Reporting 48	1 day	Tue 12/7/21	Tue 12/7/21
1.10.1.2.1.49		Weekly Project Status Reporting 49	1 day	Tue 12/14/21	Tue 12/14/21
1.10.1.2.1.50		Weekly Project Status Reporting 50	1 day	Tue 12/21/21	Tue 12/21/21
1.10.1.2.1.51		Weekly Project Status Reporting 51	1 day	Tue 12/28/21	Tue 12/28/21
1.10.1.2.1.52		Weekly Project Status Reporting 52	1 day	Tue 1/4/22	Tue 1/4/22
1.10.1.2.1.53		Weekly Project Status Reporting 53	1 day	Tue 1/11/22	Tue 1/11/22
1.10.1.2.1.54		Weekly Project Status Reporting 54	1 day	Tue 1/18/22	Tue 1/18/22
1.10.1.2.1.55		Weekly Project Status Reporting 55	1 day	Tue 1/25/22	Tue 1/25/22
1.10.1.2.1.56		Weekly Project Status Reporting 56	1 day	Tue 2/1/22	Tue 2/1/22
1.10.1.2.1.57		Weekly Project Status Reporting 57	1 day	Tue 2/8/22	Tue 2/8/22
1.10.1.2.1.58		Weekly Project Status Reporting 58	1 day	Tue 2/15/22	Tue 2/15/22
1.10.1.2.1.59		Weekly Project Status Reporting 59	1 day	Tue 2/22/22	Tue 2/22/22
1.10.1.2.1.60		Weekly Project Status Reporting 60	1 day	Tue 3/1/22	Tue 3/1/22
1.10.1.2.1.61		Weekly Project Status Reporting 61	1 day	Tue 3/8/22	Tue 3/8/22
1.10.1.2.1.62		Weekly Project Status Reporting 62	1 day	Tue 3/15/22	Tue 3/15/22
1.10.1.2.1.63		Weekly Project Status Reporting 63	1 day	Tue 3/22/22	Tue 3/22/22

1.10.1.2.1.64		Weekly Project Status Reporting 64		1 day	Tue 3/29/22	Tue 3/29/22		
1.10.1.2.1.65		Weekly Project Status Reporting 65		1 day	Tue 4/5/22	Tue 4/5/22		
1.10.1.2.1.66		Weekly Project Status Reporting 66		1 day	Tue 4/12/22	Tue 4/12/22		
1.10.1.2.1.67		Weekly Project Status Reporting 67		1 day	Tue 4/19/22	Tue 4/19/22		
1.10.1.2.1.68		Weekly Project Status Reporting 68		1 day	Tue 4/26/22	Tue 4/26/22		
1.10.1.2.1.69		Weekly Project Status Reporting 69		1 day	Tue 5/3/22	Tue 5/3/22		
1.10.1.2.1.70		Weekly Project Status Reporting 70		1 day	Tue 5/10/22	Tue 5/10/22		
1.10.1.2.1.71		Weekly Project Status Reporting 71		1 day	Tue 5/17/22	Tue 5/17/22		
1.10.1.2.1.72		Weekly Project Status Reporting 72		1 day	Tue 5/24/22	Tue 5/24/22		
1.10.1.2.1.73		Weekly Project Status Reporting 73		1 day	Tue 5/31/22	Tue 5/31/22		
1.10.1.2.1.74		Weekly Project Status Reporting 74		1 day	Tue 6/7/22	Tue 6/7/22		
1.10.1.2.1.75		Weekly Project Status Reporting 75		1 day	Tue 6/14/22	Tue 6/14/22		
1.10.1.2.1.76		Weekly Project Status Reporting 76		1 day	Tue 6/21/22	Tue 6/21/22		
1.10.1.2.1.77		Weekly Project Status Reporting 77		1 day	Tue 6/28/22	Tue 6/28/22		
1.10.1.2.1.78		Weekly Project Status Reporting 78		1 day	Tue 7/5/22	Tue 7/5/22		
1.10.1.2.1.79		Weekly Project Status Reporting 79		1 day	Tue 7/12/22	Tue 7/12/22		
1.10.1.2.1.80		Weekly Project Status Reporting 80		1 day	Tue 7/19/22	Tue 7/19/22		
1.10.1.2.1.81		Weekly Project Status Reporting 81		1 day	Tue 7/26/22	Tue 7/26/22		
1.10.1.2.1.82		Weekly Project Status Reporting 82		1 day	Tue 8/2/22	Tue 8/2/22		
1.10.1.2.1.83		Weekly Project Status Reporting 83		1 day	Tue 8/9/22	Tue 8/9/22		
1.10.1.2.1.84		Weekly Project Status Reporting 84		1 day	Tue 8/16/22	Tue 8/16/22		
1.10.1.2.1.85		Weekly Project Status Reporting 85		1 day	Tue 8/23/22	Tue 8/23/22		
1.10.1.2.1.86		Weekly Project Status Reporting 86		1 day	Tue 8/30/22	Tue 8/30/22		
1.10.1.2.1.87		Weekly Project Status Reporting 87		1 day	Tue 9/6/22	Tue 9/6/22		
1.10.1.2.1.88		Weekly Project Status Reporting 88		1 day	Tue 9/13/22	Tue 9/13/22		
1.10.1.2.1.89		Weekly Project Status Reporting 89		1 day	Tue 9/20/22	Tue 9/20/22		
1.10.1.2.1.90		Weekly Project Status Reporting 90		1 day	Tue 9/27/22	Tue 9/27/22		
1.10.1.2.1.91		Weekly Project Status Reporting 91		1 day	Tue 10/4/22	Tue 10/4/22		
1.10.1.2.1.92		Weekly Project Status Reporting 92		1 day	Tue 10/11/22	Tue 10/11/22		
1.10.1.2.1.93		Weekly Project Status Reporting 93		1 day	Tue 10/18/22	Tue 10/18/22		
1.10.1.2.1.94		Weekly Project Status Reporting 94		1 day	Tue 10/25/22	Tue 10/25/22		
1.10.1.2.1.95		Weekly Project Status Reporting 95		1 day	Tue 11/1/22	Tue 11/1/22		
1.10.1.2.1.96		Weekly Project Status Reporting 96		1 day	Tue 11/8/22	Tue 11/8/22		
1.10.1.2.1.97		Weekly Project Status Reporting 97		1 day	Tue 11/15/22	Tue 11/15/22		
1.10.1.2.1.98		Weekly Project Status Reporting 98		1 day	Tue 11/22/22	Tue 11/22/22		
1.10.1.2.1.99		Weekly Project Status Reporting 99		1 day	Tue 11/29/22	Tue 11/29/22		
1.10.1.2.1.100		Weekly Project Status Reporting 100		1 day	Tue 12/6/22	Tue 12/6/22		
1.10.1.2.1.101		Weekly Project Status Reporting 101		1 day	Tue 12/13/22	Tue 12/13/22		
1.10.1.2.1.102		Weekly Project Status Reporting 102		1 day	Tue 12/20/22	Tue 12/20/22		
1.10.1.2.1.103		Weekly Project Status Reporting 103		1 day	Tue 12/27/22	Tue 12/27/22		
1.10.1.2.1.104		Weekly Project Status Reporting 104		1 day	Tue 1/3/23	Tue 1/3/23		
1.10.1.2.1.105		Weekly Project Status Reporting 105		1 day	Tue 1/10/23	Tue 1/10/23		
1.10.1.2.1.106		Weekly Project Status Reporting 106		1 day	Tue 1/17/23	Tue 1/17/23		
1.10.1.2.1.107		Weekly Project Status Reporting 107		1 day	Tue 1/24/23	Tue 1/24/23		
1.10.1.2.1.108		Weekly Project Status Reporting 108		1 day	Tue 1/31/23	Tue 1/31/23		
1.10.1.2.1.109		Weekly Project Status Reporting 109		1 day	Tue 2/7/23	Tue 2/7/23		
1.10.1.2.1.110		Weekly Project Status Reporting 110		1 day	Tue 2/14/23	Tue 2/14/23		
1.10.1.2.1.111		Weekly Project Status Reporting 111		1 day	Tue 2/21/23	Tue 2/21/23		
1.10.1.2.1.112		Weekly Project Status Reporting 112		1 day	Tue 2/28/23	Tue 2/28/23		
1.10.1.2.1.113		Weekly Project Status Reporting 113		1 day	Tue 3/7/23	Tue 3/7/23		
1.10.1.2.1.114		Weekly Project Status Reporting 114		1 day	Tue 3/14/23	Tue 3/14/23		
1.10.1.2.1.115		Weekly Project Status Reporting 115		1 day	Tue 3/21/23	Tue 3/21/23		
1.10.1.2.1.116		Weekly Project Status Reporting 116		1 day	Tue 3/28/23	Tue 3/28/23		
1.10.1.2.1.117		Weekly Project Status Reporting 117		1 day	Tue 4/4/23	Tue 4/4/23		
1.10.1.2.1.118		Weekly Project Status Reporting 118		1 day	Tue 4/11/23	Tue 4/11/23		
1.10.1.2.1.119		Weekly Project Status Reporting 119		1 day	Tue 4/18/23	Tue 4/18/23		
1.10.1.2.1.120		Weekly Project Status Reporting 120		1 day	Tue 4/25/23	Tue 4/25/23		
1.10.1.2.1.121		Weekly Project Status Reporting 121		1 day	Tue 5/2/23	Tue 5/2/23		
1.10.1.2.1.122		Weekly Project Status Reporting 122		1 day	Tue 5/9/23	Tue 5/9/23		
1.10.1.2.1.123		Weekly Project Status Reporting 123		1 day	Tue 5/16/23	Tue 5/16/23		
1.10.1.2.1.124		Weekly Project Status Reporting 124		1 day	Tue 5/23/23	Tue 5/23/23		
1.10.1.2.1.125		Weekly Project Status Reporting 125		1 day	Tue 5/30/23	Tue 5/30/23		
1.10.1.2.1.126		Weekly Project Status Reporting 126		1 day	Tue 6/6/23	Tue 6/6/23		
1.10.1.2.1.127		Weekly Project Status Reporting 127		1 day	Tue 6/13/23	Tue 6/13/23		
1.10.1.2.1.128		Weekly Project Status Reporting 128		1 day	Wed 6/21/23	Wed 6/21/23		
1.10.1.2.1.129		Weekly Project Status Reporting 129		1 day	Tue 6/27/23	Tue 6/27/23		
1.10.1.2.1.130		Weekly Project Status Reporting 130		1 day	Wed 7/5/23	Wed 7/5/23		
1.10.1.2.1.131		Weekly Project Status Reporting 131		1 day	Tue 7/11/23	Tue 7/11/23		
1.10.1.2.1.132		Weekly Project Status Reporting 132		1 day	Tue 7/18/23	Tue 7/18/23		
1.10.1.2.1.133		Weekly Project Status Reporting 133		1 day	Tue 7/25/23	Tue 7/25/23		
1.10.1.2.1.134		Weekly Project Status Reporting 134		1 day	Tue 8/1/23	Tue 8/1/23		
1.10.1.2.1.135		Weekly Project Status Reporting 135		1 day	Tue 8/8/23	Tue 8/8/23		

1.10.1.2.1.136	Weekly Project Status Reporting 136	1 day	Tue 8/15/23	Tue 8/15/23
1.10.1.2.1.137	Weekly Project Status Reporting 137	1 day	Tue 8/22/23	Tue 8/22/23
1.10.1.2.1.138	Weekly Project Status Reporting 138	1 day	Tue 8/29/23	Tue 8/29/23
1.10.1.2.1.139	Weekly Project Status Reporting 139	1 day	Tue 9/5/23	Tue 9/5/23
1.10.1.2.1.140	Weekly Project Status Reporting 140	1 day	Tue 9/12/23	Tue 9/12/23
1.10.1.2.1.141	Weekly Project Status Reporting 141	1 day	Tue 9/19/23	Tue 9/19/23
1.10.1.2.1.142	Weekly Project Status Reporting 142	1 day	Tue 9/26/23	Tue 9/26/23
1.10.1.2.1.143	Weekly Project Status Reporting 143	1 day	Tue 10/3/23	Tue 10/3/23
1.10.1.2.1.144	Weekly Project Status Reporting 144	1 day	Tue 10/10/23	Tue 10/10/23
1.10.1.2.1.145	Weekly Project Status Reporting 145	1 day	Tue 10/17/23	Tue 10/17/23
1.10.1.2.1.146	Weekly Project Status Reporting 146	1 day	Tue 10/24/23	Tue 10/24/23
1.10.1.2.1.147	Weekly Project Status Reporting 147	1 day	Tue 10/31/23	Tue 10/31/23
1.10.1.2.1.148	Weekly Project Status Reporting 148	1 day	Tue 11/7/23	Tue 11/7/23
1.10.1.2.1.149	Weekly Project Status Reporting 149	1 day	Tue 11/14/23	Tue 11/14/23
1.10.1.2.1.150	Weekly Project Status Reporting 150	1 day	Tue 11/21/23	Tue 11/21/23
1.10.1.2.1.151	Weekly Project Status Reporting 151	1 day	Tue 11/28/23	Tue 11/28/23
1.10.1.2.1.152	Weekly Project Status Reporting 152	1 day	Tue 12/5/23	Tue 12/5/23
1.10.1.2.1.153	Weekly Project Status Reporting 153	1 day	Tue 12/12/23	Tue 12/12/23
1.10.1.2.1.154	Weekly Project Status Reporting 154	1 day	Tue 12/19/23	Tue 12/19/23
1.10.1.2.1.155	Weekly Project Status Reporting 155	1 day	Tue 12/26/23	Tue 12/26/23
1.10.1.2.1.156	Weekly Project Status Reporting 156	1 day	Tue 1/2/24	Tue 1/2/24
1.10.1.2.1.157	Weekly Project Status Reporting 157	1 day	Tue 1/9/24	Tue 1/9/24
1.10.1.2.1.158	Weekly Project Status Reporting 158	1 day	Tue 1/16/24	Tue 1/16/24
1.10.1.2.1.159	Weekly Project Status Reporting 159	1 day	Tue 1/23/24	Tue 1/23/24
1.10.1.2.1.160	Weekly Project Status Reporting 160	1 day	Tue 1/30/24	Tue 1/30/24
1.10.1.2.1.161	Weekly Project Status Reporting 161	1 day	Tue 2/6/24	Tue 2/6/24
1.10.1.2.1.162	Weekly Project Status Reporting 162	1 day	Tue 2/13/24	Tue 2/13/24
1.10.1.2.1.163	Weekly Project Status Reporting 163	1 day	Tue 2/20/24	Tue 2/20/24
1.10.1.2.1.164	Weekly Project Status Reporting 164	1 day	Tue 2/27/24	Tue 2/27/24
1.10.1.2.1.165	Weekly Project Status Reporting 165	1 day	Tue 3/5/24	Tue 3/5/24
1.10.1.2.1.166	Weekly Project Status Reporting 166	1 day	Tue 3/12/24	Tue 3/12/24
1.10.1.2.1.167	Weekly Project Status Reporting 167	1 day	Tue 3/19/24	Tue 3/19/24
1.10.1.2.1.168	Weekly Project Status Reporting 168	1 day	Tue 3/26/24	Tue 3/26/24
1.10.1.2.1.169	Weekly Project Status Reporting 169	1 day	Tue 4/2/24	Tue 4/2/24
1.10.1.2.1.170	Weekly Project Status Reporting 170	1 day	Tue 4/9/24	Tue 4/9/24
1.10.1.2.1.171	Weekly Project Status Reporting 171	1 day	Tue 4/16/24	Tue 4/16/24
1.10.1.2.1.172	Weekly Project Status Reporting 172	1 day	Tue 4/23/24	Tue 4/23/24
1.10.1.2.1.173	Weekly Project Status Reporting 173	1 day	Tue 4/30/24	Tue 4/30/24
1.10.1.2.1.174	Weekly Project Status Reporting 174	1 day	Tue 5/7/24	Tue 5/7/24
1.10.1.2.1.175	Weekly Project Status Reporting 175	1 day	Tue 5/14/24	Tue 5/14/24
1.10.1.2.1.176	Weekly Project Status Reporting 176	1 day	Tue 5/21/24	Tue 5/21/24
1.10.1.2.1.177	Weekly Project Status Reporting 177	1 day	Tue 5/28/24	Tue 5/28/24
1.10.1.2.1.178	Weekly Project Status Reporting 178	1 day	Tue 6/4/24	Tue 6/4/24
1.10.1.2.1.179	Weekly Project Status Reporting 179	1 day	Tue 6/11/24	Tue 6/11/24
1.10.1.2.1.180	Weekly Project Status Reporting 180	1 day	Tue 6/18/24	Tue 6/18/24
1.10.1.2.1.181	Weekly Project Status Reporting 181	1 day	Tue 6/25/24	Tue 6/25/24
1.10.1.2.1.182	Weekly Project Status Reporting 182	1 day	Tue 7/2/24	Tue 7/2/24
1.10.1.2.1.183	Weekly Project Status Reporting 183	1 day	Tue 7/9/24	Tue 7/9/24
1.10.1.2.1.184	Weekly Project Status Reporting 184	1 day	Tue 7/16/24	Tue 7/16/24
1.10.1.2.1.185	Weekly Project Status Reporting 185	1 day	Tue 7/23/24	Tue 7/23/24
1.10.1.2.1.186	Weekly Project Status Reporting 186	1 day	Tue 7/30/24	Tue 7/30/24
1.10.1.2.1.187	Weekly Project Status Reporting 187	1 day	Tue 8/6/24	Tue 8/6/24
1.10.1.2.1.188	Weekly Project Status Reporting 188	1 day	Tue 8/13/24	Tue 8/13/24
1.10.1.2.1.189	Weekly Project Status Reporting 189	1 day	Tue 8/20/24	Tue 8/20/24
1.10.1.2.1.190	Weekly Project Status Reporting 190	1 day	Tue 8/27/24	Tue 8/27/24
1.10.1.2.1.191	Weekly Project Status Reporting 191	1 day	Tue 9/3/24	Tue 9/3/24
1.10.1.2.1.192	Weekly Project Status Reporting 192	1 day	Tue 9/10/24	Tue 9/10/24
1.10.1.2.1.193	Weekly Project Status Reporting 193	1 day	Tue 9/17/24	Tue 9/17/24
1.10.1.2.1.194	Weekly Project Status Reporting 194	1 day	Tue 9/24/24	Tue 9/24/24
1.10.1.2.1.195	Weekly Project Status Reporting 195	1 day	Tue 10/1/24	Tue 10/1/24
1.10.1.2.1.196	Weekly Project Status Reporting 196	1 day	Tue 10/8/24	Tue 10/8/24
1.10.1.2.1.197	Weekly Project Status Reporting 197	1 day	Tue 10/15/24	Tue 10/15/24
1.10.1.2.1.198	Weekly Project Status Reporting 198	1 day	Tue 10/22/24	Tue 10/22/24
1.10.1.2.1.199	Weekly Project Status Reporting 199	1 day	Tue 10/29/24	Tue 10/29/24
1.10.1.2.1.200	Weekly Project Status Reporting 200	1 day	Tue 11/5/24	Tue 11/5/24
1.10.1.2.1.201	Weekly Project Status Reporting 201	1 day	Tue 11/12/24	Tue 11/12/24
1.10.1.2.1.202	Weekly Project Status Reporting 202	1 day	Tue 11/19/24	Tue 11/19/24
1.10.1.2.1.203	Weekly Project Status Reporting 203	1 day	Tue 11/26/24	Tue 11/26/24
1.10.1.2.1.204	Weekly Project Status Reporting 204	1 day	Tue 12/3/24	Tue 12/3/24
1.10.1.2.1.205	Weekly Project Status Reporting 205	1 day	Tue 12/10/24	Tue 12/10/24
1.10.1.2.1.206	Weekly Project Status Reporting 206	1 day	Tue 12/17/24	Tue 12/17/24
1.10.1.2.1.207	Weekly Project Status Reporting 207	1 day	Thu 12/26/24	Thu 12/26/24

1.10.1.2.1.208		Weekly Project Status Reporting 208	1 day	Thu 1/2/25	Thu 1/2/25
1.10.1.2.1.209		Weekly Project Status Reporting 209	1 day	Tue 1/7/25	Tue 1/7/25
1.10.1.2.1.210		Weekly Project Status Reporting 210	1 day	Tue 1/14/25	Tue 1/14/25
1.10.1.2.1.211		Weekly Project Status Reporting 211	1 day	Tue 1/21/25	Tue 1/21/25
1.10.1.2.1.212		Weekly Project Status Reporting 212	1 day	Tue 1/28/25	Tue 1/28/25
1.10.1.2.1.213		Weekly Project Status Reporting 213	1 day	Tue 2/4/25	Tue 2/4/25
1.10.1.2.1.214		Weekly Project Status Reporting 214	1 day	Tue 2/11/25	Tue 2/11/25
1.10.1.2.1.215		Weekly Project Status Reporting 215	1 day	Tue 2/18/25	Tue 2/18/25
1.10.1.2.1.216		Weekly Project Status Reporting 216	1 day	Tue 2/25/25	Tue 2/25/25
1.10.1.2.1.217		Weekly Project Status Reporting 217	1 day	Tue 3/4/25	Tue 3/4/25
1.10.1.2.1.218		Weekly Project Status Reporting 218	1 day	Tue 3/11/25	Tue 3/11/25
1.10.1.2.1.219		Weekly Project Status Reporting 219	1 day	Tue 3/18/25	Tue 3/18/25
1.10.1.2.1.220		Weekly Project Status Reporting 220	1 day	Tue 3/25/25	Tue 3/25/25
1.10.1.2.1.221		Weekly Project Status Reporting 221	1 day	Tue 4/1/25	Tue 4/1/25
1.10.1.2.1.222		Weekly Project Status Reporting 222	1 day	Tue 4/8/25	Tue 4/8/25
1.10.1.2.1.223		Weekly Project Status Reporting 223	1 day	Tue 4/15/25	Tue 4/15/25
1.10.1.2.1.224		Weekly Project Status Reporting 224	1 day	Tue 4/22/25	Tue 4/22/25
1.10.1.2.1.225		Weekly Project Status Reporting 225	1 day	Tue 4/29/25	Tue 4/29/25
1.10.1.2.1.226		Weekly Project Status Reporting 226	1 day	Tue 5/6/25	Tue 5/6/25
1.10.1.2.1.227		Weekly Project Status Reporting 227	1 day	Tue 5/13/25	Tue 5/13/25
1.10.1.2.1.228		Weekly Project Status Reporting 228	1 day	Tue 5/20/25	Tue 5/20/25
1.10.1.2.1.229		Weekly Project Status Reporting 229	1 day	Tue 5/27/25	Tue 5/27/25
1.10.1.2.1.230		Weekly Project Status Reporting 230	1 day	Tue 6/3/25	Tue 6/3/25
1.10.1.2.1.231		Weekly Project Status Reporting 231	1 day	Tue 6/10/25	Tue 6/10/25
1.10.1.2.1.232		Weekly Project Status Reporting 232	1 day	Tue 6/17/25	Tue 6/17/25
1.10.1.2.1.233		Weekly Project Status Reporting 233	1 day	Tue 6/24/25	Tue 6/24/25
1.10.1.2.1.234		Weekly Project Status Reporting 234	1 day	Tue 7/1/25	Tue 7/1/25
1.10.1.2.1.235		Weekly Project Status Reporting 235	1 day	Tue 7/8/25	Tue 7/8/25
1.10.1.2.1.236		Weekly Project Status Reporting 236	1 day	Tue 7/15/25	Tue 7/15/25
1.10.1.2.1.237		Weekly Project Status Reporting 237	1 day	Tue 7/22/25	Tue 7/22/25
1.10.1.2.1.238		Weekly Project Status Reporting 238	1 day	Tue 7/29/25	Tue 7/29/25
1.10.1.2.1.239		Weekly Project Status Reporting 239	1 day	Tue 8/5/25	Tue 8/5/25
1.10.1.2.1.240		Weekly Project Status Reporting 240	1 day	Tue 8/12/25	Tue 8/12/25
1.10.1.2.1.241		Weekly Project Status Reporting 241	1 day	Tue 8/19/25	Tue 8/19/25
1.10.1.2.1.242		Weekly Project Status Reporting 242	1 day	Tue 8/26/25	Tue 8/26/25
1.10.1.2.1.243		Weekly Project Status Reporting 243	1 day	Tue 9/2/25	Tue 9/2/25
1.10.1.2.1.244		Weekly Project Status Reporting 244	1 day	Tue 9/9/25	Tue 9/9/25
1.10.1.2.1.245		Weekly Project Status Reporting 245	1 day	Tue 9/16/25	Tue 9/16/25
1.10.1.2.1.246		Weekly Project Status Reporting 246	1 day	Tue 9/23/25	Tue 9/23/25
1.10.1.2.1.247		Weekly Project Status Reporting 247	1 day	Tue 9/30/25	Tue 9/30/25
1.10.1.2.1.248		Weekly Project Status Reporting 248	1 day	Tue 10/7/25	Tue 10/7/25
1.10.1.2.1.249		Weekly Project Status Reporting 249	1 day	Tue 10/14/25	Tue 10/14/25
1.10.1.2.1.250		Weekly Project Status Reporting 250	1 day	Tue 10/21/25	Tue 10/21/25
1.10.1.2.1.251		Weekly Project Status Reporting 251	1 day	Tue 10/28/25	Tue 10/28/25
1.10.1.2.1.252		Weekly Project Status Reporting 252	1 day	Tue 11/4/25	Tue 11/4/25
1.10.1.2.1.253		Weekly Project Status Reporting 253	1 day	Tue 11/11/25	Tue 11/11/25
1.10.1.2.1.254		Weekly Project Status Reporting 254	1 day	Tue 11/18/25	Tue 11/18/25
1.10.1.2.1.255		Weekly Project Status Reporting 255	1 day	Tue 11/25/25	Tue 11/25/25
1.10.1.2.1.256		Weekly Project Status Reporting 256	1 day	Tue 12/2/25	Tue 12/2/25
1.10.1.2.1.257		Weekly Project Status Reporting 257	1 day	Tue 12/9/25	Tue 12/9/25
1.10.1.2.1.258		Weekly Project Status Reporting 258	1 day	Tue 12/16/25	Tue 12/16/25
1.10.1.2.1.259		Weekly Project Status Reporting 259	1 day	Tue 12/23/25	Tue 12/23/25
1.10.1.2.1.260		Weekly Project Status Reporting 260	1 day	Tue 12/30/25	Tue 12/30/25
1.10.1.2.1.261		Weekly Project Status Reporting 261	1 day	Tue 1/6/26	Tue 1/6/26
1.10.1.2.1.262		Weekly Project Status Reporting 262	1 day	Tue 1/13/26	Tue 1/13/26
1.10.1.2.1.263		Weekly Project Status Reporting 263	1 day	Tue 1/20/26	Tue 1/20/26
1.10.1.2.1.264		Weekly Project Status Reporting 264	1 day	Tue 1/27/26	Tue 1/27/26
1.10.1.2.1.265		Weekly Project Status Reporting 265	1 day	Tue 2/3/26	Tue 2/3/26
1.10.1.2.1.266		Weekly Project Status Reporting 266	1 day	Tue 2/10/26	Tue 2/10/26
1.10.1.2.1.267		Weekly Project Status Reporting 267	1 day	Tue 2/17/26	Tue 2/17/26
1.10.1.2.1.268		Weekly Project Status Reporting 268	1 day	Tue 2/24/26	Tue 2/24/26
1.10.1.2.1.269		Weekly Project Status Reporting 269	1 day	Tue 3/3/26	Tue 3/3/26
1.10.1.2.1.270		Weekly Project Status Reporting 270	1 day	Tue 3/10/26	Tue 3/10/26
1.10.1.2.1.271		Weekly Project Status Reporting 271	1 day	Tue 3/17/26	Tue 3/17/26
1.10.1.2.1.272		Weekly Project Status Reporting 272	1 day	Tue 3/24/26	Tue 3/24/26
1.10.1.2.1.273		Weekly Project Status Reporting 273	1 day	Tue 3/31/26	Tue 3/31/26
1.10.1.2.1.274		Weekly Project Status Reporting 274	1 day	Tue 4/7/26	Tue 4/7/26
1.10.1.2.1.275		Weekly Project Status Reporting 275	1 day	Tue 4/14/26	Tue 4/14/26
1.10.1.2.1.276		Weekly Project Status Reporting 276	1 day	Tue 4/21/26	Tue 4/21/26
1.10.1.2.1.277		Weekly Project Status Reporting 277	1 day	Tue 4/28/26	Tue 4/28/26
1.10.1.2.1.278		Weekly Project Status Reporting 278	1 day	Tue 5/5/26	Tue 5/5/26
1.10.1.2.1.279		Weekly Project Status Reporting 279	1 day	Tue 5/12/26	Tue 5/12/26

1.10.1.2.1.280		Weekly Project Status Reporting 280	1 day	Tue 5/19/26	Tue 5/19/26
1.10.1.2.1.281		Weekly Project Status Reporting 281	1 day	Tue 5/26/26	Tue 5/26/26
1.10.1.2.1.282		Weekly Project Status Reporting 282	1 day	Tue 6/2/26	Tue 6/2/26
1.10.1.2.1.283		Weekly Project Status Reporting 283	1 day	Tue 6/9/26	Tue 6/9/26
1.10.1.2.1.284		Weekly Project Status Reporting 284	1 day	Tue 6/16/26	Tue 6/16/26
1.10.1.2.1.285		Weekly Project Status Reporting 285	1 day	Tue 6/23/26	Tue 6/23/26
1.10.1.2.1.286		Weekly Project Status Reporting 286	1 day	Tue 6/30/26	Tue 6/30/26
1.10.1.2.1.287		Weekly Project Status Reporting 287	1 day	Tue 7/7/26	Tue 7/7/26
1.10.1.2.1.288		Weekly Project Status Reporting 288	1 day	Tue 7/14/26	Tue 7/14/26
1.10.1.2.1.289		Weekly Project Status Reporting 289	1 day	Tue 7/21/26	Tue 7/21/26
1.10.1.2.1.290		Weekly Project Status Reporting 290	1 day	Tue 7/28/26	Tue 7/28/26
1.10.1.2.1.291		Weekly Project Status Reporting 291	1 day	Tue 8/4/26	Tue 8/4/26
1.10.1.2.1.292		Weekly Project Status Reporting 292	1 day	Tue 8/11/26	Tue 8/11/26
1.10.1.2.1.293		Weekly Project Status Reporting 293	1 day	Tue 8/18/26	Tue 8/18/26
1.10.1.2.1.294		Weekly Project Status Reporting 294	1 day	Tue 8/25/26	Tue 8/25/26
1.10.1.2.1.295		Weekly Project Status Reporting 295	1 day	Tue 9/1/26	Tue 9/1/26
1.10.1.2.1.296		Weekly Project Status Reporting 296	1 day	Tue 9/8/26	Tue 9/8/26
1.10.1.2.1.297		Weekly Project Status Reporting 297	1 day	Tue 9/15/26	Tue 9/15/26
1.10.1.2.1.298		Weekly Project Status Reporting 298	1 day	Tue 9/22/26	Tue 9/22/26
1.10.1.2.1.299		Weekly Project Status Reporting 299	1 day	Tue 9/29/26	Tue 9/29/26
1.10.1.2.1.300		Weekly Project Status Reporting 300	1 day	Tue 10/6/26	Tue 10/6/26
1.10.1.2.1.301		Weekly Project Status Reporting 301	1 day	Tue 10/13/26	Tue 10/13/26
1.10.1.2.1.302		Weekly Project Status Reporting 302	1 day	Tue 10/20/26	Tue 10/20/26
1.10.1.2.1.303		Weekly Project Status Reporting 303	1 day	Tue 10/27/26	Tue 10/27/26
1.10.1.2.1.304		Weekly Project Status Reporting 304	1 day	Tue 11/3/26	Tue 11/3/26
1.10.1.2.1.305		Weekly Project Status Reporting 305	1 day	Tue 11/10/26	Tue 11/10/26
1.10.1.2.1.306		Weekly Project Status Reporting 306	1 day	Tue 11/17/26	Tue 11/17/26
1.10.1.2.1.307		Weekly Project Status Reporting 307	1 day	Tue 11/24/26	Tue 11/24/26
1.10.1.2.1.308		Weekly Project Status Reporting 308	1 day	Tue 12/1/26	Tue 12/1/26
1.10.1.2.1.309		Weekly Project Status Reporting 309	1 day	Tue 12/8/26	Tue 12/8/26
1.10.1.2.1.310		Weekly Project Status Reporting 310	1 day	Tue 12/15/26	Tue 12/15/26
1.10.1.2.1.311		Weekly Project Status Reporting 311	1 day	Tue 12/22/26	Tue 12/22/26
1.10.1.2.1.312		Weekly Project Status Reporting 312	1 day	Tue 12/29/26	Tue 12/29/26
1.10.1.2.2		**Monthly Project Status Reporting**	**1485 days**	**Wed 2/3/21**	**Mon 1/4/27**
1.10.1.2.2.1		Monthly Project Status Reporting 1	1 day	Wed 2/3/21	Wed 2/3/21
1.10.1.2.2.2		Monthly Project Status Reporting 2	1 day	Wed 3/3/21	Wed 3/3/21
1.10.1.2.2.3		Monthly Project Status Reporting 3	1 day	Wed 4/7/21	Wed 4/7/21
1.10.1.2.2.4		Monthly Project Status Reporting 4	1 day	Wed 5/5/21	Wed 5/5/21
1.10.1.2.2.5		Monthly Project Status Reporting 5	1 day	Wed 6/2/21	Wed 6/2/21
1.10.1.2.2.6		Monthly Project Status Reporting 6	1 day	Wed 7/7/21	Wed 7/7/21
1.10.1.2.2.7		Monthly Project Status Reporting 7	1 day	Wed 8/4/21	Wed 8/4/21
1.10.1.2.2.8		Monthly Project Status Reporting 8	1 day	Wed 9/1/21	Wed 9/1/21
1.10.1.2.2.9		Monthly Project Status Reporting 9	1 day	Wed 10/6/21	Wed 10/6/21
1.10.1.2.2.10		Monthly Project Status Reporting 10	1 day	Wed 11/3/21	Wed 11/3/21
1.10.1.2.2.11		Monthly Project Status Reporting 11	1 day	Wed 12/1/21	Wed 12/1/21
1.10.1.2.2.12		Monthly Project Status Reporting 12	1 day	Wed 1/5/22	Wed 1/5/22
1.10.1.2.2.13		Monthly Project Status Reporting 13	1 day	Wed 2/2/22	Wed 2/2/22
1.10.1.2.2.14		Monthly Project Status Reporting 14	1 day	Wed 3/2/22	Wed 3/2/22
1.10.1.2.2.15		Monthly Project Status Reporting 15	1 day	Wed 4/6/22	Wed 4/6/22
1.10.1.2.2.16		Monthly Project Status Reporting 16	1 day	Wed 5/4/22	Wed 5/4/22
1.10.1.2.2.17		Monthly Project Status Reporting 17	1 day	Wed 6/1/22	Wed 6/1/22
1.10.1.2.2.18		Monthly Project Status Reporting 18	1 day	Wed 7/6/22	Wed 7/6/22
1.10.1.2.2.19		Monthly Project Status Reporting 19	1 day	Wed 8/3/22	Wed 8/3/22
1.10.1.2.2.20		Monthly Project Status Reporting 20	1 day	Wed 9/7/22	Wed 9/7/22
1.10.1.2.2.21		Monthly Project Status Reporting 21	1 day	Wed 10/5/22	Wed 10/5/22
1.10.1.2.2.22		Monthly Project Status Reporting 22	1 day	Wed 11/2/22	Wed 11/2/22
1.10.1.2.2.23		Monthly Project Status Reporting 23	1 day	Wed 12/7/22	Wed 12/7/22
1.10.1.2.2.24		Monthly Project Status Reporting 24	1 day	Wed 1/4/23	Wed 1/4/23
1.10.1.2.2.25		Monthly Project Status Reporting 25	1 day	Wed 2/1/23	Wed 2/1/23
1.10.1.2.2.26		Monthly Project Status Reporting 26	1 day	Wed 3/1/23	Wed 3/1/23
1.10.1.2.2.27		Monthly Project Status Reporting 27	1 day	Wed 4/5/23	Wed 4/5/23
1.10.1.2.2.28		Monthly Project Status Reporting 28	1 day	Wed 5/3/23	Wed 5/3/23
1.10.1.2.2.29		Monthly Project Status Reporting 29	1 day	Wed 6/7/23	Wed 6/7/23
1.10.1.2.2.30		Monthly Project Status Reporting 30	1 day	Wed 7/5/23	Wed 7/5/23
1.10.1.2.2.31		Monthly Project Status Reporting 31	1 day	Wed 8/2/23	Wed 8/2/23
1.10.1.2.2.32		Monthly Project Status Reporting 32	1 day	Wed 9/6/23	Wed 9/6/23
1.10.1.2.2.33		Monthly Project Status Reporting 33	1 day	Wed 10/4/23	Wed 10/4/23
1.10.1.2.2.34		Monthly Project Status Reporting 34	1 day	Wed 11/1/23	Wed 11/1/23
1.10.1.2.2.35		Monthly Project Status Reporting 35	1 day	Wed 12/6/23	Wed 12/6/23
1.10.1.2.2.36		Monthly Project Status Reporting 36	1 day	Wed 1/3/24	Wed 1/3/24
1.10.1.2.2.37		Monthly Project Status Reporting 37	1 day	Wed 2/7/24	Wed 2/7/24
1.10.1.2.2.38		Monthly Project Status Reporting 38	1 day	Wed 3/6/24	Wed 3/6/24

1.10.1.2.2.39		Monthly Project Status Reporting 39	1 day	Wed 4/3/24	Wed 4/3/24		
1.10.1.2.2.40		Monthly Project Status Reporting 40	1 day	Wed 5/1/24	Wed 5/1/24		
1.10.1.2.2.41		Monthly Project Status Reporting 41	1 day	Wed 6/5/24	Wed 6/5/24		
1.10.1.2.2.42		Monthly Project Status Reporting 42	1 day	Wed 7/3/24	Wed 7/3/24		
1.10.1.2.2.43		Monthly Project Status Reporting 43	1 day	Wed 8/7/24	Wed 8/7/24		
1.10.1.2.2.44		Monthly Project Status Reporting 44	1 day	Wed 9/4/24	Wed 9/4/24		
1.10.1.2.2.45		Monthly Project Status Reporting 45	1 day	Wed 10/2/24	Wed 10/2/24		
1.10.1.2.2.46		Monthly Project Status Reporting 46	1 day	Wed 11/6/24	Wed 11/6/24		
1.10.1.2.2.47		Monthly Project Status Reporting 47	1 day	Wed 12/4/24	Wed 12/4/24		
1.10.1.2.2.48		Monthly Project Status Reporting 48	1 day	Thu 1/2/25	Thu 1/2/25		
1.10.1.2.2.49		Monthly Project Status Reporting 49	1 day	Wed 2/5/25	Wed 2/5/25		
1.10.1.2.2.50		Monthly Project Status Reporting 50	1 day	Wed 3/5/25	Wed 3/5/25		
1.10.1.2.2.51		Monthly Project Status Reporting 51	1 day	Wed 4/2/25	Wed 4/2/25		
1.10.1.2.2.52		Monthly Project Status Reporting 52	1 day	Wed 5/7/25	Wed 5/7/25		
1.10.1.2.2.53		Monthly Project Status Reporting 53	1 day	Wed 6/4/25	Wed 6/4/25		
1.10.1.2.2.54		Monthly Project Status Reporting 54	1 day	Wed 7/2/25	Wed 7/2/25		
1.10.1.2.2.55		Monthly Project Status Reporting 55	1 day	Wed 8/6/25	Wed 8/6/25		
1.10.1.2.2.56		Monthly Project Status Reporting 56	1 day	Wed 9/3/25	Wed 9/3/25		
1.10.1.2.2.57		Monthly Project Status Reporting 57	1 day	Wed 10/1/25	Wed 10/1/25		
1.10.1.2.2.58		Monthly Project Status Reporting 58	1 day	Wed 11/5/25	Wed 11/5/25		
1.10.1.2.2.59		Monthly Project Status Reporting 59	1 day	Wed 12/3/25	Wed 12/3/25		
1.10.1.2.2.60		Monthly Project Status Reporting 60	1 day	Wed 1/7/26	Wed 1/7/26		
1.10.1.2.2.61		Monthly Project Status Reporting 61	1 day	Wed 2/4/26	Wed 2/4/26		
1.10.1.2.2.62		Monthly Project Status Reporting 62	1 day	Wed 3/4/26	Wed 3/4/26		
1.10.1.2.2.63		Monthly Project Status Reporting 63	1 day	Wed 4/1/26	Wed 4/1/26		
1.10.1.2.2.64		Monthly Project Status Reporting 64	1 day	Wed 5/6/26	Wed 5/6/26		
1.10.1.2.2.65		Monthly Project Status Reporting 65	1 day	Wed 6/3/26	Wed 6/3/26		
1.10.1.2.2.66		Monthly Project Status Reporting 66	1 day	Wed 7/1/26	Wed 7/1/26		
1.10.1.2.2.67		Monthly Project Status Reporting 67	1 day	Wed 8/5/26	Wed 8/5/26		
1.10.1.2.2.68		Monthly Project Status Reporting 68	1 day	Wed 9/2/26	Wed 9/2/26		
1.10.1.2.2.69		Monthly Project Status Reporting 69	1 day	Wed 10/7/26	Wed 10/7/26		
1.10.1.2.2.70		Monthly Project Status Reporting 70	1 day	Wed 11/4/26	Wed 11/4/26		
1.10.1.2.2.71		Monthly Project Status Reporting 71	1 day	Wed 12/2/26	Wed 12/2/26		
1.10.1.2.2.72		Monthly Project Status Reporting 72	1 day	Mon 1/4/27	Mon 1/4/27		
1.10.1.3	**5.3.**	**D069 Risk Register/Exception Plan**	**15 days**	**Mon 4/5/21**	**Mon 4/26/21**		
1.10.1.3.1	5.3.	Review D069 Risk Register/Exception Plan Requirements	0.25 days	Mon 4/5/21	Mon 4/5/21	1095	Account BA
1.10.1.3.2	5.3.	Create Draft D069 Risk Register/Exception Plan	3 days	Mon 4/5/21	Thu 4/8/21	1650	Account BA
1.10.1.3.3	5.3.	Conduct Internal Work Product Review of D069 Risk Register/Exception Plan	1 day	Thu 4/8/21	Fri 4/9/21	1651	Account BA
1.10.1.3.4	5.3.	Revise Draft D069 Risk Register/Exception Plan based on Internal Review	2 days	Fri 4/9/21	Tue 4/13/21	1652	Account BA,Account Quality Mgr
1.10.1.3.5	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
1.10.1.3.6	5.3.	Conduct Work Product Review with Client of Draft D069 Risk Register/Exception Plan	0.25 days	Tue 4/13/21	Tue 4/13/21	1654	Client Project Mgr[25%],Account Proj Mgr[25%]
1.10.1.3.7	5.3.	DHHR and Stakeholders Conducts Review of Draft D069 Risk Register/Exception Plan	5 days	Wed 4/14/21	Tue 4/20/21	1655	Account BA,Account Quality Mgr,Client Project Mgr,Client SME
1.10.1.3.8	5.3.	Walkthrough Client Deliverable Review Comments	0.25 days	Wed 4/21/21	Wed 4/21/21	1656	Client Project Mgr,Client SME
1.10.1.3.9	5.3.	Revise D069 Risk Register/Exception Plan based on Client Review	2 days	Wed 4/21/21	Fri 4/23/21	1657	Account BA[50%],Account Quality Mgr[50%],Client Project Mgr[50%],Client SME[50%]
1.10.1.3.10	5.3.	Distribute Updated D069 Risk Register/Exception Plan to Client for Approval	0.25 days	Fri 4/23/21	Fri 4/23/21	1658	Account BA[25%]
1.10.1.3.11	5.3.	DHHR and Stakeholders Conducts Review of Revisions to D069 Risk Register/Exception Plan	1 day	Fri 4/23/21	Mon 4/26/21	1659	Account Quality Mgr[20%]
1.10.1.3.12	[illegible]	[illegible]stone - Client Approves D069 Risk Register/Exception Plan	[illegible]	[illegible]	[illegible]	1660	Client Project Mgr,Client SME
1.10.1.4	**5.4.**	**D070 Updated Project Management Components**	**1230 days**	**Mon 2/7/22**	**Mon 1/4/27**		
1.10.1.4.1		**Update Project Management Components at Least Annually**	**1230 days**	**Mon 2/7/22**	**Mon 1/4/27**		
1.10.1.4.1.1		Update Project Management Components at Least Annually 1	1 day	Mon 2/7/22	Mon 2/7/22		
1.10.1.4.1.2		Update Project Management Components at Least Annually 2	1 day	Mon 2/6/23	Mon 2/6/23		
1.10.1.4.1.3		Update Project Management Components at Least Annually 3	1 day	Mon 2/5/24	Mon 2/5/24		
1.10.1.4.1.4		Update Project Management Components at Least Annually 4	1 day	Mon 2/3/25	Mon 2/3/25		
1.10.1.4.1.5		Update Project Management Components at Least Annually 5	1 day	Mon 2/2/26	Mon 2/2/26		
1.10.1.4.1.6		Update Project Management Components at Least Annually 6	1 day	Mon 1/4/27	Mon 1/4/27		
1.10.1.5	**5.5.**	**D071 Updated Requirements Traceability Matrix**	**1254 days**	**Mon 1/3/22**	**Mon 1/4/27**		
1.10.1.5.1		**Review and Update RTM at Least Annually**	**1254 days**	**Mon 1/3/22**	**Mon 1/4/27**		
1.10.1.5.1.1		Review and Update RTM at Least Annually 1	1 day	Mon 1/3/22	Mon 1/3/22		
1.10.1.5.1.2		Review and Update RTM at Least Annually 2	1 day	Mon 1/2/23	Mon 1/2/23		
1.10.1.5.1.3		Review and Update RTM at Least Annually 3	1 day	Tue 1/2/24	Tue 1/2/24		
1.10.1.5.1.4		Review and Update RTM at Least Annually 4	1 day	Mon 1/6/25	Mon 1/6/25		
1.10.1.5.1.5		Review and Update RTM at Least Annually 5	1 day	Mon 1/5/26	Mon 1/5/26		
1.10.1.5.1.6		Review and Update RTM at Least Annually 6	1 day	Mon 1/4/27	Mon 1/4/27		
1.10.1.6	**5.6.**	**D072 Updated Training Management Plan**	**1230 days**	**Mon 2/7/22**	**Mon 1/4/27**		
1.10.1.6.1		**Review and Update Training Plan at Least Annually**	**1230 days**	**Mon 2/7/22**	**Mon 1/4/27**		
1.10.1.6.1.1		Review and Update Training Plan at Least Annually 1	1 day	Mon 2/7/22	Mon 2/7/22		
1.10.1.6.1.2		Review and Update Training Plan at Least Annually 2	1 day	Mon 2/6/23	Mon 2/6/23		
1.10.1.6.1.3		Review and Update Training Plan at Least Annually 3	1 day	Mon 2/5/24	Mon 2/5/24		
1.10.1.6.1.4		Review and Update Training Plan at Least Annually 4	1 day	Mon 2/3/25	Mon 2/3/25		
1.10.1.6.1.5		Review and Update Training Plan at Least Annually 5	1 day	Mon 2/2/26	Mon 2/2/26		
1.10.1.6.1.6		Review and Update Training Plan at Least Annually 6	1 day	Mon 1/4/27	Mon 1/4/27		

1.10.1.7	**5.7.**	**D073 Contract Monitoring Overview Meeting**	**1489 days**	**Tue 1/5/21**	**Mon 12/7/26**
1.10.1.7.1		**Monthly Contract Monitoring Meeting**	**1489 days**	**Tue 1/5/21**	**Mon 12/7/26**
1.10.1.7.1.1		Monthly Contract Monitoring Meeting 1	1 day	Tue 1/5/21	Tue 1/5/21
1.10.1.7.1.2		Monthly Contract Monitoring Meeting 2	1 day	Fri 2/5/21	Fri 2/5/21
1.10.1.7.1.3		Monthly Contract Monitoring Meeting 3	1 day	Fri 3/5/21	Fri 3/5/21
1.10.1.7.1.4		Monthly Contract Monitoring Meeting 4	1 day	Mon 4/5/21	Mon 4/5/21
1.10.1.7.1.5		Monthly Contract Monitoring Meeting 5	1 day	Wed 5/5/21	Wed 5/5/21
1.10.1.7.1.6		Monthly Contract Monitoring Meeting 6	1 day	Mon 6/7/21	Mon 6/7/21
1.10.1.7.1.7		Monthly Contract Monitoring Meeting 7	1 day	Mon 7/5/21	Mon 7/5/21
1.10.1.7.1.8		Monthly Contract Monitoring Meeting 8	1 day	Thu 8/5/21	Thu 8/5/21
1.10.1.7.1.9		Monthly Contract Monitoring Meeting 9	1 day	Tue 9/7/21	Tue 9/7/21
1.10.1.7.1.10		Monthly Contract Monitoring Meeting 10	1 day	Tue 10/5/21	Tue 10/5/21
1.10.1.7.1.11		Monthly Contract Monitoring Meeting 11	1 day	Fri 11/5/21	Fri 11/5/21
1.10.1.7.1.12		Monthly Contract Monitoring Meeting 12	1 day	Mon 12/6/21	Mon 12/6/21
1.10.1.7.1.13		Monthly Contract Monitoring Meeting 13	1 day	Wed 1/5/22	Wed 1/5/22
1.10.1.7.1.14		Monthly Contract Monitoring Meeting 14	1 day	Mon 2/7/22	Mon 2/7/22
1.10.1.7.1.15		Monthly Contract Monitoring Meeting 15	1 day	Mon 3/7/22	Mon 3/7/22
1.10.1.7.1.16		Monthly Contract Monitoring Meeting 16	1 day	Tue 4/5/22	Tue 4/5/22
1.10.1.7.1.17		Monthly Contract Monitoring Meeting 17	1 day	Thu 5/5/22	Thu 5/5/22
1.10.1.7.1.18		Monthly Contract Monitoring Meeting 18	1 day	Mon 6/6/22	Mon 6/6/22
1.10.1.7.1.19		Monthly Contract Monitoring Meeting 19	1 day	Tue 7/5/22	Tue 7/5/22
1.10.1.7.1.20		Monthly Contract Monitoring Meeting 20	1 day	Fri 8/5/22	Fri 8/5/22
1.10.1.7.1.21		Monthly Contract Monitoring Meeting 21	1 day	Tue 9/6/22	Tue 9/6/22
1.10.1.7.1.22		Monthly Contract Monitoring Meeting 22	1 day	Wed 10/5/22	Wed 10/5/22
1.10.1.7.1.23		Monthly Contract Monitoring Meeting 23	1 day	Mon 11/7/22	Mon 11/7/22
1.10.1.7.1.24		Monthly Contract Monitoring Meeting 24	1 day	Mon 12/5/22	Mon 12/5/22
1.10.1.7.1.25		Monthly Contract Monitoring Meeting 25	1 day	Thu 1/5/23	Thu 1/5/23
1.10.1.7.1.26		Monthly Contract Monitoring Meeting 26	1 day	Mon 2/6/23	Mon 2/6/23
1.10.1.7.1.27		Monthly Contract Monitoring Meeting 27	1 day	Mon 3/6/23	Mon 3/6/23
1.10.1.7.1.28		Monthly Contract Monitoring Meeting 28	1 day	Wed 4/5/23	Wed 4/5/23
1.10.1.7.1.29		Monthly Contract Monitoring Meeting 29	1 day	Fri 5/5/23	Fri 5/5/23
1.10.1.7.1.30		Monthly Contract Monitoring Meeting 30	1 day	Mon 6/5/23	Mon 6/5/23
1.10.1.7.1.31		Monthly Contract Monitoring Meeting 31	1 day	Wed 7/5/23	Wed 7/5/23
1.10.1.7.1.32		Monthly Contract Monitoring Meeting 32	1 day	Mon 8/7/23	Mon 8/7/23
1.10.1.7.1.33		Monthly Contract Monitoring Meeting 33	1 day	Tue 9/5/23	Tue 9/5/23
1.10.1.7.1.34		Monthly Contract Monitoring Meeting 34	1 day	Thu 10/5/23	Thu 10/5/23
1.10.1.7.1.35		Monthly Contract Monitoring Meeting 35	1 day	Mon 11/6/23	Mon 11/6/23
1.10.1.7.1.36		Monthly Contract Monitoring Meeting 36	1 day	Tue 12/5/23	Tue 12/5/23
1.10.1.7.1.37		Monthly Contract Monitoring Meeting 37	1 day	Fri 1/5/24	Fri 1/5/24
1.10.1.7.1.38		Monthly Contract Monitoring Meeting 38	1 day	Mon 2/5/24	Mon 2/5/24
1.10.1.7.1.39		Monthly Contract Monitoring Meeting 39	1 day	Tue 3/5/24	Tue 3/5/24
1.10.1.7.1.40		Monthly Contract Monitoring Meeting 40	1 day	Fri 4/5/24	Fri 4/5/24
1.10.1.7.1.41		Monthly Contract Monitoring Meeting 41	1 day	Mon 5/6/24	Mon 5/6/24
1.10.1.7.1.42		Monthly Contract Monitoring Meeting 42	1 day	Wed 6/5/24	Wed 6/5/24
1.10.1.7.1.43		Monthly Contract Monitoring Meeting 43	1 day	Fri 7/5/24	Fri 7/5/24
1.10.1.7.1.44		Monthly Contract Monitoring Meeting 44	1 day	Mon 8/5/24	Mon 8/5/24
1.10.1.7.1.45		Monthly Contract Monitoring Meeting 45	1 day	Thu 9/5/24	Thu 9/5/24
1.10.1.7.1.46		Monthly Contract Monitoring Meeting 46	1 day	Mon 10/7/24	Mon 10/7/24
1.10.1.7.1.47		Monthly Contract Monitoring Meeting 47	1 day	Tue 11/5/24	Tue 11/5/24
1.10.1.7.1.48		Monthly Contract Monitoring Meeting 48	1 day	Thu 12/5/24	Thu 12/5/24
1.10.1.7.1.49		Monthly Contract Monitoring Meeting 49	1 day	Mon 1/6/25	Mon 1/6/25
1.10.1.7.1.50		Monthly Contract Monitoring Meeting 50	1 day	Wed 2/5/25	Wed 2/5/25
1.10.1.7.1.51		Monthly Contract Monitoring Meeting 51	1 day	Wed 3/5/25	Wed 3/5/25
1.10.1.7.1.52		Monthly Contract Monitoring Meeting 52	1 day	Mon 4/7/25	Mon 4/7/25
1.10.1.7.1.53		Monthly Contract Monitoring Meeting 53	1 day	Mon 5/5/25	Mon 5/5/25
1.10.1.7.1.54		Monthly Contract Monitoring Meeting 54	1 day	Thu 6/5/25	Thu 6/5/25
1.10.1.7.1.55		Monthly Contract Monitoring Meeting 55	1 day	Mon 7/7/25	Mon 7/7/25
1.10.1.7.1.56		Monthly Contract Monitoring Meeting 56	1 day	Tue 8/5/25	Tue 8/5/25
1.10.1.7.1.57		Monthly Contract Monitoring Meeting 57	1 day	Fri 9/5/25	Fri 9/5/25
1.10.1.7.1.58		Monthly Contract Monitoring Meeting 58	1 day	Mon 10/6/25	Mon 10/6/25
1.10.1.7.1.59		Monthly Contract Monitoring Meeting 59	1 day	Wed 11/5/25	Wed 11/5/25
1.10.1.7.1.60		Monthly Contract Monitoring Meeting 60	1 day	Fri 12/5/25	Fri 12/5/25
1.10.1.7.1.61		Monthly Contract Monitoring Meeting 61	1 day	Mon 1/5/26	Mon 1/5/26
1.10.1.7.1.62		Monthly Contract Monitoring Meeting 62	1 day	Thu 2/5/26	Thu 2/5/26
1.10.1.7.1.63		Monthly Contract Monitoring Meeting 63	1 day	Thu 3/5/26	Thu 3/5/26
1.10.1.7.1.64		Monthly Contract Monitoring Meeting 64	1 day	Mon 4/6/26	Mon 4/6/26
1.10.1.7.1.65		Monthly Contract Monitoring Meeting 65	1 day	Tue 5/5/26	Tue 5/5/26
1.10.1.7.1.66		Monthly Contract Monitoring Meeting 66	1 day	Fri 6/5/26	Fri 6/5/26
1.10.1.7.1.67		Monthly Contract Monitoring Meeting 67	1 day	Mon 7/6/26	Mon 7/6/26
1.10.1.7.1.68		Monthly Contract Monitoring Meeting 68	1 day	Wed 8/5/26	Wed 8/5/26
1.10.1.7.1.69		Monthly Contract Monitoring Meeting 69	1 day	Tue 9/8/26	Tue 9/8/26
1.10.1.7.1.70		Monthly Contract Monitoring Meeting 70	1 day	Mon 10/5/26	Mon 10/5/26

1.10.1.7.1.71		Monthly Contract Monitoring Meeting 71	1 day	Thu 11/5/26	Thu 11/5/26	
1.10.1.7.1.72		Monthly Contract Monitoring Meeting 72	1 day	Mon 12/7/26	Mon 12/7/26	
1.10.1.8		Milestone -Task Group 5 - Deliverables Complete	0 days	Mon 1/4/27	Mon 1/4/27	##########
1.10.1.9	5	Payment Milestone: Monthly Implementation Project Management Invoice (recurring deliverables D067 through D073).	0 days	Mon 1/4/21	Mon 1/4/21	
1.10.1.10		Monthly Implementation Project Management Invoice	1483 days	Fri 2/5/21	Mon 1/4/27	
1.10.1.10.1		Monthly Implementation Project Management Invoice 1	1 day	Fri 2/5/21	Fri 2/5/21	
1.10.1.10.2		Monthly Implementation Project Management Invoice 2	1 day	Fri 3/5/21	Fri 3/5/21	
1.10.1.10.3		Monthly Implementation Project Management Invoice 3	1 day	Mon 4/5/21	Mon 4/5/21	
1.10.1.10.4		Monthly Implementation Project Management Invoice 4	1 day	Wed 5/5/21	Wed 5/5/21	
1.10.1.10.5		Monthly Implementation Project Management Invoice 5	1 day	Mon 6/7/21	Mon 6/7/21	
1.10.1.10.6		Monthly Implementation Project Management Invoice 6	1 day	Mon 7/5/21	Mon 7/5/21	
1.10.1.10.7		Monthly Implementation Project Management Invoice 7	1 day	Thu 8/5/21	Thu 8/5/21	
1.10.1.10.8		Monthly Implementation Project Management Invoice 8	1 day	Tue 9/7/21	Tue 9/7/21	
1.10.1.10.9		Monthly Implementation Project Management Invoice 9	1 day	Tue 10/5/21	Tue 10/5/21	
1.10.1.10.10		Monthly Implementation Project Management Invoice 10	1 day	Fri 11/5/21	Fri 11/5/21	
1.10.1.10.11		Monthly Implementation Project Management Invoice 11	1 day	Mon 12/6/21	Mon 12/6/21	
1.10.1.10.12		Monthly Implementation Project Management Invoice 12	1 day	Wed 1/5/22	Wed 1/5/22	
1.10.1.10.13		Monthly Implementation Project Management Invoice 13	1 day	Mon 2/7/22	Mon 2/7/22	
1.10.1.10.14		Monthly Implementation Project Management Invoice 14	1 day	Mon 3/7/22	Mon 3/7/22	
1.10.1.10.15		Monthly Implementation Project Management Invoice 15	1 day	Tue 4/5/22	Tue 4/5/22	
1.10.1.10.16		Monthly Implementation Project Management Invoice 16	1 day	Thu 5/5/22	Thu 5/5/22	
1.10.1.10.17		Monthly Implementation Project Management Invoice 17	1 day	Mon 6/6/22	Mon 6/6/22	
1.10.1.10.18		Monthly Implementation Project Management Invoice 18	1 day	Tue 7/5/22	Tue 7/5/22	
1.10.1.10.19		Monthly Implementation Project Management Invoice 19	1 day	Fri 8/5/22	Fri 8/5/22	
1.10.1.10.20		Monthly Implementation Project Management Invoice 20	1 day	Tue 9/6/22	Tue 9/6/22	
1.10.1.10.21		Monthly Implementation Project Management Invoice 21	1 day	Wed 10/5/22	Wed 10/5/22	
1.10.1.10.22		Monthly Implementation Project Management Invoice 22	1 day	Mon 11/7/22	Mon 11/7/22	
1.10.1.10.23		Monthly Implementation Project Management Invoice 23	1 day	Mon 12/5/22	Mon 12/5/22	
1.10.1.10.24		Monthly Implementation Project Management Invoice 24	1 day	Thu 1/5/23	Thu 1/5/23	
1.10.1.10.25		Monthly Implementation Project Management Invoice 25	1 day	Mon 2/6/23	Mon 2/6/23	
1.10.1.10.26		Monthly Implementation Project Management Invoice 26	1 day	Mon 3/6/23	Mon 3/6/23	
1.10.1.10.27		Monthly Implementation Project Management Invoice 27	1 day	Wed 4/5/23	Wed 4/5/23	
1.10.1.10.28		Monthly Implementation Project Management Invoice 28	1 day	Fri 5/5/23	Fri 5/5/23	
1.10.1.10.29		Monthly Implementation Project Management Invoice 29	1 day	Mon 6/5/23	Mon 6/5/23	
1.10.1.10.30		Monthly Implementation Project Management Invoice 30	1 day	Wed 7/5/23	Wed 7/5/23	
1.10.1.10.31		Monthly Implementation Project Management Invoice 31	1 day	Mon 8/7/23	Mon 8/7/23	
1.10.1.10.32		Monthly Implementation Project Management Invoice 32	1 day	Tue 9/5/23	Tue 9/5/23	
1.10.1.10.33		Monthly Implementation Project Management Invoice 33	1 day	Thu 10/5/23	Thu 10/5/23	
1.10.1.10.34		Monthly Implementation Project Management Invoice 34	1 day	Mon 11/6/23	Mon 11/6/23	
1.10.1.10.35		Monthly Implementation Project Management Invoice 35	1 day	Tue 12/5/23	Tue 12/5/23	
1.10.1.10.36		Monthly Implementation Project Management Invoice 36	1 day	Fri 1/5/24	Fri 1/5/24	
1.10.1.10.37		Monthly Implementation Project Management Invoice 37	1 day	Mon 2/5/24	Mon 2/5/24	
1.10.1.10.38		Monthly Implementation Project Management Invoice 38	1 day	Tue 3/5/24	Tue 3/5/24	
1.10.1.10.39		Monthly Implementation Project Management Invoice 39	1 day	Fri 4/5/24	Fri 4/5/24	
1.10.1.10.40		Monthly Implementation Project Management Invoice 40	1 day	Mon 5/6/24	Mon 5/6/24	
1.10.1.10.41		Monthly Implementation Project Management Invoice 41	1 day	Wed 6/5/24	Wed 6/5/24	
1.10.1.10.42		Monthly Implementation Project Management Invoice 42	1 day	Fri 7/5/24	Fri 7/5/24	
1.10.1.10.43		Monthly Implementation Project Management Invoice 43	1 day	Mon 8/5/24	Mon 8/5/24	
1.10.1.10.44		Monthly Implementation Project Management Invoice 44	1 day	Thu 9/5/24	Thu 9/5/24	
1.10.1.10.45		Monthly Implementation Project Management Invoice 45	1 day	Mon 10/7/24	Mon 10/7/24	
1.10.1.10.46		Monthly Implementation Project Management Invoice 46	1 day	Tue 11/5/24	Tue 11/5/24	
1.10.1.10.47		Monthly Implementation Project Management Invoice 47	1 day	Thu 12/5/24	Thu 12/5/24	
1.10.1.10.48		Monthly Implementation Project Management Invoice 48	1 day	Mon 1/6/25	Mon 1/6/25	
1.10.1.10.49		Monthly Implementation Project Management Invoice 49	1 day	Wed 2/5/25	Wed 2/5/25	
1.10.1.10.50		Monthly Implementation Project Management Invoice 50	1 day	Wed 3/5/25	Wed 3/5/25	
1.10.1.10.51		Monthly Implementation Project Management Invoice 51	1 day	Mon 4/7/25	Mon 4/7/25	
1.10.1.10.52		Monthly Implementation Project Management Invoice 52	1 day	Mon 5/5/25	Mon 5/5/25	
1.10.1.10.53		Monthly Implementation Project Management Invoice 53	1 day	Thu 6/5/25	Thu 6/5/25	
1.10.1.10.54		Monthly Implementation Project Management Invoice 54	1 day	Mon 7/7/25	Mon 7/7/25	
1.10.1.10.55		Monthly Implementation Project Management Invoice 55	1 day	Tue 8/5/25	Tue 8/5/25	
1.10.1.10.56		Monthly Implementation Project Management Invoice 56	1 day	Fri 9/5/25	Fri 9/5/25	
1.10.1.10.57		Monthly Implementation Project Management Invoice 57	1 day	Mon 10/6/25	Mon 10/6/25	
1.10.1.10.58		Monthly Implementation Project Management Invoice 58	1 day	Wed 11/5/25	Wed 11/5/25	
1.10.1.10.59		Monthly Implementation Project Management Invoice 59	1 day	Fri 12/5/25	Fri 12/5/25	
1.10.1.10.60		Monthly Implementation Project Management Invoice 60	1 day	Mon 1/5/26	Mon 1/5/26	
1.10.1.10.61		Monthly Implementation Project Management Invoice 61	1 day	Thu 2/5/26	Thu 2/5/26	
1.10.1.10.62		Monthly Implementation Project Management Invoice 62	1 day	Thu 3/5/26	Thu 3/5/26	
1.10.1.10.63		Monthly Implementation Project Management Invoice 63	1 day	Mon 4/6/26	Mon 4/6/26	
1.10.1.10.64		Monthly Implementation Project Management Invoice 64	1 day	Tue 5/5/26	Tue 5/5/26	
1.10.1.10.65		Monthly Implementation Project Management Invoice 65	1 day	Fri 6/5/26	Fri 6/5/26	
1.10.1.10.66		Monthly Implementation Project Management Invoice 66	1 day	Mon 7/6/26	Mon 7/6/26	
1.10.1.10.67		Monthly Implementation Project Management Invoice 67	1 day	Wed 8/5/26	Wed 8/5/26	

1.10.1.10.68		Monthly Implementation Project Management Invoice 68	1 day	Tue 9/8/26	Tue 9/8/26		
1.10.1.10.69		Monthly Implementation Project Management Invoice 69	1 day	Mon 10/5/26	Mon 10/5/26		
1.10.1.10.70		Monthly Implementation Project Management Invoice 70	1 day	Thu 11/5/26	Thu 11/5/26		
1.10.1.10.71		Monthly Implementation Project Management Invoice 71	1 day	Mon 12/7/26	Mon 12/7/26		
1.10.1.10.72		Monthly Implementation Project Management Invoice 72	1 day	Mon 1/4/27	Mon 1/4/27		
1.11		Milestone - Task Group 5: Project Monitor and Control (Recurring Deliverables) Complete	0 days	Mon 1/4/27	Mon 1/4/27	17,601,762	
1.12	MR043, MR044	CMS MES Certification	TBD	TBD	TBD		
1.12.1	MR043, MR044	Certification Startup	TBD	TBD	TBD		
1.12.1.1	MR043, MR044	Determine which certification checklists and criteria are applicable	TBD	TBD	TBD		Account Certification Lead,Client Operations Manager
1.12.1.2	MR043, MR044	Assign owners to each criteria & determine due dates	TBD	TBD	TBD		Account Certification Lead[20%],Acct Business Lead - SME[20%],HMS Project Mgr[20%]
1.12.1.3	MR043, MR044	Create template for evidence files	TBD	TBD	TBD		Account Certification Lead
1.12.1.4	MR043, MR044	Complete Repository	TBD	TBD	TBD		
1.12.1.4.1	MR043, MR044	Setup HMS Certification Repository	TBD	TBD	TBD		Account Certification Lead,HMS Repository Admin,Acct Business Lead - SME
1.12.1.4.2	MR043, MR044	Provide access to HMS Certification Repository	TBD	TBD	TBD		Account Certification Lead
1.12.2	MR043, MR044	CMS R2 Review Activities (ORR)	TBD	TBD	TBD		
1.12.2.1	MR043, MR044	Create and Review R2 Evidence Documents	TBD	TBD	TBD		
1.12.2.1.1	MR043, MR044	Populate R2 validation and artifacts in template	TBD	TBD	TBD		HMS Assigned Owners
1.12.2.1.2	MR043, MR044	Review R2 Evidence Documents	TBD	TBD	TBD		Account Certification Lead
1.12.2.1.3	MR043, MR044	Review / Update R2 Evidence Documentation	TBD	TBD	TBD		HMS Assigned Owners,Client Operations Manager
1.12.2.1.4	MR043, MR044	Approval of R2 Evidence Documents	TBD	TBD	TBD		Client Operations Manager
1.12.2.1.5	MR043, MR044	Create R2 Checklists	TBD	TBD	TBD		Account Certification Lead
1.12.2.1.6	MR043, MR044	DHHR Review of R2 Checklists	TBD	TBD	TBD		
1.12.2.1.7	MR043, MR044	DHHR Sends R2 Checklists	TBD	TBD	TBD		
1.12.2.2	MR043, MR044	Complete R2 Milestone	TBD	TBD	TBD		
1.12.2.2.1	MR043, MR044	Determine R2 Logistics	TBD	TBD	TBD		Account Certification Lead,Client Operations Manager
1.12.2.2.2	MR043, MR044	Create Presentations for R2	TBD	TBD	TBD		HMS Assigned Owners,Client Operations Manager
1.12.2.2.3	MR043, MR044	Practice R2 Presentation	TBD	TBD	TBD		HMS Assigned Owners,Client Operations Manager
1.12.2.2.4	MR043, MR044	Complete R2 Meeting(s) (CMS Onsite Review)	TBD	TBD	TBD		HMS Assigned Owners,CMS Personnel[200%],Client Operations Manager
1.12.2.2.5	MR043, MR044	Milestone - R2 Certification Meeting Complete	TBD	TBD	TBD		
1.12.2.3	MR043, MR044	Complete R2 Corrective Action	TBD	TBD	TBD		
1.12.2.3.1	MR043, MR044	Get R2 feedback from CMS/DHHR	TBD	TBD	TBD		Client Operations Manager
1.12.2.3.2	MR043, MR044	Identify DXC R2 Corrective Action tasks	TBD	TBD	TBD		Account Certification Lead,Client Operations Manager
1.12.2.3.3	MR043, MR044	Complete DXC Corrective Action tasks	TBD	TBD	TBD		HMS Assigned Owners
1.12.2.3.4	MR043, MR044	Approval for R2 Corrective Actions	TBD	TBD	TBD		Client Operations Manager
1.12.3	MR043, MR044	CMS R3 Review Activities (CMS Certification Final Review)	TBD	TBD	TBD		
1.12.3.1	MR043, MR044	Create and Review R3 Evidence Documents	TBD	TBD	TBD		
1.12.3.1.1	MR043, MR044	Populate R3 validation and artifacts in template	TBD	TBD	TBD		HMS Assigned Owners
1.12.3.1.2	MR043, MR044	Review R3 Evidence Documents	TBD	TBD	TBD		Account Certification Lead
1.12.3.1.3	MR043, MR044	Review / Update R3 Evidence Documentation	TBD	TBD	TBD		HMS Assigned Owners,Client Operations Manager
1.12.3.1.4	MR043, MR044	Approval of R3 Evidence Documents	TBD	TBD	TBD		Client Operations Manager
1.12.3.1.5	MR043, MR044	Update Checklists for R3	TBD	TBD	TBD		Account Certification Lead
1.12.3.1.6	MR043, MR044	DHHR Review of R3 Checklists	TBD	TBD	TBD		
1.12.3.1.7	MR043, MR044	DHHR Sends R3 Checklists	TBD	TBD	TBD		
1.12.3.2	MR043, MR044	Complete R3 Milestone	TBD	TBD	TBD		
1.12.3.2.1	MR043, MR044	Send Certification R3 request letter to CMS	TBD	TBD	TBD		Client Operations Manager
1.12.3.2.2	MR043, MR044	Determine R3 Logistics - Setup Meetings	TBD	TBD	TBD		Account Certification Lead,Client Operations Manager
1.12.3.2.3	MR043, MR044	Create Presentations for R3	TBD	TBD	TBD		HMS Assigned Owners,Client Operations Manager
1.12.3.2.4	MR043, MR044	Practice R3 Presentation	TBD	TBD	TBD		HMS Assigned Owners,Client Operations Manager
1.12.3.2.5	MR043, MR044	Dry Run #1	TBD	TBD	TBD		HMS Assigned Owners,Client Operations Manager
1.12.3.2.6	MR043, MR044	Updates and Practice	TBD	TBD	TBD		HMS Assigned Owners,Client Operations Manager
1.12.3.2.7	MR043, MR044	Dry Run #2	TBD	TBD	TBD		HMS Assigned Owners,Client Operations Manager
1.12.3.2.8	MR043, MR044	Updates and Practice	TBD	TBD	TBD		Account Certification Lead
1.12.3.2.9	MR043, MR044	Send R3 Material	TBD	TBD	TBD		HMS Assigned Owners,CMS Personnel[200%],Client Operations Manager
1.12.3.2.10	MR043, MR044	Complete R3 Certification Meeting(s) (CMS Onsite Review)	TBD	TBD	TBD		
1.12.3.2.11	MR043, MR044	Milestone - R3 Certification Meeting Complete	TBD	TBD	TBD		
1.12.4	MR043, MR044	Certification Completion	TBD	TBD	TBD		
1.12.4.1	MR043, MR044	Certification Lessons Learned	TBD	TBD	TBD		
1.12.4.1.1	MR043, MR044	Document Lessons Learned for Certification	TBD	TBD	TBD		Account Certification Lead
1.12.4.2	MR043, MR044	Action Items and Follow Up Questions	TBD	TBD	TBD		
1.12.4.2.1	MR043, MR044	Complete all action items and follow up questions from CMS	TBD	TBD	TBD		Account Certification Lead,Client Operations Manager
1.12.4.3	MR043, MR044	Certification Report	TBD	TBD	TBD		
1.12.4.3.1	MR043, MR044	Send Certification Report to DHHR	TBD	TBD	TBD		CMS Personnel
1.12.4.3.2	MR043, MR044	Complete any requests/findings	TBD	TBD	TBD		Account Certification Lead,Client Operations Manager
1.13	MR043, MR044	Milestone - Certification Acceptance and Completion	TBD	TBD	TBD		
1.14		Optional Program Activities	63 days	Mon 1/4/21	Fri 4/2/21		
1.14.1		Premium Reimbursement Program(s)	63 days	Mon 1/4/21	Fri 4/2/21		
1.14.1.1		Task Group 1 & 2: Sub-Project Initiation and Solution Planning	14 days	Mon 1/4/21	Fri 1/22/21		
1.14.1.1.1		Phase 1 Project Start Up	14 days	Mon 1/4/21	Fri 1/22/21		

1.14.1.1.1.1		Prepare and Schedule the Formal Kickoff Meeting	1 day	Mon 1/4/21	Mon 1/4/21		3
1.14.1.1.1.2		Create and Publish the Project Charter	5 days	Mon 1/4/21	Fri 1/8/21		3
1.14.1.1.1.3		Conduct the Formal Kickoff Meeting	1 day	Tue 1/5/21	Tue 1/5/21		1898
1.14.1.1.1.4		Determine Approval Process	1 day	Tue 1/5/21	Tue 1/5/21	1900SS	
1.14.1.1.1.5		Perform Requirements Analysis	6 days	Wed 1/6/21	Wed 1/13/21		1900
1.14.1.1.1.6		Update and Publish Project Plans, Project Schedule/Project Work Plan, and other project Strategy documents	5 days	Mon 1/11/21	Fri 1/15/21	3FS+5 days	
1.14.1.1.1.7		Determine resource needs (HMS, BMS, other)	2 days	Thu 1/21/21	Fri 1/22/21		1908
1.14.1.1.1.8		Establish the Date and Time for Weekly Project Status Calls	1 day	Tue 1/5/21	Tue 1/5/21	1900SS	
1.14.1.1.1.9		Establish Schedules for Executive Status Reporting and Phase-Gate Reviews	1 day	Tue 1/5/21	Tue 1/5/21	1900SS	
1.14.1.1.1.10		Agree on Methods to Acquire/Onboard Client Data	1 day	Tue 1/5/21	Tue 1/5/21	1900SS	
1.14.1.1.1.11		Update RTM and Other Documentation	4 days	Thu 1/14/21	Wed 1/20/21		1902
1.14.1.2		Task Group 3: Solution Design, Testing, and Operational Readiness	45 days	Thu 1/14/21	Fri 3/19/21		
1.14.1.2.1		Phase 2 Data Analysis and Design	15 days	Thu 1/14/21	Thu 2/4/21		
1.14.1.2.1.1		Perform Regulatory Research	5 days	Thu 1/21/21	Wed 1/27/21		1908
1.14.1.2.1.2		Conduct Data Mining Analysis	5 days	Thu 1/14/21	Thu 1/21/21	1908SS	
1.14.1.2.1.3		Perform Design Activities	10 days	Fri 1/22/21	Thu 2/4/21		1912
1.14.1.2.2		Phase 3 Configuration	10 days	Fri 2/5/21	Fri 2/19/21		
1.14.1.2.2.1		Perform Configuration and Unit Test	10 days	Fri 2/5/21	Fri 2/19/21		1913
1.14.1.2.3		Phase 4 & 5 Testing	20 days	Mon 2/22/21	Fri 3/19/21		
1.14.1.2.3.1		Perform System Testing	5 days	Mon 2/22/21	Fri 2/26/21		1915
1.14.1.2.3.2		Perform Integration Testing	5 days	Mon 3/1/21	Fri 3/5/21		1917
1.14.1.2.3.3		Perform Performance Testing	5 days	Mon 3/1/21	Fri 3/5/21	1918SS	
1.14.1.2.3.4		Perform Proof of Concept Testing (UAT)	5 days	Mon 3/8/21	Fri 3/12/21		1919
1.14.1.2.3.5		Perform Operational Readiness Testing	5 days	Mon 3/15/21	Fri 3/19/21		1920
1.14.1.3		Task Group 4: Solution Deployment	10 days	Mon 3/22/21	Fri 4/2/21		
1.14.1.3.1		Phase 6 Deployment	10 days	Mon 3/22/21	Fri 4/2/21		
1.14.1.3.1.1		Perform Deployment Activities	10 days	Mon 3/22/21	Fri 4/2/21		1921
1.14.1.3.1.2		Milestone: Go-Live	0 days	Fri 4/2/21	Fri 4/2/21		1924
1.14.2		Work Incentive/Premium Program(s)	63 days	Mon 1/4/21	Fri 4/2/21		
1.14.2.1		Task Group 1 & 2: Sub-Project Initiation and Solution Planning	13 days	Mon 1/4/21	Thu 1/21/21		
1.14.2.1.1		Phase 1 Project Start Up	13 days	Mon 1/4/21	Thu 1/21/21		
1.14.2.1.1.1		Prepare and Schedule the Formal Kickoff Meeting	1 day	Mon 1/4/21	Mon 1/4/21		3
1.14.2.1.1.2		Create and Publish the Project Charter	5 days	Mon 1/4/21	Fri 1/8/21		3
1.14.2.1.1.3		Conduct the Formal Kickoff Meeting	1 day	Tue 1/5/21	Tue 1/5/21		1929
1.14.2.1.1.4		Determine Approval Process	1 day	Tue 1/5/21	Tue 1/5/21	1931SS	
1.14.2.1.1.5		Perform Requirements Analysis	6 days	Wed 1/6/21	Wed 1/13/21		1931
1.14.2.1.1.6		Update and Publish Project Plans, Project Schedule/Project Work Plan, and other project Strategy documents	5 days	Mon 1/11/21	Fri 1/15/21	3FS+5 days	
1.14.2.1.1.7		Determine resource needs (HMS, BMS, other)	2 days	Wed 1/20/21	Thu 1/21/21		1939
1.14.2.1.1.8		Establish the Date and Time for Weekly Project Status Calls	1 day	Tue 1/5/21	Tue 1/5/21	1931SS	
1.14.2.1.1.9		Establish Schedules for Executive Status Reporting and Phase-Gate Reviews	1 day	Tue 1/5/21	Tue 1/5/21	1931SS	
1.14.2.1.1.10		Agree on Methods to Acquire/Onboard Client Data	1 day	Tue 1/5/21	Tue 1/5/21	1931SS	
1.14.2.1.1.11		Update RTM and Other Documentation	3 days	Thu 1/14/21	Tue 1/19/21		1933
1.14.2.2		Task Group 3: Solution Design, Testing, and Operational Readiness	45 days	Thu 1/14/21	Fri 3/19/21		
1.14.2.2.1		Phase 2 Data Analysis and Design	15 days	Thu 1/14/21	Thu 2/4/21		
1.14.2.2.1.1		Perform Regulatory Research	5 days	Wed 1/20/21	Tue 1/26/21		1939
1.14.2.2.1.2		Conduct Data Mining Analysis	5 days	Thu 1/14/21	Thu 1/21/21	1939SS	
1.14.2.2.1.3		Perform Design Activities	10 days	Fri 1/22/21	Thu 2/4/21		1943
1.14.2.2.2		Phase 3 Configuration	10 days	Fri 2/5/21	Fri 2/15/21		
1.14.2.2.2.1		Perform Configuration and Unit Test	10 days	Fri 2/5/21	Fri 2/19/21		1944
1.14.2.2.3		Phase 4 & 5 Testing	20 days	Mon 2/22/21	Fri 3/19/21		
1.14.2.2.3.1		Perform System Testing	5 days	Mon 2/22/21	Fri 2/26/21		1946
1.14.2.2.3.2		Perform Integration Testing	5 days	Mon 3/1/21	Fri 3/5/21		1948
1.14.2.2.3.3		Perform Performance Testing	5 days	Mon 3/1/21	Fri 3/5/21	1949SS	
1.14.2.2.3.4		Perform Proof of Concept Testing (UAT)	5 days	Mon 3/8/21	Fri 3/12/21		1950
1.14.2.2.3.5		Perform Operational Readiness Testing	5 days	Mon 3/15/21	Fri 3/19/21		1951
1.14.2.3		Task Group 4: Solution Deployment	10 days	Mon 3/22/21	Fri 4/2/21		
1.14.2.3.1		Phase 6 Deployment	10 days	Mon 3/22/21	Fri 4/2/21		
1.14.2.3.1.1		Perform Deployment Activities	10 days	Mon 3/22/21	Fri 4/2/21		1952
1.14.2.3.1.2		Milestone: Go-Live	0 days	Fri 4/2/21	Fri 4/2/21		1955
1.14.3		Medicare Buy-In program	63 days	Mon 1/4/21	Fri 4/2/21		
1.14.3.1		Task Group 1 & 2: Sub-Project Initiation and Solution Planning	13 days	Mon 1/4/21	Thu 1/21/21		
1.14.3.1.1		Phase 1 Project Start Up	13 days	Mon 1/4/21	Thu 1/21/21		
1.14.3.1.1.1		Prepare and Schedule the Formal Kickoff Meeting	1 day	Mon 1/4/21	Mon 1/4/21		3
1.14.3.1.1.2		Create and Publish the Project Charter	5 days	Mon 1/4/21	Fri 1/8/21		3
1.14.3.1.1.3		Conduct the Formal Kickoff Meeting	1 day	Tue 1/5/21	Tue 1/5/21		1960
1.14.3.1.1.4		Determine Approval Process	1 day	Tue 1/5/21	Tue 1/5/21	1962SS	
1.14.3.1.1.5		Perform Requirements Analysis	6 days	Wed 1/6/21	Wed 1/13/21		1962
1.14.3.1.1.6		Update and Publish Project Plans, Project Schedule/Project Work Plan, and other project Strategy documents	5 days	Mon 1/11/21	Fri 1/15/21	3FS+5 days	
1.14.3.1.1.7		Determine resource needs (HMS, BMS, other)	2 days	Wed 1/20/21	Thu 1/21/21		1970
1.14.3.1.1.8		Establish the Date and Time for Weekly Project Status Calls	1 day	Tue 1/5/21	Tue 1/5/21	1962SS	
1.14.3.1.1.9		Establish Schedules for Executive Status Reporting and Phase-Gate Reviews	1 day	Tue 1/5/21	Tue 1/5/21	1962SS	
1.14.3.1.1.10		Agree on Methods to Acquire/Onboard Client Data	1 day	Tue 1/5/21	Tue 1/5/21	1962SS	

1.14.3.1.1.11	Update RTM and Other Documentation	3 days	Thu 1/14/21	Tue 1/19/21		1964
1.14.3.2	**Task Group 3: Solution Design, Testing, and Operational Readiness**	**45 days**	**Thu 1/14/21**	**Fri 3/19/21**		
1.14.3.2.1	**Phase 2 Data Analysis and Design**	**15 days**	**Thu 1/14/21**	**Thu 2/4/21**		
1.14.3.2.1.1	Perform Regulatory Research	5 days	Wed 1/20/21	Tue 1/26/21		1970
1.14.3.2.1.2	Conduct Data Mining Analysis	5 days	Thu 1/14/21	Thu 1/21/21	1970SS	
1.14.3.2.1.3	Perform Design Activities	10 days	Fri 1/22/21	Thu 2/4/21		1974
1.14.3.2.2	**Phase 3 Configuration**	**10 days**	**Fri 2/5/21**	**Fri 2/19/21**		
1.14.3.2.2.1	Perform Configuration and Unit Test	10 days	Fri 2/5/21	Fri 2/19/21		1975
1.14.3.2.3	**Phase 4 & 5 Testing**	**20 days**	**Mon 2/22/21**	**Fri 3/19/21**		
1.14.3.2.3.1	Perform System Testing	5 days	Mon 2/22/21	Fri 2/26/21		1977
1.14.3.2.3.2	Perform Integration Testing	5 days	Mon 3/1/21	Fri 3/5/21		1979
1.14.3.2.3.3	Perform Performance Testing	5 days	Mon 3/1/21	Fri 3/5/21	1980SS	
1.14.3.2.3.4	Perform Proof of Concept Testing (UAT)	5 days	Mon 3/8/21	Fri 3/12/21		1981
1.14.3.2.3.5	Perform Operational Readiness Testing	5 days	Mon 3/15/21	Fri 3/19/21		1982
1.14.3.3	**Task Group 4: Solution Deployment**	**10 days**	**Mon 3/22/21**	**Fri 4/2/21**		
1.14.3.3.1	**Phase 6 Deployment**	**10 days**	**Mon 3/22/21**	**Fri 4/2/21**		
1.14.3.3.1.1	Perform Deployment Activities	10 days	Mon 3/22/21	Fri 4/2/21		1983
1.14.3.3.1.2	Milestone: Go-Live	0 days	Fri 4/2/21	Fri 4/2/21		1984
1.14.4	**RAC program**	**63 days**	**Mon 1/4/21**	**Fri 4/2/21**		
1.14.4.1	**Task Group 1 & 2: Sub-Project Initiation and Solution Planning**	**13 days**	**Mon 1/4/21**	**Thu 1/21/21**		
1.14.4.1.1	**Phase 1 Project Start Up**	**13 days**	**Mon 1/4/21**	**Thu 1/21/21**		
1.14.4.1.1.1	Prepare and Schedule the Formal Kickoff Meeting	1 day	Mon 1/4/21	Mon 1/4/21		3
1.14.4.1.1.2	Create and Publish the Project Charter	5 days	Mon 1/4/21	Fri 1/8/21		3
1.14.4.1.1.3	Conduct the Formal Kickoff Meeting	1 day	Tue 1/5/21	Tue 1/5/21		1991
1.14.4.1.1.4	Determine Approval Process	1 day	Tue 1/5/21	Tue 1/5/21	1993SS	
1.14.4.1.1.5	Perform Requirements Analysis	6 days	Wed 1/6/21	Wed 1/13/21		1993
1.14.4.1.1.6	Update and Publish Project Plans, Project Schedule/Project Work Plan, and other project Strategy documents	5 days	Mon 1/11/21	Fri 1/15/21	3FS+5 days	
1.14.4.1.1.7	Determine resource needs (HMS, BMS, other)	2 days	Wed 1/20/21	Thu 1/21/21		2001
1.14.4.1.1.8	Establish the Date and Time for Weekly Project Status Calls	1 day	Tue 1/5/21	Tue 1/5/21	1993SS	
1.14.4.1.1.9	Establish Schedules for Executive Status Reporting and Phase-Gate Reviews	1 day	Tue 1/5/21	Tue 1/5/21	1993SS	
1.14.4.1.1.10	Agree on Methods to Acquire/Onboard Client Data	1 day	Tue 1/5/21	Tue 1/5/21	1993SS	
1.14.4.1.1.11	Update RTM and Other Documentation	3 days	Thu 1/14/21	Tue 1/19/21		1995
1.14.4.2	**Task Group 3: Solution Design, Testing, and Operational Readiness**	**45 days**	**Thu 1/14/21**	**Fri 3/19/21**		
1.14.4.2.1	**Phase 2 Data Analysis and Design**	**15 days**	**Thu 1/14/21**	**Thu 2/4/21**		
1.14.4.2.1.1	Perform Regulatory Research	5 days	Wed 1/20/21	Tue 1/26/21		2001
1.14.4.2.1.2	Conduct Data Mining Analysis	5 days	Thu 1/14/21	Thu 1/21/21	2001SS	
1.14.4.2.1.3	Perform Design Activities	10 days	Fri 1/22/21	Thu 2/4/21		2005
1.14.4.2.2	**Phase 3 Configuration**	**10 days**	**Fri 2/5/21**	**Fri 2/19/21**		
1.14.4.2.2.1	Perform Configuration and Unit Test	10 days	Fri 2/5/21	Fri 2/19/21		2006
1.14.4.2.3	**Phase 4 & 5 Testing**	**20 days**	**Mon 2/22/21**	**Fri 3/19/21**		
1.14.4.2.3.1	Perform System Testing	5 days	Mon 2/22/21	Fri 2/26/21		2008
1.14.4.2.3.2	Perform Integration Testing	5 days	Mon 3/1/21	Fri 3/5/21		2010
1.14.4.2.3.3	Perform Performance Testing	5 days	Mon 3/1/21	Fri 3/5/21	2011SS	
1.14.4.2.3.4	Perform Proof of Concept Testing (UAT)	5 days	Mon 3/8/21	Fri 3/12/21		2012
1.14.4.2.3.5	Perform Operational Readiness Testing	5 days	Mon 3/15/21	Fri 3/19/21		2013
1.14.4.3	**Task Group 4: Solution Deployment**	**10 days**	**Mon 3/22/21**	**Fri 4/2/21**		
1.14.4.3.1	**Phase 6 Deployment**	**10 days**	**Mon 3/22/21**	**Fri 4/2/21**		
1.14.4.3.1.1	Perform Deployment Activities	10 days	Mon 3/22/21	Fri 4/2/21		2014
1.14.4.3.1.2	Milestone: Go-Live	0 days	Fri 4/2/21	Fri 4/2/21		2017

6.0 MANDATORY REQUIREMENTS

HMS affirms that we meet or exceed all mandatory requirements, set forth in RFP Attachment 6: Mandatory Requirements, or as amended in Addendum 4. In **Exhibit 6-1** below, we provide our response to each mandatory requirement and indicate where we exceed a specific requirement. We also provide the proposal Section where more information can be found regarding our approach and methodologies.

Exhibit 6-1 HMS' Mandatory Requirements Response

HMS affirms we meet or exceed all mandatory requirements, set forth in RFP Attachment 6 or as amended in Addendum 4.

Req ID #	RFP Mandatory Requirement	HMS Response	Proposal Section for More Information
MR001	The Vendor must design the Third-Party Liability (TPL) solution to support the current and future Medicaid Information Technology Architecture (MITA) goals for the Bureau as defined in the Bureau's MITA State Self-Assessment (SS-A) (https://www.medicaid.gov/medicaid/data-and-systems/mita/index.html).	**HMS complies and meets this mandatory requirement.** We recognize that the Medicaid environment is dynamic and that we need to be flexible. HMS has designed our TPL solution to support BMS' current and future goals. We are well-positioned to support BMS with any such forthcoming MMIS migration and/or MES transformation initiatives during the new contract. Over the past three decades HMS has successfully interfaced with Medicaid Management Information Systems (MMISs), including WV's, to deliver our TPL services. We have also worked with our Medicaid TPL clients as many transitioned from one MMIS vendor to another. We have also designed our solutions to align with modularity and MITA. We have prepared our TPL platform and solutions to be fully compliant with the Certification process for other states. Our supporting systems are already MITA-aligned and meet the Medicaid Enterprise Certification Toolkit (MECT) 2.3 checklist requirements.	5.0
MR002	The Vendor must agree that the Bureau retains ownership of all data, procedures, applications, licenses, and all materials developed during design, development, and implementation (DDI) and operations, as well as the licensing for installed commercial off-the-shelf (COTS) software in alignment with 45 Code of Federal Regulation (CFR) §95.615 (https://ecfr.io/Title-45/se45.1.95_1615) and 45 CFR §95.617 (https://ecfr.io/Title-45/se45.1.95_1617). Manufacturers' support and maintenance for the COTS software licensing subsequent to the initial install must be provided only for the life of the contract. The Bureau will not issue change orders related to software cost increases.	**HMS complies and meets this mandatory requirement.**	
MR003	The Vendor must provide a software and hardware solution that is upgradeable and expandable to meet the Bureau's current and future needs.	**HMS complies and meets this mandatory requirement.** We keep flexibility in mind when designing our TPL solutions. We know system components, comprised of both software and hardware, need to be both scalable and upgradeable to meet current and future needs of BMS in a highly dynamic Medicaid environment.	7.3.5

Req ID #	RFP Mandatory Requirement	HMS Response	Proposal Section for More Information
MR004	The Vendor must be responsible for all expenses required to obtain and maintain access to the Bureau's systems. Such expenses include, but are not limited to, hardware, software, network infrastructure, and any licensing costs.	**HMS complies and meets this mandatory requirement.**	
MR005	The Vendor must have the capability to interface with necessary computer systems in specified formats necessary to accomplish third-party recoveries.	**HMS complies and meets this mandatory requirement.** We currently exchange numerous files back and forth with BMS – daily, weekly, and monthly. This is handled through established interfaces with the MMIS, specifically import and extract files transmitted through secure file transfer protocol (SFTP). We also maintain write-access to the MMIS TPL screens in order to interface and update TPL policy information real-time when an escalation occurs.	7.1.6
MR006	The Vendor must provide an automated means of updating the Medicaid Management Information System (MMIS) file with new complete Third-Party Liability (TPL) information within the timeframes specified by the Bureau.	**HMS complies and meets this mandatory requirement.** We affirm that we currently provide an automated means of updating the MMIS file with new complete TPL information within the timeframe specified by BMS. When HMS sends the file to the State, in our weekly deliverable or through our COB on Demand process, the WV Fiscal Agent has the process scheduled to kick off automatically and update the MMIS, once the information is received.	7.1.6
MR007	The Vendor must operate a Technical Support Call Center that is located within the continental United States, as established in requirements related to handling of Federal Tax Information (FTI) contained in Internal Revenue Service (IRS) Publication 1075 (https://www.irs.gov/pub/irs-pdf/p1075.pdf), Section 5.3 Access to FTI via State Tax Files or through other agencies under the authority granted by United States Code §6013(p)(4)(C) (https://www.govinfo.gov/content/pkg/USCODE-2011-title26/html/USCODE-2011-title26-subtitleF-chap61.htm).	**HMS complies and meets this mandatory requirement.** We have a Technical Support Help Desk available between the hours of 7:00 a.m. to 7:00 p.m. Eastern time, excluding national holidays, and on an emergency basis as requested. Located within the continental United States, we provide this technical support to BMS-authorized solution users who report a technical problem, require assistance with developing or running queries and reports, and/or require assistance utilizing the TPL solution. We keep BMS staff informed of the status of active technical issues through to resolution and will continue to openly communicate with BMS in the upcoming contract.	7.1.1 7.2.3

Req ID #	RFP Mandatory Requirement	HMS Response	Proposal Section for More Information
MR008	The Vendor must ensure that all applications inclusive of internet, intranet, and extranet applications associated with this contract are compliant with Section 508 of the Rehabilitation Act of 1973, as amended by 29 U.S. Code §794d (https://www.govinfo.gov/app/details/USCODE-2011-title29/USCODE-2011-title29-chap16-subchapV-sec794d), and 36 Code of Federal Regulation (CFR) 1194.21 and 36 CFR 1194.22 (https://www.ecfr.gov/cgi-bin/text-idx?SID=0c6038b2b0f453ef6ac2d78411eda5a4&mc=true&node=pt36.3.1194&rgn=div5#se36.3.1194_11).	**HMS complies and meets this mandatory requirement.**	
MR009	The Vendor must safeguard information obtained from and exchanged with other agencies and stakeholders in accordance with requirements in 42 Code of Federal Regulation (CFR) Subpart F – Safeguarding Information on Applicants and Beneficiaries (https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5&node=42:1.0.1.4.23).	**HMS complies and meets this mandatory requirement.** We affirm our understanding that we must safeguard information obtained from and exchanged with other agencies and stakeholders. Our protocols include secure handling of BMS data while in transit, in transit, at rest, and when archived.	7.5.0 7.5.2
MR010	The Vendor must comply with all federal and state laws, regulations, policies and procedures regarding Third-Party Liability (https://ecfr.io/Title-42/sp42.4.433.d).	**HMS complies and meets this mandatory requirement.** Our dedicated Government Relations team not only apprises us of current and relevant State and federal laws and regulations that govern TPL processes including the Deficit Reduction Act of 2005 (DRA), but also keeps us apprised of amendments and proposed legislation that may impact our TPL clients and solutions.	7.1.0
MR011	The Vendor's solution must maintain full Health Insurance Portability and Accountability Act (HIPAA) compliance throughout the life of the contract at no additional cost to the Bureau (https://www.hhs.gov/hipaa/for-professionals/privacy/index.html).	**HMS complies and meets this mandatory requirement.** We affirm that our solution will maintain full HIPAA compliance throughout the life of the contract at no additional cost to BMS. As part of our Information Security Policy, HMS has protocols in place for how we actively address privacy and protect personal health information (PHI) and other confidential information for clients. Our HITRUST certification, which we currently maintain, encompasses the following frameworks: ◉ Health Information Technology for Economic and Clinical Health (HITECH) (enacted February 17, 2009) ◉ Health Insurance Portability and Accountability Act (HIPAA) (Public Law 104–191, 110 Statute 1936, enacted August 21, 1996) ◉ HIPAA Security Rule	7.5.0 7.5.2

Req ID #	RFP Mandatory Requirement	HMS Response	Proposal Section for More Information
MR012	The Vendor must comply with the baseline security controls for moderate impact information systems as recommended by the National Institute of Standards and Technology (NIST) Special Publication (SP) 800-61 guidance (https://csrc.nist.gov/publications/detail/sp/800-61/rev-2/final), Code of Federal Regulations (CFR), and Centers for Medicare and Medicaid Services (CMS) (https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/InformationSecurity/index.html).	**HMS complies and meets this mandatory requirement.** As a healthcare services company, HMS is required to maintain a secure processing environment that meets or exceeds the standards of our state, federal, and commercial clients. HMS maintains an industry-compliant, National Institute of Standards and Technology (NIST)-based Security Plan that meets the guidance provided by the Centers for Medicare & Medicaid Services (CMS).	7.5.2
MR013	The Vendor must ensure that data entered, maintained, or generated to meet the requirements of this Request for Proposal (RFP) is retained and/or accessible according to the federal requirements in 45 Code of Federal Regulation (CFR) Part 75 (https://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75) and/or applicable State and/or federal requirements.	**HMS complies and meets this mandatory requirement.**	
MR014	The Vendor must agree to incorporate all requirements mandated through federal (https://ecfr.io/Title-42/sp42.4.433.d) and State regulations and legislation (http://www.wvlegislature.gov/wvcode/chapterentire.cfm?chap=9&art=5&section=11), including new reporting requirements. The Vendor must ensure that the Third-Party Liability (TPL) solution is current in its ability to accept and employ new standards and requirements as they occur. Formalized change control will be used for all such changes, during all phases of the project, as defined in the Change Management Plan.	**HMS complies and meets this mandatory requirement.** We ensure that our solution continues to adhere to all applicable state and federal laws and regulations that govern TPL processes. HMS affirms that we will incorporate all requirements mandated through federal and State regulation and legislation. HMS has purposely designed our processes and systems to retain the flexibility to accommodate these changes, and we proactively work to help ensure we are ready for any new requirements. HMS follows standard practices, based on Project Management Institute principles and CMS guidelines, for managing and implementing change, which we tailor to individual client projects as appropriate. To support our practice, we will maintain a Change Management Plan, which helps provide direction for managing our change control process and documents the roles and responsibilities of the various resources involved in the process. This Plan will be provided to BMS with the overall Project Management Plan.	7.1.0 7.3.4 7.3.0

Req ID #	RFP Mandatory Requirement	HMS Response	Proposal Section for More Information
MR015	The Vendor must not publish or copyright any data using the Bureau's name or logo without prior written approval by the Bureau for every instance. In addition, the Vendor must not publicly distribute any documents, whether finished or unfinished, without prior written approval. Except with respect to any commercial software, the Bureau will be and remain the owner of all data provided to the Bureau by the Vendor or its agents, subcontractors, or representatives pursuant to the contract other than the Vendor's internal administrative procedure records.	**HMS complies and meets this mandatory requirement.**	
MR016	Vendors proposing commercial off-the-shelf (COTS) components must develop all documentation necessary to support the receipt of federal match related to the implementation of the component, upon request by the Bureau (https://www.ecfr.gov/cgi-bin/text-idx?SID=0a0f2c4293fbf2710236e235ea7ee699&mc=true&node=se42.4.433_110&rgn=div8).	**HMS complies and meets this mandatory requirement.**	
MR017	The Vendor must comply with 45 Code of Federal Regulation (CFR) 95.617 - Software and Ownership Rights (https://www.ecfr.gov/cgi-bin/text-idx?SID=f24e840d26cda6373cf54e57380d9663&mc=true&node=pt45.1.95&rgn=div5#se45.1.95_1617)	**HMS complies and meets this mandatory requirement.**	

Req ID #	RFP Mandatory Requirement	HMS Response	Proposal Section for More Information
MR018	Prior to the start of the contract, the Vendor must enter into and maintain trading partner agreements with insurers that provide major medical, pharmacy, vision, dental, Medicare Health Maintenance Organization (HMO), and/or Medicare supplemental coverage. These trading partner agreements will allow the Vendor to receive commercial insurance coverage information for members that they insure in accordance with Department, State (https://dhhr.wv.gov/bms/CMS/SMP/Pages/WV-State-Medicaid-Plan.aspx), and federal requirements (https://www.congress.gov/bill/109th-congress/senate-bill/1932).	**HMS complies and exceeds this mandatory requirement.** Under our current contract with BMS, HMS has existing data usage agreements (DUAs) and receives eligibility data from insurance carriers covering more than 97% of WV's insured residents. Our data sharing network extends well beyond the top commercial insurance carriers in WV and also includes specialty sources of healthcare coverage eligibility, including: local, regional, and national commercial payors including minor coverage (pharmacy, vision, dental); TPAs; PBMs; and federal programs such as TRICARE and Medicare. We continue to maintain these carrier relationships, and our dedicated Carrier Relations team works closely with carriers to negotiate and implement new DUAs.	7.1.6
MR019	The Vendor must provide compliance support services to include providing up-to-date documentation and reporting for regulatory and State compliance auditing.	**HMS complies and meets this mandatory requirement.** We affirm our understanding that we must provide compliance support services, including up-to-date documentation and reporting, to BMS for regulatory and State compliance auditing purposes. For all scopes of work, we have established tracking and record-keeping system features and processes that enable us to document and report recoveries in accordance with BMS and CMS requirements.	
MR020	The Vendor must make available to the Bureau the results of any third-party audit conducted on the Vendor's organization, including, but not limited to, Service Organization Control (SOC) 2.	**HMS complies and meets this mandatory requirement.** An independent, third-party organization conducts an annual SOC 2® audit on HMS. Our most recent report covers the period from January 1, 2019 through December 31, 2019, which we can provide to BMS upon request.	7.5.2
MR021	The Vendor must adhere to and support all security risks, standards, policies, and procedures of the Bureau, State, and the West Virginia Office of Technology (WVOT). The Vendor must ensure compatibility with the most current WVOT supported versions and standards (https://www.wvdhhr.org/mis/policies.asp), (https://technology.wv.gov/security/Pages/policies-issued-by-the-cto.aspx).	**HMS complies and meets this mandatory requirement.**	

Req ID #	RFP Mandatory Requirement	HMS Response	Proposal Section for More Information
MR022	The Vendor must be responsible for any lost recoveries due to system deficiencies or deficiencies noted during federal reviews. The Vendor shall be responsible for only the portion of a recovery lost that is determined by the Bureau to be the fault of the Vendor.	**HMS complies and meets this mandatory requirement.**	
MR023	The Vendor staff must not access, edit, disclose, or use protected information data, with unauthorized users or in an unauthorized manner, in accordance with Department, State, and federal requirements. This data includes, but is not limited to, Protected Health Information (PHI), Personally Identifiable Information (PII), Federal Tax Information (FTI), and Social Security Information (SSI).	**HMS complies and meets this mandatory requirement.** We have numerous logical and security controls (including monitoring of physical and system access), architecture, and processes in place to reduce or mitigate risk and safeguard the data our clients entrust to use, including but not limited to, PHI, PII, FTI, and SSI.	7.5.0 7.5.2
MR024	The Vendor must immediately replace any of its personnel who refuse to sign a required confidentiality agreement, acknowledgment form, or non-disclosure agreement, or to undergo a fingerprint-based background check (if applicable). When the Vendor performs services under this contract that require the Vendor and subcontractor personnel to access facilities, data, or systems that the Bureau in its sole discretion deems sensitive, the Bureau will require the Vendor and subcontractor personnel with such access to sign individual confidentiality agreements, non-disclosure agreements, and policy acknowledgements before accessing those facilities, data, or systems. The Bureau reserves the right to require certain Vendor and subcontractor personnel with access to certain facilities, data, or systems to undergo fingerprint-based State and federal background checks. Each State agency, board, and commission may require the Vendor and subcontractor personnel to sign different confidentiality agreements, acknowledgement forms, and non-disclosure agreements.	**HMS complies and meets this mandatory requirement.** For the services we provide to BMS under the new contract, our Project team or other HMS staff (and subcontractors, if applicable) may need to access facilities, data, or systems for their role duties that BMS deem sensitive. In addition to having logical/technical security controls in place to safeguarding these areas, we understand that these staff members (or subcontractors) will be required to sign individual confidentiality agreements, non-disclosure agreements, and policy acknowledgements before accessing those facilities, data, or systems; in some cases they may be required to sign multiple versions. They may also be required to undergo additional background checks, such as fingerprint-based checks. HMS' Human Resources (HR) Department, Security team, and Compliance team, combined manage all internal processes required to ensure we meet this requirement. Our HR team also has staff termination procedure and contingency plans developed for the replacement of staff who do refuse to adhere to the specifications.	7.3.3 7.5.2

Req ID #	RFP Mandatory Requirement	HMS Response	Proposal Section for More Information
MR025	The Vendor must provide Bureau stakeholders access to conference space with accommodations for twenty (20) participants at a minimum during the design, development, and implementation (DDI) phase and any audits. The conference space must be sufficient enough to support the responsibilities of the Vendor as defined in this RFP.	**HMS complies and meets this mandatory requirement.**	
MR026	The Vendor must propose a plan to provide the necessary staff to be on-site for monthly meetings and ad hoc on-site assistance, with advanced notice, at no additional costs to the Bureau.	**HMS complies and meets this mandatory requirement.** Our proposed key staff for the new contract are in place and currently providing oversight of TPL service delivery for the BMS contract. They will continue to be available for on-site monthly meetings and ad hoc on-site assistance, with advance notice, at no additional costs to BMS. Our assigned project manager, Lea Ann Duffield is local to Charleston, WV.	4.0 7.3.3
MR027	The Vendor must seek and obtain the State's prior written approval for any relocation of the Vendor facility at, from, or through which the services are provided. The Vendor shall mitigate any impact to the State. Any such relocation shall be without additional cost to the State through the life of the contract.	**HMS complies and meets this mandatory requirement.**	
MR028	The Vendor must operate the Third-Party Liability (TPL) solution, perform all functions described in the Request for Proposal (RFP), and continue all operations from the date of acceptance of each release until each function is turned over to a successor at the end of the contract, including optional renewals.	**HMS complies and meets this mandatory requirement.**	
MR029	The Vendor must ensure compliance with all Service-Level Agreements (SLAs) and identified Key Performance Indicators (KPIs) with associated metrics listed in Appendix 3: Service-Level Agreements (SLAs) & Performance Standards.	**HMS complies and meets this mandatory requirement.**	
MR030	The Bureau may award other contracts for additional or related work, and the Vendor shall fully cooperate with such other contractors and Bureau employees or designated agents. The Vendor must not commit or permit any act that will interfere with the performance of work by any other contractor or Bureau employees.	**HMS complies and meets this mandatory requirement.**	

Req ID #	RFP Mandatory Requirement	HMS Response	Proposal Section for More Information
MR031	The Vendor must agree to changes in the Scope of Work (SOW) for any additional services as a result of State and federal regulation changes or Bureau operating procedure changes. This will be executed utilizing the change management process as detailed in the approved Change Management Plan.	**HMS complies and meets this mandatory requirement.** We agree to changes in the scope of work for any additional services as a result of State and federal regulation changes or BMS operating procedure changes. We have purposely designed our processes and systems to retain the flexibility to accommodate future potential changes, and we proactively work to help ensure we are ready for any new requirements. HMS follows standard practices, based on Project Management Institute principles and CMS guidelines, for managing and implementing change, which we tailor to individual client projects as appropriate. To support our practice, we will maintain a Change Management Plan, which helps provide direction for managing our change control process and documents the roles and responsibilities of the various resources involved in the process. This Plan will be provided to BMS with the overall Project Management Plan.	7.1.0 7.3.4
MR032	The Vendor must use industry-standard professional project management standards, methodologies, and processes to ensure the project is delivered on time, within scope, within budget, and in accordance with the Bureau's quality expectations. The Bureau's preferred project management methodology is the Project Management Institute®'s (PMI®'s) Project Management Body of Knowledge (PMBOK®) methodology. (Reference: https://www.pmi.org/pmbok-guide-standards)	**HMS complies and meets this mandatory requirement.** We follow industry-standard, professional project management standards, methodologies, and processes consistent with State and BMS guidelines. We use the Project Management Institute (PMI®) Project Management Body of Knowledge (PMBOK®) guidelines, and the Software Development Lifecycle (SDLC) to manage projects, which we tailor to fulfill the specific client needs. Our approach helps to ensure projects are delivered on time, within scope, within budget, and in accordance with clients' quality expectations	7.3.0
MR033	The Vendor must maintain audit trails for all system transactions.	**HMS complies and meets this mandatory requirement.**	

Req ID #	RFP Mandatory Requirement	HMS Response	Proposal Section for More Information
MR034	The Vendor must utilize a lockbox for the Bureau to receive recoveries from third-party resources.	**HMS complies and meets this mandatory requirement.** We affirm that HMS will continue to use a lockbox process for BMS to receive recoveries from third-party resources, as they are received. While we use a BMS-provided lockbox currently, we will offer an HMS-managed lockbox as an option, preferred by most state clients.	
MR035	The Vendor must respond within one (1) business day to requests from the Bureau for information requested by any state and/or federal auditors or the Centers for Medicare and Medicaid Services (CMS). Response should be in the mode agreed upon (i.e., email, memo, and summary).	**HMS complies and meets this mandatory requirement.**	
MR036	The Vendor must pay all expenses incurred in the performance of its duties under this contract including, but not limited to, costs associated with marketing, travel, postage, training, and administrative staffing.	**HMS complies and meets this mandatory requirement.**	
MR037	The Vendor must prepare responses to all inquiries, write articles for publication, and speak at meetings as requested and authorized by the Bureau.	**HMS complies and meets this mandatory requirement.** As requested, and authorized by BMS, HMS understands that we must prepare responses to all inquiries, write articles for publication, and speak at meetings. Because of our deep knowledge and reputation in the TPL space, HMS has naturally emerged as an industry thought leader. Our experts are often invited to provide thought leadership input and quotes for industry articles as well as speak at meetings and conferences. We are an active participant in all major industry associations that focus on payment accuracy. We regularly conduct presentations and seminars (some in conjunction with our state client partners), participate in roundtable and panel discussions, and provide significant sponsorship for select events. Our membership keeps us at the cutting edge of discussion surrounding this complex area. We are also active in multiple organizations that develop and implement state Medicaid policies and advance education and best practices related to care management, program administration, cost containment, and FWA.	

Req ID #	RFP Mandatory Requirement	HMS Response	Proposal Section for More Information
MR038	As a corrective action, the Vendor must provide increased staffing levels if requirements, timelines, quality, or other standards are not being met, based solely on the discretion of, and without additional cost to, the Bureau. In making this determination, the Bureau will evaluate whether the Vendor is meeting deliverable dates, producing quality materials, consistently maintaining high quality, and meeting the Request for Proposal (RFP) and contract standards without significant rework or revision.	**HMS complies and meets this mandatory requirement.** We have an established staffing approach and process by which we determined the appropriate resources, and workload levels required to fulfill the requested scopes of work and RFP requirements. We affirm our understanding that HMS must provide increased staffing levels if requirements, timelines, quality, or other standards are not being met, at no additional cost to BMS. We have the in-house capabilities to hire more staff, or adjust staff workloads accordingly, for a contract.	4.0
MR039	Each key staff role is a full-time position, to be filled by one stall member only. Key staff must be fully in place by the agreed-upon date in the Staffing Management Plan."	**HMS complies and exceeds this mandatory requirement.** All Project team key staff named in this proposal are HMS full-time positions and currently support BMS on the WV TPL Services contract and will be available at contract award.	4.0 3.3
MR040	The Bureau has an interest in ensuring that its operations are carried out in an efficient, professional, legal, and secure manner. The Vendor must remove any staff involved in the project, if the Bureau determines that any such staff has interfered or may interfere with the Bureau's interests identified above.	**HMS complies and meets this mandatory requirement.**	
MR041	The Vendor must accept financial, legal, ethical, and all other forms of responsibility for the conduct of all staff, business partners, independent contractors, subcontractors, and other entities supporting the Vendor or working with the Vendor on the project.	**HMS complies and meets this mandatory requirement.**	

Req ID #	RFP Mandatory Requirement	HMS Response	Proposal Section for More Information
MR042	The Vendor must designate one named individual in its proposal as the Vendor's Health Insurance Portability and Accountability Act (HIPAA) compliance officer.	**HMS complies and meets this mandatory requirement.** HMS' Chief Compliance Officer, David Alexander, serves on the HMS Project Advisory Council for the BMS TPL Services project. David directs the corporate compliance program for all the company's operating entities, providing adherence to state and federal regulations concerning privacy, security, and transaction processing (including HIPAA). David is responsible for policy development and implementation, compliance training and communications, auditing, and issue reporting and resolution. The Advisory Council consists of experts in their respective fields who provide service delivery guidance and support, including education and thought leadership.	4.0
MR043	The Vendor must coordinate with the Bureau to develop all documentation required by the Centers for Medicare & Medicaid Services (CMS) certification process as defined in the most recent Medicaid Enterprise Certification Toolkit (MECT) (https://www.medicaid.gov/medicaid/data-and-systems/mect/index.html).	**HMS complies and meets this mandatory requirement.** We have already produced extensive documentation and deliverables to serve as artifacts for CMS' review for other states that we are currently undergoing CMS Certification with for TPL services. We are prepared and will remain flexible to develop all documentation and support BMS as the State undergoes the CMS Certification process as defined in the most recent MECT.	7.3.2
MR044	For any portions of the entire Third-Party Liability (TPL) solution that are to be certified, the Vendor is responsible for preparing all documentation and operational examples to demonstrate criteria are met, and the system and services address all business functions and performance standards and business model expectations for certification. The Vendor must work with the Medicaid Management Information System (MMIS) **Vendor as well as any other partner Vendors** and subcontractors to achieve Centers for Medicare & Medicaid Services (CMS) certification.	**HMS complies and meets this mandatory requirement.**	

Req ID #	RFP Mandatory Requirement	HMS Response	Proposal Section for More Information
MR045	The Vendor must perform a data match of the eligibility information received from the health insurers with the Bureau member eligibility file at least monthly.	**HMS complies and exceeds this mandatory requirement.** With our standard cost avoidance services, HMS receives monthly eligibility files from BMS and performs a data match and verification weekly against these files. With our COB on Demand service, we also receive a daily eligibility file from BMS that includes any new WV Medicaid members who have become eligible in the past 24 hours for us to run data matches off the new "eligibles."	7.1.6
MR046	The Vendor must provide the Bureau all verified matched records using the Vendor's match criteria as defined in its response to this Request for Proposal (RFP) and further approved by the Bureau. All verified data match insurance information, as well as any updates thereto, must be transferred to the Bureau electronically using the established Third-Party Liability (TPL) file layout, including the Medicaid ID (MAID).	**HMS complies and meets this mandatory requirement.** We affirm that we accomplish this currently through our weekly deliverable and reverification processes for both verified data match insurance information as well as any updates. Upon completion of BMS' review, HMS updates the file as needed, then transfers the TPL Add and Update file of verified policies through SFTP to the State's fiscal agent, each Monday, for upload into the MMIS. We transmit the file electronically through an agreed-on TPL file layout (including the Medicaid ID (MAID), using the fiscal agent's SFTP server to protect the security and integrity of the data.	7.1.6.
MR047	The Vendor must take reasonable measures, pursuant to 42 Code of Federal Regulation (CFR) 433.138 (https://ecfr.io/Title-42/sp42.4.433.d), to determine the legal liability of a liable party to pay for services to members. To ensure that the Bureau is in compliance with the federally mandated cost avoidance requirements to deny and avoid the cost of claims when there is a known liable party, the Vendor must maintain valid Third-Party Liability (TPL) records in the Bureau's third-party leads file database.	**HMS complies and meets this mandatory requirement.** As we have done for more than 26 years, HMS will continue to collaborate with BMS to tap into every opportunity to save money for the State. We understand national obligations under federal law as well as the importance of ensuring Medicaid programs, including CHIP, remain the payor of last resort.	7.1.6 7.1.0
MR048	The Vendor must associate third-party recoveries to individual claims.	**HMS complies and meets this mandatory requirement.** We affirm that we balance all recoveries to our accounts receivable (A/R) at the claim level.	7.1.4

Req ID #	RFP Mandatory Requirement	HMS Response	Proposal Section for More Information
MR049	The Vendor must prepare operational manuals for its cost avoidance and recovery programs, and ensure the operational manuals are kept current to maximize the Bureau's Third-Party Liability (TPL) recoveries and to remain in compliance with federal and State requirements. Any changes shall be coordinated with the Bureau and finalized with a revision completed within thirty (30) calendar days of the operational change. The operational manuals will address all required timeframes per individual recovery program.	**HMS complies and meets this mandatory requirement.** We affirm that our internal teams prepare operations manuals, specific to each client, and for all product/services we provide, including our cost avoidance and recovery programs. These manuals are for our Operations team reference and include standard operating procedures, product requirements documents, and other relevant information. We maintain and update these manuals regularly as the client requests changes to be made and can provide confirmation they were updated, just not copies.	7.3.2
MR050	The Vendor must have a minimum of three years or experience with Third-Party Liability (TPL) work in a health insurance field.	**HMS complies and exceeds this mandatory requirement.** We affirm we meet the minimum experience requirement of a minimum of three years of experience providing TPL services in a health insurance field. To demonstrate this experience requirement, we refer BMS to **Section 3.0**, which includes a sample list of our 40+ state Medicaid agency clients for TPL Services, along with number of years we have been providing the specific TPL services to benefit their public health programs.	3.0
MR051	The Vendor must comply with all changes specified by the Bureau. The Bureau requirements regarding report format, report content, and frequency of submission of reports are subject to change at any time during the term of the contract.	**HMS complies and meets this mandatory requirement.** We affirm our understanding that BMS requirements regarding report format, content, and submission frequency are subject to change at any time during the term of the contract.	7.1.2 7.1.3 7.1.4 7.1.5 7.2.1 7.2.2 7.2.3 7.2.4
MR052	The Vendor must perform continued reporting beyond the term of the contract for the finalization of cases, if any, retained by the Vendor beyond the transition to the new Vendor. The Vendor shall comply with all reporting requirements summarized in Appendix 5: Periodic Reports Requirements.	**HMS complies and meets this mandatory requirement.** We affirm that we will comply with all reporting requirements summarized in Appendix 5: Periodic Reports Requirements in the new BMS contract and will perform continued reporting beyond the contract term, as needed, for finalization of cases.	

Req ID #	RFP Mandatory Requirement	HMS Response	Proposal Section for More Information
MR053	The Vendor must document a minimum of three years of experience of successful recoveries working with a State Medicaid Agency or a minimum of four years of experience with recoveries in the health insurance field or with a health insurance organization.	**HMS complies and exceeds this mandatory requirement.** We affirm we meet the minimum experience requirement of three years of experience of successful recoveries with a Medicaid Agency, and we also meet the minimum of four years of experience performing recoveries in the health insurance field. To demonstrate this experience requirement, we refer BMS to **Section 3.0,** which includes a sample list of our 40+ state Medicaid agency clients along with the number of years we have been providing TPL Services to each client, including recoveries.	3.0
MR054	The Vendor must identify and verify all TPL coverage including, but not limited to, medical, dental, vision, and pharmacy.	**HMS complies and meets this mandatory requirement.** We perform enrollment and eligibility (including Medicaid member data) matches with numerous entities, as required by BMS, to identify the appropriate third parties responsible for paying Medicaid claims. In addition to identifying and recruiting carriers that provide major medical insurance benefits, we have worked with BMS to identify other sources of healthcare coverage eligibility, including: ◉ Private commercial health insurance including specialty carriers (pharmacy, dental, vision) ◉ Special health coverage plans such as TPAs, long-term care (LTC) facilities, and union plans ◉ TRICARE coverage ◉ CMS/Medicare	7.1.6
MR055	The Vendor shall not seek additional payment for the identification of the same policy that affects members of the same family or household if a member is identified to have third party insurance and the health coverage information is verified.	**HMS complies and meets this mandatory requirement.** We will adjust our invoicing to not seek additional payment when members of the same family or household are on the same identified third party policy (as indicated by policy number per Q&A).	
MR056	The Vendor must assume software and hardware licensing costs related to legacy and modern solutions beginning upon execution of the contract and extending through completion of the contract.	**HMS complies and meets this mandatory requirement.**	

Req ID #	RFP Mandatory Requirement	HMS Response	Proposal Section for More Information
MR057	The Vendor must procure the necessary licenses required to support its modernized solution. The Vendor is responsible for all licenses required at project initiation and will procure and renew licenses as needed throughout the project, with no additional cost to and approved by the Bureau.	**HMS complies and meets this mandatory requirement.**	
MR058	The Vendor must assume up to fifty (50) concurrent Bureau licenses that are required for the User Acceptance Testing (UAT) environment, training environment, and any additional licenses necessary for operations. The Vendor is responsible for all costs associated with solution updates or enhancements that are within the scope of the Request for Proposal (RFP).	**HMS complies and meets this mandatory requirement.**	
MR059	The Vendor must provide the Bureau ten (10) business days' notice for non-key staffing changes and two (2) business days' notice for key staffing changes.	**HMS complies and meets this mandatory requirement.**	
MR060	The Vendor must perform cross-reference activities for identified Third-Party Liability (TPL) policies from the State's Managed Care Organizations (MCOs) that impacts members across the Medicaid Enterprise, as applicable.	**HMS complies and meets this mandatory requirement.**	

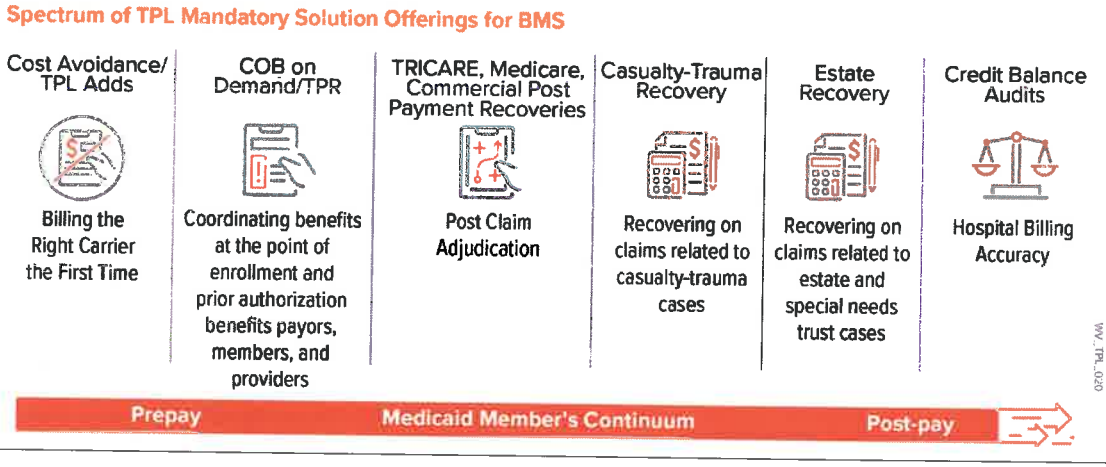
7.1.0 TPL SERVICES OVERVIEW

Our TPL service approach for BMS addresses the individual needs of each RFP scope area, while enhancing payment accuracy to support BMS' goals and achieve the best use of WV Medicaid and WVCHIP funds.

In this overview, we present HMS' understanding of the project and scopes of work as well as the problems or challenges BMS wishes to solve with our proposed solution. We also introduce our approach for providing and managing the TPL Expected Services, the innovative components of our TPL services, and our scope of work experience – all which qualify our organization as the ongoing best choice to partner with BMS. It is important to note that our comprehensive solution offering for BMS includes both the TPL Mandatory Services and Optional Services; we similarly describe our approach to providing all Optional Services in proposal **Section 7.2.0 Optional Services Overview.**

We deliver all requested TPL scopes of work today for the State, addressing BMS' needs across the payment spectrum, from pre-service through post-pay. By working with HMS in the new contract term, our industry-leading TPL solutions and expertise will continue to position WV as a national payment accuracy leader. **Exhibit 7.1.0-1** provides an at-a-glance overview of HMS' proposed TPL solution for BMS.

Exhibit 7.1.0-1 HMS' Proposed TPL Mandatory Solutions for BMS
Our comprehensive TPL solution will deliver maximum cost savings and recovery dollars for BMS.



We will continue to provide these services for the State's Fee-for-Service (FFS) population and propose that we incorporate managed care encounter claims into our workflows, should BMS wish to do so in the future. Additionally, while we include WVCHIP in our proposed cost avoidance and casualty-trauma recovery solutions, we would like BMS to know that HMS can provide the full scope of TPL services to WVCHIP or other program populations.

Although our solutions and services are in place and generating recoveries for BMS today, we will work in partnership with BMS during project kickoff in a new contract term to:

- Review all TPL program requirements described in the RFP and confirm compliance with new requirements, business rule changes, and integration requirements
- Review current processes to ensure any adjustments required by BMS are incorporated into our final Work Plan and schedule for implementation and operations

The administration of our customized Work Plan will continue to produce recoveries and cost avoidance value for BMS while implementing new processes and adjusting existing processes to maximize contract performance. We have the resources necessary to help ensure all taxpayer funds used to power Medicaid are used appropriately.

In addition to the solution enhancements proposed for the new contract period, within each scope area, HMS offers BMS several optional, value-added projects that align with BMS' vision to help West Virginians. We describe these in **Section 7.2.5 Additional Value Add Projects**.

BMS can continue to trust HMS to provide complete, end-to-end TPL services to increase recovery and savings results for the State. We represent the low-risk, high-return choice for BMS as evidenced by our years of experience providing the services, both in WV and nationally. Our approaches are collaborative, innovative, proven, and attainable.

Understanding of Project and Scope

We understand national obligations under federal law as well as the importance of ensuring Medicaid programs, including CHIP, remain the payor of last resort. We have a keen understanding of the ongoing challenges that all state Medicaid agencies face in controlling costs and generating additional funds that allow them to continue providing quality healthcare for vulnerable populations, while remaining compliant with all state and federal regulations and requirements. As the designated single State agency responsible for administration of the WV Medicaid program, BMS faces these same challenges, as does WVCHIP and many others, in the quest to provide access and appropriate healthcare for qualifying West Virginians to help them maintain and improve their health.

From our more than 26 years working with the State on its TPL program, we have answered the call. In the current contract period, HMS has achieved more than $91 million of TPL recoveries for the WV Medicaid program and more than $1.3 billion in cost avoidance savings. These contributions are vital to sustaining the Medicaid program and directly improve the quality of healthcare provided to West Virginians. From our thorough review of the RFP and supporting documentation, we know that BMS seeks a flexible and comprehensive TPL solution that continues to produce savings and recoveries as well as further enhances Medicaid and the WVCHIP program cost avoidance and recovery efforts by improving operational efficiency, workflow management, and overall identification and recovery.

As a result of our hands-on experience as the current provider of the TPL Services and majority of the Optional Services requested in this RFP, we understand the goals and objectives for each of the services noted in the scope of work. HMS has produced strong and consistent results for

the State. We appreciate the level of effort required to deliver these services and have insight on improvements for the future.

We ensure that our solution continues to comply with all applicable state and federal laws, regulations, policies, and procedures regarding TPL. Our dedicated Government Relations team not only apprises us of current and relevant State and federal laws and regulations that govern TPL processes including the Deficit Reduction Act of 2005 (DRA), but also keeps us apprised of amendments and proposed legislation that may impact our TPL clients and solutions. We have purposely designed our processes and systems to retain the flexibility to accommodate these changes, and we proactively work to help ensure we are ready for any new requirements.

HMS' Innovative Approach to Delivering TPL Services

HMS was founded on an innovative concept – to determine the most efficient and effective means of recovering payments made by Medicaid when a separate entity is legally liable to make that payment. From that idea, HMS has developed the nation's leading TPL solution, leveraging the most advanced technology, highly sought-after subject-matter experts, and HMS-built processes developed and refined over decades while working with Medicaid agencies and Medicaid managed care plans.

HMS' collaboration with BMS on industry-leading payment accuracy solutions and new approaches, positions WV as a national leader in innovation, industry developments, and enhancements.

Our services have become the industry's highest standard, and we continue to innovate to deliver additional value to our clients year after year. We are first to market with new TPL solutions each year. We were the first to offer TPL cost avoidance, customized subrogation case management, health insurance premium payment solutions, estate recovery, special needs trust services, real-time coordination of benefits, and many other innovative services. We are also the only solution provider who has successfully leveraged artificial intelligence, machine learning, natural language processing and robotic process automation to increase TPL program performance.

We are proud of our decades of experience within an industry that we helped create and shape. From the roots of our first-ever TPL contract with BMS in 1994, to our current work with the Bureau, we are grateful to have the opportunity to continue to best support the financial and operational needs of BMS.

Our TPL service approach for BMS addresses the individual needs of each scope area while best fulfilling the overall TPL goals of the State. Our TPL services combine both established processes and innovative ideas to best support the ongoing financial and operational viability of the WV Medicaid and WVCHIP programs.

OUR INNOVATIVE TPL CAPABILITIES

Since we began performing TPL services for BMS, process improvement initiatives and new technology features have been put in place across our entire client portfolio to help drive faster results through internal process and workflow environments as well as more efficient data ingestion processes using robotic process automation (RPA) technologies. Our innovations augment existing methods used by HMS and add incremental value, contain costs, enhance reporting, improve transparency, and increase recovery opportunities for the WV TPL program.

Our proposed TPL solution includes these unique capabilities, listed below in **Exhibit 7.1.0-2,** as well as other BMS-specific service enhancements that we call out in the relevant proposal sections.

Exhibit 7.1.0-2 HMS' Innovative Methods for Providing TPL Scope of Work Services
We will continue to offer the industry's most innovative methods and incorporate them at no cost to BMS

Scope of Work	Innovative Method(s)	Description	Value Provided
Cost Avoidance	National Eligibility Data Platform (NEDP) **See Section 7.1.6 – TPL Adds)**	Our comprehensive, scalable NEDP represents one of the largest commercial datasets in the U.S. for identifying other healthcare coverage for Medicaid and CHIP program members. The NEDP includes the largest commercial insurance carriers in WV and eligibility records spanning decades.	Through this dataset, we process more than 43 million insurance policy segments per month across the nation, covering more than 1.7 million current West Virginians.
	iMatch **See Section 7.1.6 – TPL Adds**	Using sophisticated logic, iMatch is HMS' iterative data-matching process that identifies potential data matches for verification. Our deep TPL knowledge and use of machine learning to expand on our algorithms, increases our ability to maintain an accurate TPL Master Resource File and effectively recover post pay from carriers and providers.	Leveraging the latest advances in data science, we produce a unique, powerful match that achieves 99.99% accuracy and finds matches other solutions miss. While most matches rely on public sources (e.g. U.S. Census Bureau) for statistical data that drives critical probabilistic match decisions, we use the NEDP's nationwide coverage to calculate current accurate statistical data to drive our match.
	COB*Connect* **See Section 7.1.6 – TPL Adds**	**COB***Connect,* HMS' verification engine, helps us confirm other health coverage with third parties and develop a complete policy profile for each member. This process combines automated and complex processes to verify eligibility information with payors, directing the polices to the appropriate verification method.	Helps HMS deliver complete verifications and results to BMS in a timely and accurate manner. Our process supports all payor types – from large national carriers to WV-specific TPAs and other types of specialty carriers, regardless of their electronic-transmittal capabilities.
	Cost Avoidance Requirements Document (CARD)	The HMS CARD captures BMS-specific business rules with examples to ensure only the policy information	Using the CARD to compare the HMS Master File with BMS' other known coverage file allows us to maximize cost avoidance value for BMS as well as

Scope of Work	Innovative Method(s)	Description	Value Provided
	See Section 7.1.6 – TPL Adds	that should be cost avoided is sent into the State's MMIS.	eliminates churn of records and member and/or provider abrasion.
Post Payment Recovery and Health Insurance Billing	Business Rules Management System (BRMS) **See Section 7.1.4 – TRICARE, Medicare, and Commercial Recoveries**	Supporting our edit-driven, direct billing process, *BRMS* provides increased visibility into individual direct bill cycles, including claim level edits and client action items. Edit management enhancements allow for all appropriate edits to be applied, providing all steps necessary to create a billable claim. *BRMS'* reporting features include trending, benchmarks, and averages for comparative and analytical comparisons. ***BRMS will be incorporated into BMS workflows in the new contract.***	Helps HMS protect the interests of BMS by generating claims with the greatest likelihood of recovery and least likelihood of abrasion. Our BRMS system design and processes are flexible and permit us to modify and customize our billing platforms rapidly. They also allow us to adjust claims- and population-selection criteria to include additional types of data to meet BMS' timely billing requirements.
	HMS Portal **See Section 7.1.4 – TRICARE, Medicare, and Commercial Recoveries**	HMS implemented the *HMS Portal* for WV providers and stakeholders earlier this year. The portal is a robust, secure, web-based application that allows authorized users to view both summary and detail information about all aspects of HMS processes.	Integrates information from HMS' policy verification, provider overpayment projects, and recovery tracking systems. Presents the information in a simple format for authorized users to view, track, and analyze relevant information throughout the recovery process. Provides BMS with direct access to many of the same tools that we developed to support our cost avoidance and recovery processes.
Estate and Casualty-Trauma Recoveries	**Maestro** **See Sections 7.1.2 – Casualty-Trauma & 7.1.3 Estate Recovery**	Highly robust case tracking, management, and reporting system that supports more than 30 clients currently for our estate recovery and casualty-trauma solutions.	Secure and HIPAA-client, Maestro provides access to electronic case records, tracks and manages case information, and automates workflows to easily document and streamline tasks.
Credit Balance Audits	InVision **See Section 7.1.5 Credit Balance Audits**	Designed to support our CBA reviews, InVision houses claim and audit information, tracks review findings, monitors claim aging, stores backup documentation, and generates audit worksheets and reports	Keeps information and functionality in one location and enables automation of tasks and communication across stakeholders (BMS, HMS, providers, etc.) through two recently deployed, innovative portals.

CROSS-SOLUTION INNOVATION - HMS 360® REPORTING

HMS 360 is an interactive financial application, designed to support our payment accuracy initiatives. HMS 360 provides users with 24/7 access to HMS' TPL services and results for BMS. With just a glance at the dashboard, users can easily understand the status of our efforts to recover and save actual dollars to support the financial viability of the West Virginia Medicaid program. This application, used by many of our state and health plan clients, will soon be made available to BMS and integrates all TPL service offerings presented in our proposal.

The HMS 360 tool promotes transparency and supports reporting, planning, and outcomes measurement by:

- Providing BMS with results of the work performed by our HMS team
- Benchmarking BMS' performance against its peers
- Modeling new opportunities for BMS savings based on the latest data

While results and benchmarks are important, HMS 360 also identifies opportunities for future savings. The application shows estimated savings value for TPL solutions and enhancements that are not currently implemented. This enables our clients to understand how the full range of our TPL services can respond to their evolving needs. HMS 360 also provides BMS users with quick access to an HMS Project team representative who can answer any project-related questions and provide more detail on how our solutions support daily BMS operations.

The current HMS 360 environment will be made available to BMS prior to the end of the current contract with HMS. A future release of HMS 360 will integrate with our Tableau® analytics database, which will offer BMS expanded oversight of carrier and operational metrics. For sample HMS 360 design options, please refer to the **Exhibits 7.1.0-3 through 7.1.0-6** included in proposal **Appendix 1**. This analytics capability will enable BMS to use the data to gain greater insights into various metrics, such as file loads and trends, data quality, subrogation reporting, cycle statistics and scorecards. We are confident that HMS 360 strengthens transparency and provides for a more comprehensive view of BMS' TPL solutions. We will collaborate with BMS to ensure the future release includes reporting that is customized according to BMS' preferences, including the incorporation of other types of reporting information in addition to financial performance.

HMS' TPL Full-Service Scope of Work Expertise

As evidenced in **Section 3.0 Qualifications and Experience**, we provide end-to-end domain expertise across all requested scope areas, including the Optional Services, backed by a culture of total accountability. Our TPL solution is purpose-built, which maximizes value for BMS. We combine deep Medicaid program knowledge, highly trained specialists, flexible processes, and data-driven technology to offer a proposed solution that delivers the entire requested scope of work for BMS –with the results to back it up. HMS represents the low-risk, high-return choice for

Exhibit 7.1.0-3 HMS' Full-Service, Scope of Work Experience
We have extensive experience delivering the full scope of work the RFP requests, including the Optional Services.

Scope of Work Service	HMS Years of National Experience
Third Party Liability	35
TPL Recoveries	35
Medicaid Estate Recovery	28
Casualty-Trauma Recovery	21
Credit Balance Audits	16
Cost Avoidance/Third Party Adds	35
Premium Reimbursement Programs	24
Recovery Audit Contractor (RAC) Services	15

BMS, as evidenced by our years of experience, both in WV and nationally, providing the services required by the State as shown in **Exhibit 7.1.0-4**.

Exhibit 7.1.0-4 HMS' Full-Service, Scope of Work Experience
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Cost Avoidance/Third Party Adds	35
Premium Reimbursement Programs	24
Recovery Audit Contractor (RAC) Services	15

7.1.1 TPL MANAGEMENT

7.1.1.1 REFERRAL RETURNS (APP 1, TM002-TM004)

To meet BMS' expectations for our scope of work, the projects and associated timelines must be met in order to deploy all the deliverables required for a comprehensive TPL program that delivers results and affirms our ability to meet the deadlines set forth by the State. We have developed and implemented project management protocols and systems for our current TPL services that ensure contract service success. HMS' experience offers BMS a proven record of accomplishment and effectiveness in delivering TPL recovery services to the State.

By applying our proven methods and leveraging extensive resources, we can ensure all tasks are managed, controlled, and supervised, not only to meet the contractual requirements of this engagement but also to continue to perform in a manner that exceeds BMS' expectations.

We describe our process for conducting initial verification of insurance coverage information in proposal **Section 7.1.6 Third Party Adds**. For this process, we confirm that we use industry-accepted practices and adhere to BMS' timeliness criteria, including:

- Return of verified and unverified referrals to BMS within three business days of initial transmission
- Return of verified or not verified direct entry referrals into the Vendor's web portal to the Bureau within three (3) business days.

We describe our process for identifying and processing casualty-trauma referrals in proposal **Section 7.1.2 Casualty-Trauma Recovery**. For this process, we also confirm that we use industry-accepted practices and adhere to BMS' timeliness criteria, including:

- Return of trauma and/or casualty referrals to BMS within 90 calendar days

7.1.1.2 CUSTOMER SERVICE (APP 1, TM008–TM012)

Our commitment to quality results, paired with our customer-centric service approach, enables us to establish and maintain long-term service partnerships with a wide range of clients, including BMS – each with unique and complex service needs.

We understand the importance of collaborating with BMS and all relevant State stakeholders in our processes to further improve the performance of our TPL solutions; not only in the identification and recovery of third party liability and improper payments, but also in the identification of program improvement opportunities overall that can further improve cost savings and recoveries for West Virginia.

Because of our extensive experience and thought leadership, we are directly involved in the ongoing development of industry best practices, which we can easily and appropriately incorporate into our customer solutions; we have presented many of these innovative ideas and solution enhancements throughout our proposal.

Providing outstanding customer service to West Virginia's Medicaid members, providers, and other stakeholders is a key component of our approach to ensuring the success of BMS' TPL program. Our focus on customer service applies to our solution-supporting teams and call centers, the websites that we maintain for BMS, the outreach and educational activities that we conduct in support of multiple BMS programs, and the documents and materials that we develop and distribute on behalf of the State.

OUTREACH AND EDUCATIONAL ACTIVITIES

For our TPL Services scope of work, we are committed to providing promotional and informative communications in the State of West Virginia by providing outreach and education regarding both the West Virginia Casualty and Estate Recovery programs. Our approach includes training seminars for Trial Lawyers Association members, local welfare offices, social workers, the West Virginia Hospital Association, and nursing homes. HMS supplies educational brochures for our Casualty and Estate Recovery programs and has developed educational posters to display in local welfare offices.

TPL WEBSITE FOR WV

We have developed and continue to actively maintain an HMS TPL-specific website (http://www.wvrecovery.com/) on behalf of the WV TPL program. We load new content, revise or remove existing content, and make sure the appropriate external-facing users can continue to access the website to stay informed as well as perform necessary tasks. This easy-to-navigate website (**Exhibit 7.1.1-1**) includes, but is not limited to, the following information:

- Up-to-date program contact information
- Frequently Asked Questions
- Information that supports the program goals
- Timely updates on policy and program changes
- Direct links to the HIPP application
- Information about West Virginia's Casualty and Estate Recovery programs relating to Medicaid members

Exhibit 7.1.1-1 The WV TPL Website
We maintain an HMS TPL-specific website on behalf of the BMS TPL Program.

We will continue to work with BMS to obtain approval for updating specific content prior to publishing updates to the site. Our team will help ensure that the website is compatible with the primary web browsers without requiring a site visitor to manually install plug-ins to access it.

HMS acknowledges that BMS reserves the right to direct us to amend or update the website when required due to a change in federal or state policy or in accordance with the best interests of the State, and we affirm that revisions will be made throughout the contract period at no additional cost to BMS.

HMS' Customer Service Centers

We have dedicated program-level Customer Service Centers that support our TPL services. Our experienced staff receive telephone calls, emails, and faxes from WV providers, members, and BMS staff. To provide the highest level of customer service, HMS operates our call center in conjunction with BMS' business hours of 7:00 a.m. to 5:00 p.m. Eastern Time, Monday through Friday, excluding state holidays. Please refer to the individual scope sections, which include the specific customer service support teams that are already in place for BMS today.

We presently maintain appropriate staffing levels to support BMS' incoming call and email volumes without experiencing any degradation in service quality. Likewise, HMS has

consistently met BMS' performance standards, and during the new contract term, we will continue to provide the high-quality customer service BMS has a right to expect.

Our Support Teams are Trained and Professional

The customer service staff required to serve BMS' engagement must be trained, professional employees with effective communications skills that go beyond those required of typical call center personnel who may not have the necessary skills or do not possess sufficient professional experience.

Across programs, HMS follows our "One-Call Resolution" philosophy, which means we focus on solving the individual's question when they call. If we cannot answer the question directly, as it may not be related, we always attempt to refer the individual to another party who can address the member's concerns. Our team is knowledgeable of a wide range of West Virginia programs and service offerings. As we have demonstrated during the current contract, we hire the right people for the job. Our staff will continue to demonstrate professionalism and high-quality service when responding to caller inquiries or addressing member or provider concerns.

HMS Communicates with Program Stakeholders

Our customer service representatives interact with program stakeholders, who vary by TPL program. For each program, our staff responds to calls, answers questions, and provides other assistance as relevant for that specific stakeholder group and program. We list the primary stakeholder groups that we communicate routinely with the corresponding HMS Customer Service Centers available as part of our TPL Services. Please refer to the noted scope of work proposal section for more details surrounding a specific Customer Service Center.

HMS brings established, long-standing working relationships with BMS and other WV stakeholders—providers, carriers, and local attorney networks.

- **WV Medicaid and WVCHIP members.** Our customer service representatives handle calls received by members and other stakeholders to address their inquiries about a specific TPL program. Following are the TPL programs in which we routinely interact with members through distinct, dedicated, toll-free telephone lines.
  - HMS' Casualty (see **Section 7.1.2 Casualty-Trauma Recovery**)
  - HMS' Estate, Special Needs Trusts (see **Section 7.1.3 Estate Recovery**)
  - HMS' Third Party Referral (TPR) service (see **Section 7.1.6 Third Party Adds**)
- **WV Provider Community.** Our Provider Relations team interacts with providers throughout the TPL identification and recovery process (see **Section 7.1.4 TRICARE, Medicare, Commercial Recoveries**). This team leverages our cloud-based HMS Portal, which facilitates communications with providers and simplifies the recovery process using state-of-the-art call center technology and innovative tools, thus helping to minimize provider abrasion.

- **Insurance Carriers and Other Payors.** Our Carrier Relations and Revenue Cycle Management teams work in tandem to focus on claims at both the client and carrier level. These teams, comprised of industry experts who have previous payor experience, communicate daily with carriers and payors to ensure that all issues at the carrier and billing level are closely monitored until resolved. Excellent verbal and written communications are fundamental to building and maintaining the strong relationships required to effectively work with carriers and payors across the nation:
  - HMS' Carrier Relations team works closely with carriers and payors to obtain, review, analyze, and help ensure the quality of eligibility files submitted to HMS (see **Section 7.1.4 TRICARE, Medicare, Commercial Recoveries**) as well as maximize the claims adjudication processes performed by carriers and payors
  - HMS' Revenue Cycle Management team achieves unparalleled results in identifying instances of other health coverage and gathers more claims data than any other revenue recovery vendor (see **Section 7.1.0 TPL Services Overview**)

CALL TRACKING/REPORTING

We track, monitor, and document communications sent and received, including telephone calls and materials, through various internal mechanisms that integrate where applicable with our robust case management tools. We describe additional details on each of the internal mechanisms or case management tools within the individual scope sections of this proposals. For example, our Casualty Recovery System, Maestro, tracks all interactions and correspondence including complaints. Our Case History Report provides detail of these interactions and can be generated on demand.

ISSUES AND COMPLAINTS

Management of our TPL solution for BMS includes ensuring efficient and effective operations as well as communicating appropriately with project stakeholders and resolving any issues as needed to fulfill the State's goals. We commit to a transparent and accountable partnership with BMS.

We recognize that caller concerns or complaints related to BMS' TPL programs may arise on occasion, and we have documented procedures in place to manage these issues quickly and efficiently, including escalating such matters to expedite resolution. We take complaints and issues seriously because they can erode trust and create abrasion with stakeholders. Complaints also offer an opportunity to make program improvements that impact the State in positive ways and provide a unique window into the issues that impact the people tasked with providing important services to WV's citizens. Our policy is to remain open to feedback that improves our ISO-certified processes.

Complaint Resolution Process and Notification

While most often we receive complaints through telephone, we offer other methods for project stakeholders to submit complaints and inquiries, including email, fax, and United States Postal Service (USPS).

Should we receive an issue or complaint, HMS has established processes in place to escalate such matters to expedite resolution. To fully address caller issues and complaints we:

- Acknowledge any issues or complaints through an initial outreach
- Log and document the issue or complaint in the appropriate tool related to that TPL service
- Proceed with taking the appropriate steps to complete resolution of the issue or complaint within time frames required to meet the needs of BMS.
  - Specific follow-up activities are determined on a case-by-case basis.
  - We help ensure that the issue resolution "next steps" are clearly and succinctly communicated to the appropriate parties involved.

We resolve issues and complaints in a timely manner, and frequently during the initial contact. However, if an issue necessitates further research and/or obtaining and reviewing additional documentation, then resolution may take more time. We conduct a root cause analysis on each complaint to determine and document the needed actions/process changes. As needed, we put in place appropriate preventive and corrective actions, such as development of additional training material.

If we are unable to resolve the dispute, we notify BMS of the issues raised and provide a summary of the pertinent facts and applicable laws and/or rules, copies of relevant documents, the resolutions that are available and our recommended course of action. We will work with BMS to resolve the issue and then provide BMS' decision to the stakeholder.

As part of our regularly scheduled monthly meeting with BMS, we will discuss performance, including complaints, and identify opportunities for process improvements.

Technical Support Help Desk

HMS has a Technical Support Help Desk available between the hours of 7:00 a.m. to 7:00 p.m. Eastern Time, excluding national holidays, and on an emergency basis as requested. We provide this technical support to BMS-authorized solution users who report a technical problem, require assistance with developing or running queries and reports, and/or require assistance utilizing the TPL solution.

7.1.2 Casualty – Trauma

HMS recognizes that the Medicaid casualty recovery program is a core Medicaid initiative that seeks to recover funds paid by Medicaid on behalf of injured members for which a third party is liable for payment, such as insurance carriers, employers, and other responsible parties.

Our Casualty team consistently reviews the current laws and regulations governing casualty recovery in West Virginia. Through review of pertinent case law and legislation, HMS has gained extensive federal and state-specific knowledge related to Medicaid casualty/tort recovery. Our approach includes leveraging our knowledge and understanding of the casualty recovery landscape under W. VA. Code §9-5-11 and federal law 42 USC 1396 to recover Medicaid assistance properly paid, as the Medicaid Program is the payor of last resort.

We have access to numerous in-house legal resources specializing in casualty recovery, who provide continuous program updates to our team through monitoring of WV specific court rulings, landmark cases, and national trends. Our attorneys have also conducted a comprehensive review of the WV State Plan, statutes and administrative rules, court rulings, and operational procedures currently in place in the State to provide compliant casualty recovery services.

Our dedicated, in-house Government Relations team also keeps us abreast of the changing laws for Medicaid and Casualty Recovery in WV. Leveraging these industry experts, we have consulted with many of our clients, including WV, regarding legislative changes and regulatory solutions. We leverage our multi-state contracts to compare state laws and regulations to determine the most efficient procedures, resulting in recommendations to state clients, including but not limited to, strengthening statutory language, recommending claim type inclusion, expanding definitions, and adding language to state plans.

We will continue to compare these findings to national best practices and enhance an already strong knowledge base that supports our Casualty Recovery program in WV.

CASUALTY RECOVERY SUCCESS IN WEST VIRGINIA

Over the past 20 years, we have applied our knowledge of federal and State law to effectively manage a successful casualty recovery program for WV. Targeting all claims types, and including mass torts, we have worked with Bureau for Medical Services (BMS) and other stakeholders to maximize the number of cases opened and closed with recoveries.

Since 2011, HMS has opened and closed (with recoveries) more than 35,800 cases, with an additional 2,500 cases opened and closed thus far in the current SFY.

By following our established casualty and mass tort recovery processes and industry-best practices, **HMS has recovered more than $30.6 million for WV, from across all claim and case types, in the current contract term for BMS.** This equates to approximately $250,000 per month.

We have established relationships with attorneys, insurance adjusters, and providers throughout WV, allowing us to drive valuable results through increased referrals to BMS. Stakeholders in the State collaborate with us, and they frequently initiate referrals by directly contacting us.

We also support mass tort initiatives in WV for class action lawsuits and have spent many years developing strategic relationships with the Lien Resolution Groups (LRGs) and perfecting techniques to ensure that this critical coordination occurs timely, seamlessly, and accurately.

PROPOSED CASUALTY RECOVERY SOLUTION FOR WEST VIRGINIA

For the new contract, our proposed casualty-trauma recovery solution for BMS and West Virginia Children's Health Insurance Program (WVCHIP) is full-service and includes the necessary components to fulfill project requirements. We will continue to deliver our end-to-end identification and recovery services, including mass tort, and incorporate our trauma-code questionnaire process into the existing BMS identification workflows.

With our proposed solution, we will continue to leverage recently implemented innovations that we have already built for WV.

Through our current work for the State, HMS has an established recovery process, developed referral sources and compiled a vast database to support complex data mining capabilities. Our experienced staff will continue to identify leads from multiple sources, value the accident-related recoverable medical services, correspond with attorneys and insurance companies, and leverage our Maestro tracking and case management system to maintain a history of all our case activities. We also work closely with BMS and the WV General Counsel to settle cases in accordance with established guidelines. HMS makes every effort to ensure the full reimbursement of all WV Medicaid expenses that the State is entitled to recover.

During the current contract, we introduced BMS to our innovative casualty web portals submissions.hms.com and *Solaris Plus.*® We provide additional detail of the web portals' functionality in The HMS Submissions Portal section below. The web portals are an example of our continuous focus on project innovation and enhancements to make working with HMS convenient and efficient for the legal community.

We have been using the innovative capabilities of the Olive software application for BMS casualty recovery services over the past year. Powered by robotic process automation, Computer Vision, and Machine Intelligence, Olive performs repetitive tasks without intervention at the same level of accuracy and consistency as our caseworkers. This process fast-tracks case settlement by providing updated claims amounts to the attorney and/or insurance company throughout the life of the case, eliminating the timeframe from request for a claim amount to Statement of Aid Paid (SOAP) letter. It also assists to free up our resources to focus on more complex actions for BMS- leading to identification of more cases and increased recoveries.

In addition to these innovations, we recommend some supplemental data match sources for BMS that have proven successful in several state Casualty-Trauma projects. For the new contract, we will explore the viability of data matches with the following files:

- **Medical Malpractice Carrier Files and other Casualty Insurance Carrier Files.** We will work to explore the viability of obtaining medical malpractice files and other casualty insurance carrier files from the largest insurance carriers in WV. These files are matched to the BMS and WVCHIP Medicaid eligibility files to identify Medicaid members who have filed malpractice, or other casualty claims in WV.
- **County/State Court Files.** We will work with WV court systems to obtain demographic data for individuals who filed lawsuits. Upon receipt of a data file with a unique identifier for the member, (e.g., SSN), we will match the Medicaid eligibility file to the court data to identify

members who filed civil personal injury lawsuits and follow up to notify those members and their legal representatives of the BMS and WVCHIP casualty recovery requirements.

As the State's current vendor, HMS will be fully operational with casualty services on Day 1 of the new contract term. This ensures ongoing service and uninterrupted recoveries for BMS and WVCHIP.

7.1.2.1 Fund Recovery (App 1, TM001)

Throughout our Casualty Recovery process, HMS' objective is to increase recoveries through case lead identifications and collections. As the payor of last resort, Medicaid seeks 100% of claims paid for which a third party is liable. A member or the member's attorney has the option of submitting a compromise (reduction) request for consideration by BMS if they do not want to pay the full amount of the casualty claim. We refer merited consideration to BMS for review and consideration and gather all compromise request information and documentation received from the member's attorney prior to our submission to BMS.

BMS' position regarding cases in which the ruling in Arkansas Department of Human Services v. Ahlborn, 547 U.S. 268 (2006) ("Ahlborn") is asserted by the member's attorney is not bound by the Ahlborn case calculation. As a result, when an attorney cites the Ahlborn case as a reason for BMS to compromise its claim amount, we provide BMS' position to avoid submitting unnecessary compromise requests to BMS. We require the attorney provide the settlement allocation or judgement for medical services when submitting a compromise request, along with the detailed justification of a reduction based on Ahlborn. Attorneys for Plaintiffs often misapply the Ahlborn ruling resulting in an understated allocation for medical items or services. If the attorney incorrectly requests the compromise, HMS walks attorneys through the proper application of Ahlborn. Our thorough understanding of Ahlborn consistently results in recovery of the maximum amount available for medical and pharmacy claims in accordance with Ahlborn.

Once all the compromise request information and documentation compiled, HMS forwards the request to BMS along with a written memo that provides summary background on the case, the reason for the request, and a recommendation including factual and legal reasoning supporting our recommendation within five (5) business days of receipt. If deadlines dictate a shorter time frame, HMS will escalate it to BMS with the information available at that time. This process allows us to complete compromise requests within 30 days of receipt. Thereafter BMS reviews the information to determine whether the request for compromise will be accepted, denied, or countered. Only BMS has the authority to compromise BMS' claim. BMS will communicate their decision to HMS, and we are then responsible for communicating this decision to the requestor. Compromise requests are processed as high priority to recoup

7.1.2.2 Identification of Claims with Certain Trauma Codes (App 1, TM046)

HMS understands that as part of our proposed casualty-trauma solution for BMS in the new contract, we are responsible for identifying members who have claims that contain specific

trauma codes that are consistent with injuries that may be covered by liable parties. This requirement is in accordance with Section 433.138 of Title 42 of the Code of Federal Regulations, effective July 5, 2016, that was amended by revising paragraph (e) to read as follows:

> *(e) **Diagnosis and trauma code edits.** Except as specified under paragraph (l) of this section, the agency must take action to identify those paid claims for Medicaid beneficiaries that contain diagnosis codes that are indicative of trauma, or injury, poisoning, and other consequences of external causes, for the purpose of determining the legal liability of third parties so that the agency may process claims under the third party liability payment procedures specified in § 433.139(b) through (f).*

We use trauma codes as a referral source in our casualty recovery services for multiple state clients currently. We will enhance our current casualty recovery solution for BMS with a sophisticated, analytics-based process to review claims with specific accident-related trauma codes that have a high probability of being the result of an accident for which a liable party is responsible. If our system finds a match, we will begin to accumulate or batch paid claims on a per-member basis and track the claims data until the minimum BMS-specified threshold is met. Incorporating a minimum threshold prevents contacting members, and causing abrasion, for small dollar claims that are not likely to be TPL. Once the threshold is met, our system automatically sends out a trauma code questionnaire to the member, requesting accident related information. We will collaborate with BMS and WVCHIP on integrating the trauma referral process into our existing casualty solution workflows.

OUR SCORING MODEL

Our HMS-developed scoring model is based on association analysis of BMS' claims data. This model:

- Identifies combinations of ICD-10 codes that have the highest likelihood to be accident-related and the greatest probability of recovery.
- Refines scoring further by additional scoring variables such as patient age, length of service period, claim paid amount, and number of claims. A score is assigned in the accumulation process and accounts are rescored continually based on changes to a member's claim history.
- Allows HMS to customize investigation treatment that allows extra effort to be applied to those cases that are most likely to be true TPL cases, leading to additional identifications, recoveries, and dollars returned to BMS and WVCHIP.

In **Section 7.1.2.4** further below, we describe our end-to-end casualty recovery process, which incorporates use of the trauma code match process as a new trauma referral source as well as our process for sending and receiving trauma code questionnaires and member outreach.

7.1.2.3 PROCESSING REFERRALS AND DETERMINING CASE TYPE (APP 1, TM046)

HMS understands that as part of our proposed casualty-trauma solution for BMS in the new contract, we are responsible for processing all referrals and determining case types.

Identifying Cases Through Referrals

For our casualty recovery process, described in **Section 7.1.2.4** below, we use a variety of proven methods to identify potential new casualty recovery cases, including referrals. When a referral is received, we review and determine whether it is a mass tort case, joint liability case, or total plan case. HMS will process referrals within 90 calendar days of receipt.

Our Casualty/Referral Identification Network allows HMS to identify the maximum number of casualty cases for WV Medicaid and WVCHIP, from across a wide range of sources.

Processing Referrals from the State

We regularly receive referrals from BMS for case leads. After receiving a referral from BMS or another State agency, we verify the named parties were eligible for Medicaid services on or after the date of the incident. Once we have confirmed this eligibility information, we open a case in Maestro and take the next steps to begin the recovery process.

Processing Referrals from Attorneys

HMS maintains a database of personal injury attorneys throughout the nation. We use a variety of methods to educate attorneys of their obligation to notify BMS when they represent a Medicaid member in a personal injury case, especially when a lawsuit has been filed, and to encourage their continued participation in providing case referrals. The casualty recovery letters created for BMS contain language that 1) identifies BMS' and WVCHIP's right of recovery, 2) members' assignment of recovery right at the time of application for Medicaid benefits and, 3) provide instruction for notifying BMS prior to settlement and disbursement of funds to verify the BMS claim is protected. Attorneys often send HMS referrals where an MCO also has the right of casualty recovery. In these situations, we will notify the referral source that the MCO has a potential recovery interest and provide the MCO contact information.

The HMS Submissions Portal

HMS has an established web portal (https://submissions.hms.com) that attorneys and insurance companies can access to submit documents and requests for claim amounts, claim dispute review, and compromises. This link is provided to Attorneys in our letters and other communications. In addition, through the HMS Submissions Portal, attorneys can refer and create new cases via the Solaris link. In 2019, Solaris went live for the WV legal community to use. Attorneys register and sign up for an account where they can create their own cases directly into our case management system, Maestro. At the time of case creation, the attorneys can also upload a HIPAA-compliant Medical Authorization that will automatically be attached and linked to the new case. Once a case is created, Solaris automatically generates an electronic Subrogation Notice Letter to the attorney in real time with the unique HMS Maestro Case ID. In addition to the Notice Letter, Solaris automatically generates a barcoded Medical Authorization release and case information form that the attorney can complete and submit later, if not submitted initially. When the documents are submitted, they are automatically scanned and linked electronically to the case.

As introduced earlier, we combined all the functions of our submission web portal as referenced above and created *SolarisPlus*-a more robust and all-inclusive web portal for the legal community. *SolarisPlus* significantly enhances our current attorney case referral process by streamlining tasks and empowering attorneys with the ability to create, manage, and settle cases without manual intervention and resultant delays. We look forward to fully rolling this out to the WV casualty attorney community in the near-future.

Referrals from Insurance Companies

HMS maintains a database of insurance companies and individual claims adjusters. Through various communication and outreach efforts, we remind them of their responsibilities to cooperate with our clients and verify that Medicaid is the payor of last resort (receiving reimbursement for services that the insurer is liable to pay).

Referrals from Providers, Including Acute Care Contractors

When HMS receives referrals from providers, our case intake staff will review the referral, set up the case in our Maestro system, and take additional steps to obtain the necessary information to pursue recovery. Providers are a great source of referrals because they often have all the TPL information on hand in addition to first-hand knowledge of injuries and related treatment.

Referrals from Medicaid Members

HMS conducts outreach to Medicaid members, or their legal representatives, by sending accident questionnaires and making outreach telephone calls requesting additional information when diagnosis and procedure codes indicate an accident or trauma. The objective of the questionnaire is to find out what caused the injury and establish whether a liable third party exists to pursue recovery. The questionnaire also allows the member to provide information about legal representation and insurance, adjuster and claim information. In addition, we process lead information resulting from telephone calls from members and/or their families.

HMS actively works to establish and strengthen relationships with Medicaid casualty lead sources. We consider it a best practice to implement periodic outreach and communication efforts to attorneys, insurance companies, and other referral sources to maximize the timely identification of casualty recovery cases. We describe these efforts below under proposal **Section 7.1.2.8 Communication Plan**.

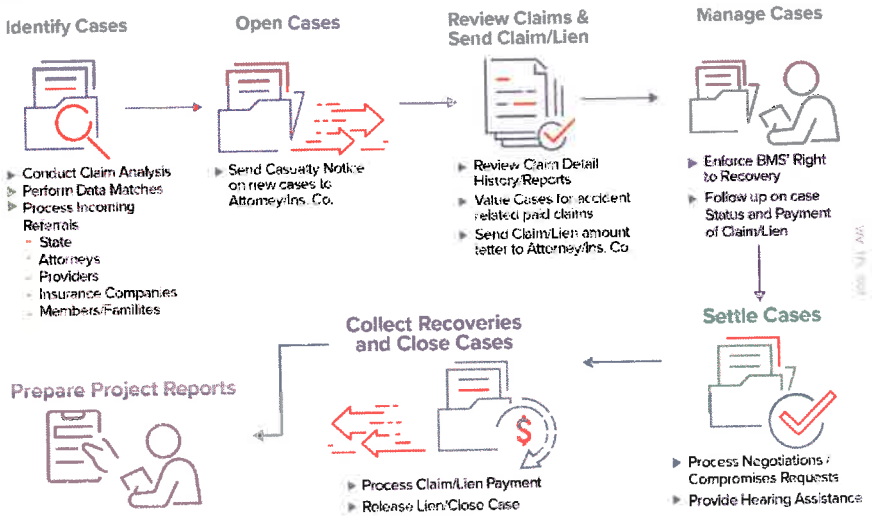
7.1.2.4 Casualty Trauma/Tort Strategy (App 1, TM046-TM047)

Our goal for BMS and WVCHIP is to increase casualty trauma/tort recoveries by optimizing our ability to identify and recover Medicaid funds for BMS. We will leverage what is established in WV today, incorporate recently deployed innovations to further streamline our processes and increase matching, and incorporate our trauma code questionnaire solution enhancement into our workflows for the new contract.

OUR CASUALTY-TRAUMA RECOVERY PROCESS

Our comprehensive solution applied for BMS incorporates activities across all stages of the process – from identifying case leads to managing cases through to payment collections, reporting, and support. In **Exhibit 7.1.2-1**, we describe in detail the different steps of our casualty recovery process.

Exhibit 7.1.2-1 HMS' Casualty Recovery Process
Our proven-effective casualty recovery process maximizes recoveries for BMS and WVCHIP.



Below we describe the primary activities carried out within each step of our casualty process.

STEP 1: IDENTIFYING CASUALTY CASE LEADS

HMS identifies potential casualty leads through a variety of methods, including our referral network, our TPL data match processes, and through targeted claim analysis to identify instances where an accident questionnaire and or outreach telephone call is made to the Medicaid member to gather accident-related information. Through a combination of these lead generation and identification tools, HMS has successfully opened more than 3,300 Casualty cases in the current contract term for BMS.

IDENTIFYING LEADS THROUGH DATA MATCHES – WORKERS COMPENSATION AND DEPARTMENT OF MOTOR VEHICLES

HMS uses proven methods to identify potential new casualty-related cases for recovery, including data matches using claims and eligibility data from various sources, such as the State Workers Compensation Board (WC) and Department of Transportation for the Department of Motor Vehicles (DMV) file for accidents.

Our data-match system uses all standard match criteria (e.g., name, date of birth [DOB], and Social Security Number [SSN], claims data) for our data matches with WC and/or DMV files.

The unique identifier for a member, such as SSN, are critical to maximizing the match results. We also apply our unique complex algorithmic formulas that process data and identify transposed numbers, letters, and other data permutations that other match systems reject outright but that, with subsequent scrutiny, we can verify as leads based on diagnosis and procedure codes. Once identified, we verify casualty recovery opportunities by determining whether a liable third party exists through accident questionnaires mailed to Medicaid members and outreach telephone calls. After confirming that a liable third party exists, our dedicated Casualty Recovery team pursues recovery by creating a new casualty case in Maestro and sending a Subrogation notice to the member's attorney and/or liable party's insurance company, putting them on notice of WV Medicaid's right of recovery and Medicaid claim.

In the current contract term, we have pursued motor vehicle accident data from the WV Department of Transportation (DOT) to identify additional accident leads for recoveries. The delays in DOT generating these yearly reports (data is usually a year aged before it is available for purchase), and the limited information available in the data for accurate matching has not historically made the reports a viable source for data matching or leads. HMS will coordinate with BMS and the DOT to see if the quality and timeliness of DOT accident reports can be addressed so that it can be used for additional data match opportunities.

In the new contract term, we will also partner with BMS and WVCHIP to work with the State Worker's Compensation Board to obtain a regular file of open and active cases with sufficient data points to match with the State eligibility file. This match will allow us to identify members who have filed claims with the Worker's Compensation Board and pursue recovery.

IDENTIFYING CASUALTY CASES THROUGH CLAIMS ANALYSES AND TRAUMA CODE QUESTIONNAIRES AND OUTREACH

We identify case leads through member claims that contain certain ICD-10 and trauma codes. To confirm the leads, we prepare and send trauma code questionnaires (TCMs) and make outreach telephone calls to Medicaid members for follow-up.

HMS' system utilizes a high degree of automation to ensure efficiency, consistency, and timely follow up while minimizing costs. This automation includes receipt and upload of data extracts into HMS' system and a trigger function that initiates the questionnaire process along with additional account treatment activity.

Our dedicated Casualty Recovery team members perform analyses of the BMS paid claims file to identify casualty recovery opportunities, as early as possible to protect BMS' and WVCHIP's right of recovery. As introduced in **Section 7.1.2.2** above, we utilize a sophisticated, analytics-based process developed by HMS to review claims with ICD-10 codes and other specific accident-related trauma codes. Unlike other process integrated solely with MMIS range of ICD-10 codes, we focus on those that have a high probability of being the result of an accident for which a liable party is responsible, and yielding a greater recovery opportunity, to minimize member abrasion.

Using the list of designated trauma codes, we search and analyze the BMS-provided claim information, at multiple levels, for those codes. If our system finds a match, we accumulate paid

claims on a per-member basis. We track the claims data until a minimum specified threshold is met, typically $250, or a threshold specified by BMS. Throughout the accumulation process, smaller balance claims are tracked and will be batched as they relate to potential cases. Once the consolidated claims meet the threshold, our system automatically sends an outreach questionnaire, developed in conjunction with and approved by BMS to the member requesting accident related information. Our outreach methodology combines follow up telephone calls with the questionnaires.

By reviewing the returned questionnaire responses, our team can determine the validity of a new casualty case to recover paid claims that are the legal responsibility of another party and place all responsible parties on notice of BMS' and WVCHIP's interest and right to reimbursement.

STEP 2: OPENING CASES

After vetting that a referral and/or lead meets specific dollar thresholds, WV business rules, and legal requirements, an HMS Casualty Recovery team member opens a casualty case in our Maestro case management system, after the following criteria have been met:

- A Medicaid member has been injured (personal injury, product liability, mass tort, Workers' compensation, premises liability, etc.)
- Third Party Liability has been established for treatment received by the member and paid for by WV Medicaid

We obtain and validate the case information listed in **Exhibit 7.1.2-2** below. If the Medicaid member is represented by an attorney, we work with that attorney to provide claim information and recover the accident related Medicaid paid claims on behalf of BMS and WVCHIP.

During the case creation and verification process, a Casualty Recovery Team member reviews medical authorizations and updates Maestro if the documentation is valid, invalid, or not submitted with the request. If a team member receives an invalid authorization or no authorization at all, we send a request for a valid medical authorization to release detail claim information.

Exhibit 7.1.2-2 HMS' Case Tracking System Includes the Case Information Needed by BMS and WVCHIP

Our system captures, logs, and validates case-specific information.

Case Information	Data Captured	
WV Medicaid Member	◉ Name ◉ Date of birth (DOB) ◉ Social Security Number (SSN)	◉ Medicaid identification number and address of the injured Medicaid member
Plaintiff Attorney	◉ Name ◉ Firm association ◉ Address	◉ Telephone and fax numbers ◉ Email address
Defense Attorney	◉ Name ◉ Firm association ◉ Address	◉ Telephone and fax numbers ◉ Email address
Accident	◉ Date of accident ◉ Type of accident	◉ First date of medical treatment ◉ Last date of medical treatment

Case Information	Data Captured	
Liable Party	◉ Address	◉ Name
Type of Injuries/Body Parts Injured	◉ Related body parts injured	◉ Type and source of injury
Case	◉ Referral/identification source ◉ Case type	◉ Case-open date
Insurance	◉ Insurance company name ◉ Address ◉ Telephone and fax numbers	◉ Insurance adjuster name ◉ Claim number
Claim Amount	◉ Related paid claims	◉ Medicaid lien/claim amount
Settlement	◉ Attorney fees ◉ Court costs and other expenses	◉ Case settlement amount

STEP 3: ESTABLISHING CLAIMS

Once the case is set up, caseworkers proceed to order a detailed claims history report, so claims can be reviewed to establish the amount of BMS' claim. Our medical claims valuation specialists review the claims and select those that are accident-related based on analyzing relevant case information. The calculated claim amount includes all Medicaid payments made from the date of injury to the present that are directly related to the injury. We provide clear documentation of our valuation so our caseworkers and subrogation attorneys can readily review the case valuation work in the event of an attorney inquiry or possible challenge.

To maximize casualty recoveries, it is important to accurately value cases by selecting all claims that are the result of an injury caused by a liable third party. Based on our extensive experience working with Medicaid claims data, our Casualty Recovery team employs selection criteria to include all accident-related claims for each case.

RELATING CLAIMS IN MAESTRO

Our medical claims valuation specialists evaluate the related claims and accumulate the medical expenses to the incident in question. These specialists use the most up-to-date ICD codes to evaluate the related claims by diagnosis code and medical history and then accumulate the expenses related to the member's accident. Each of our medical claims valuation specialists and caseworkers specializes in Medicaid subrogation and receives additional in-depth training in the usage of ICD-9 and ICD-10 codes, automobile liability and first-party coverage, utilization of pharmaceutical reference manuals, as well as WV-specific statutes, rules, regulations, and case law. We maintain current copies of reference materials and provide other available resources, including diagnosis codes, and supplement the knowledge base of our medical claims valuation specialists by requiring attendance at continuing training classes.

After establishing the claim amount, the valuation specialist updates the current total claim amount in the Maestro case and sends a Statement of Aid Paid (SOAP) Update Letter (**Exhibit 7.1.2-3** located in proposal **Appendix 1**), along with a detailed claim statement showing the provider, service dates, diagnosis, procedures, charge amount, and paid amount for all related claims. The SOAP Letter is generated in Maestro and provided to the member, member's attorney, or insurance carrier, as applicable. Once the Letter is received, upon request of an

updated claim amount by any of those parties, we subsequently review any new claims to ensure that the valuation of BMS' and WVCHIP's Medicaid Casualty claim is accurate and current and send an updated SOAP Letter. BMS has approved the content of the SOAP Letter used by HMS.

Confirming Case Valuation

When HMS receives notice that a case has settled, the case is reviewed for "final" valuation, however, pursuant to BMS' directive, a Final Notice will not be sent. HMS will respond to the attorney's request with a SOAP Update.

If a member, member's attorney, or insurance company questions our claim amount or asserts that one or more claims comprising our case do not relate to the injuries resulting from the incident, the caseworker reviews the case and claims at issue. Any errors identified in our calculation are corrected, the claims in the case are updated and a revised SOAP Update Letter is provided, as appropriate. Following review of the disputed claims, the caseworker will request an independent medical evaluation, medical records, or notes from the member's doctor to substantiate that the disputed claims are not related, if the caseworker does not agree with the disputed claims. After receipt and confirmation that the documentation meets the criteria for establishing that the claim is unrelated, the caseworker adjusts the related claims and sends a revised SOAP Update Letter to the member or member's legal representative or insurance company for the new lien amount.

Step 4: Managing Cases

We track cases, from initial creation to recovery and case closure, including correspondence to and from members, member's attorneys and liable third parties, as well as telephone calls, court filings, case deadlines, changes in case value and other case-related activities. Our Casualty Recovery team works the cases to ensure compliance with all case deadlines and statutes of limitations.

HMS uses Maestro to evaluate, track progress, report, and manage cases and workflow throughout the casualty recovery process.

Our WV-specific operational procedures provide descriptions and guidelines for case-management personnel to refer to when working on BMS and WVCHIP cases. To pursue recovery, the Casualty Recovery team regularly communicates with project stakeholders, including Medicaid members, attorneys, insurance company representatives, and others, to respond to questions and acquire information that supports recovery. We explain state and federal regulations and members' responsibilities to include BMS and WVCHIP in legal cases, provide updated case valuations, and perform other case follow-up on a regular basis. Maestro logs and tracks all work activities.

The Casualty Case File

During case development, interested parties exchange multiple documents. We retain copies of all documents in individual case files and update the electronic case record with summaries of

all conversations and actions. Maintaining all case file information and documentation in one electronic location allows for efficient and effective management of our cases.

At a minimum, a case file contains the following information:	
◉ Copy of the case lead source (e.g., Letter of representation if member has retained counsel)	◉ Copies of completed cases status inquiries returned by the law firm or insurance company
◉ Copy of BMS' or WVCHIP's notice of right of subrogation mailed to all parties involved in the case	◉ Copy of medical authorization release
◉ Complete claims detail listings used to value the case	◉ All incoming and outgoing correspondence with all parties involved in the case
◉ Copies of all SOAP letters	◉ Settlement offers and supporting documents, if applicable

Maintaining Case Records

Maestro, provides the HMS Casualty Recovery team with appropriate access to view the complete electronic case record and to generate reports. When BMS requires case information for review, users can easily access, format, and export it in a way that meets contract requirements. Given Maestro's flexibility, we can access case data immediately and transmit it securely to BMS or other authorized stakeholders.

Monitoring Casualty Cases

Our caseworkers are responsible for moving the case forward to recovery. We designed Maestro's customizable workflow system to alert caseworkers automatically for follow up on cases, based on previously entered case events or completed assignments so the performance of the follow up occurs on time. Workflows are predefined and configured based on project requirements. Maestro tracks all time frames associated with each case and automatically alerts caseworkers through a reminder (i.e., tickler) when a case requires specific follow-up.

As tasks are completed, the case moves through various recovery phases. Our caseworkers monitor their cases by viewing completed tasks or tasks needing completion. Caseworkers can also monitor their cases by viewing their caseload in stages and the status of their caseloads relative to the full life cycle. Every open case has at least one associated upcoming task until we close the case. This means that we monitor, work, review, or escalate each case to ensure appropriate and timely case-management and follow-up.

- **Case Status Follow Up.** We perform follow-up on open cases with the member's attorney or liable party to determine the status of the case litigation, settlement, or payment.
- **Revaluing Cases.** Revaluation is needed at different stages of the case as it moves to recovery. If unprocessed claims have accumulated since the case was last valued, the caseworker reviews and relates each claim, as appropriate, and then sends the system-generated SOAP Letter with the updated lien amount.

Responding to Telephone Inquiries

HMS maintains and operates a Customer Service Center with a dedicated toll-free telephone number for the WV Casualty Recovery program. All our Customer Services Representatives (CSRs) are logged into the telephone line and available to accept calls during their workdays, between the hours of 7:00 a.m. and 5:00 p.m. Eastern Time Monday through Friday, excluding State holidays. Using the reporting capabilities of our telephone system, we review call volume and staffing to meet and exceed our contractual commitments.

We have also implemented interactive voice response (IVR) functionality that allows the caller to select the option to submit his/her request through the telephone system, which logs the request directly in Maestro. If the caller selects the IVR option, the option will ask them to verify the case number and social security number (SSN) of the member before allowing them to move on. Once the correct case number and SSN are entered, the caller can choose to request an interim lien amount or final lien amount, a compromise, or medical records, if applicable. The telephone system will update Maestro with an event based on the option chosen by the caller. A message will play to the caller indicating the number of days that will pass before they receive their requested information. The caller is also provided the option to speak to one of our Casualty Recovery Team Customer Service Representatives (CSRs).

Additional features of HMS' Casualty Recovery Customer Service Center include:	
Supervisory team access to calls	Our supervisory team has access to live and recorded calls and can retrieve calls to the toll-free telephone number within 48 hours. We also can retrieve recorded calls to a caseworker's direct-dial telephone number. This capability assists with our QA and continued training of our CSRs.
Translation service	HMS employs numerous bilingual caseworkers who understand and speak English and Spanish. We also maintain a subscription with an interpretation service that offers translators for more than 150 languages, thus ensuring that we can address each caller's questions and/or concerns, providing further evidence of our commitment to excellent customer service.

Step 5: Settling Cases

After receiving notification that a case has settled, HMS conducts a final valuation of the case to present the liable third party with the Medicaid claim amount at settlement.

Our caseworker team enters the following information into Maestro, in the case History Notes:	
◉ Disclosure of the settlement amount	◉ List of any outstanding medical bills that will be paid from the settlement and have not been submitted to Medicaid
◉ Attorney's contracted fee	◉ Amount of offer to satisfy BMS' lien
◉ Amount of attorney's expenses	

Processing Negotiations

HMS requires all settlement requests to be in writing and includes certain information. If BMS' lien exceeds the settlement amount, BMS' claim must be paid after attorney fees and costs. We will not process compromise requests if the case has not reached the settlement stage. The

attorney or insurance company must request a compromise/proposed allocation to retain settlement proceeds for the Medicaid member. We describe our process for handling compromise requests up in **Section 7.1.2.1**. Should the attorney request a compromise within the authority granted HMS by BMS, HMS will send a letter reflecting the amount due and any approved reduction. In the new contract. HMS will confirm with BMS compromise authority and requirements to submit the case to BMS for final review and approval or denial of the request.

RESOLVING NON-COURT CASES

On behalf of BMS and WVCHIP, HMS will pursue appropriate non-court actions to resolve disputes and overcome obstacles to recovery with Medicaid members, attorneys, and insurance companies and pursues collection of related claims. In the past, we have been successful in obtaining collections out of court processes, ensuring that our procedures and actions comply with BMS requirements and assert the State's right to recovery in a professional manner. HMS adheres to deadlines for responding to proposed allocations and, if rejected, the deadline for seeking judicial determination. If the proposed allocation is outside the settlement authority granted HMS, we work diligently to obtain information needed so BMS can review the allocation and make an informed decision as to whether it will reject the proposed allocation or not.

STEP 6: PROCESSING RECOVERIES: COLLECTING PAYMENTS AND CLOSING CASES

HMS relies on our established BMS-approved processes for successfully recovering funds from liable third parties for casualty cases.

Our collection process includes:	
◉ Managing the receipt of payments on all subrogation claim/liens	◉ Processing payments and creating and submitting a report to BMS that describes the payments and check information that accompany the checks
◉ Confirming the check amount equals the most recent update Medicaid claim amount Following up on partial payments for the balance of the Medicaid claim amount	◉ Preparing a monthly report of all recoveries
◉ Specifying that checks should be made payable to WV Department of Health and Human Resources and providing the address in our correspondence	

After receiving the full (or agreed-on) settlement of claims, we post the payment to Maestro. Payments are processed daily following BMS-approved procedures for mail handling and payment processing, which include requisite criteria of timeliness and the safeguarding of BMS' and WVCHIP's recoveries. After depositing the payments into the State-designated account, we post individual checks in our Maestro system. HMS also has the ability to complete a disposition file for each deposit date containing case and claim information, which would be transferred to BMS' fiscal agent. We close cases if we receive payment in full. We will continue to follow our monthly established protocols for receipting, deposit, and reconciliation of casualty recoveries. HMS provides monthly reports of all cases with recoveries to BMS, as discussed in **Section 7.1.2.7** below.

Closing Cases

We close cases based on established and BMS approved protocols.

HMS closes a case when:	
◉ We receive payment and confirm that it is for the amount due, process the check, post it to the case, and acknowledge payment in writing as appropriate	◉ The member's attorney withdrew from the case and there is no new attorney or settlement with the insurance company or directly with the member
◉ The total claim calculated does not meet BMS' cost effective criteria.	◉ The State directs us to close the case.
◉ There will be no recovery by the member related to the injury	◉ The case was opened due to an administrative error

Step 7: Reporting Cases

Maestro features robust reporting capabilities for casualty recoveries. Leveraging Maestro, our HMS Casualty Recovery team generates reports for BMS, both standardized and on an ad hoc basis as described below in **Section 7.1.2.7 Reporting**.

Casualty Recovery Program Support

Throughout the Casualty Recovery process, HMS will leverage our extensive casualty program service experience. In addition to our Casualty Recovery team and caseworkers, we provide other levels of support for BMS and the Casualty Recovery program.

HMS Project Team Members Available to BMS

The HMS Project team will continue to be available to answer BMS' questions and respond to casualty project-related issues. Our Project Manager or designee will coordinate the availability of other Project team members or other agents for BMS. Should BMS request them, additional team members will be available to provide information regarding:

- **Clarification of amount of benefits provided.** HMS will continue to maintain case information in Maestro and provide updated case valuations as needed or when requested.
- **Information needed for the preparation of pleadings, affidavits, or other court documents.** We will provide requested data and documentation associated with a case to support BMS' effort. Maestro contains a secure electronic case file, so we can provide BMS with the necessary information to pursue the case.
- **Other support as needed.** HMS will support BMS' needs for cases referred to the State.

Providing BMS and WVCHIP with Case Status Updates

If requested, HMS will provide BMS and WVCHIP detailed case updates for ongoing and referred cases. We will continue to work with BMS to identify and develop reports that are responsive to its needs.

When referring cases to BMS, HMS makes a recommendation based on consideration of numerous factors, including, but not limited, to the following:

- The amount of the settlement and case value
- The number of fees and recoverable costs, total medical liens claimed, and severity of the injuries
- Whether the settlement will fund a Special Needs Trust
- Other factors that the HMS team deems relevant in assisting BMS' determination

HMS' Mass Tort Casualty Recovery Approach

In addition to individual Casualty case processing, from creation to recovery, HMS works with Mass Tort Lien Resolution Groups (LRGs) across the country to work mass tort cases that involve thousands of Medicaid members across the country injured by specific product defect. The Plaintiffs' law firms in these suits often hire settlement LRGs to work with the Medicaid agency to process liens/claims.

HMS has a dedicated Mass Tort team that works with LRGs to resolve mass tort claims nationally for an efficient process. We perform mass tort recovery for multiple state Medicaid clients nationally. By centralizing mass tort activity, LRGs benefit from contacting one entity to resolve Medicaid claims for numerous states.

By leveraging HMS' mass tort casualty processes and our proven team of in-house experts and attorneys, BMS and WVCHIP will continue to reap the benefits of a systematic, standardized process that will free up scarce BMS resources for use in other BMS activities while streamlining and maximizing recoveries from mass tort casualty cases.

At the start of each new case, the LRGs submit proposed holdbacks and offsets for BMS' review and approval. After obtaining approval or BMS' counteroffer, our team communicates the information to the LRG. We also receive and review the Qualified Protection Orders (QPOs) executed by the court to ensure HIPAA compliant release of eligibility and medical paid claims.

Our Mass Tort Casualty Recovery Process

To begin the recovery process, the LRGs will provide HMS with a monthly file of individuals eligible to receive a mass tort settlement. HMS will identify whether any of the individuals are or were entitled to Medicaid benefits. For those identified as Medicaid members, HMS will deliver entitlement matches and claim files to LRGs. Upon receiving the entitlement and claim file from us, the LRGs will review the claims and either agree to or deny the claim. The LRGs will provide HMS with the result of their review of the claims, and we will resolve discrepancies, if any, with the LRGs. After final resolution, lien/claim recoveries will be sent to the state client or appropriate HMS contact.

HMS Mass Tort Activity

- Total Open Cases (2019): 16,950
- Total Recovered (2019): $7.12 million

If there are both FFS and MCO claims in any given settlement and payment is made for a mass tort claim, HMS will work with the LRG to ensure that the BMS claim is paid first. When the BMS case has been paid in full, HMS posts the payments and closes the mass tort case.

7.1.2.5 Identification of Casualty/Tort Cases Prior to or During Litigation (App 1, TM048)

In Step 5 of our Casualty Recovery process on settling cases, HMS can provide BMS assistance with casualty/tort case-related hearings, as needed. Our Casualty Recovery team has the necessary subrogation legal support, operational, policy, and management experience; they are familiar with arguments presented by members' attorneys in courts. When requested, our Casualty and Project team members will furnish case documents to BMS and provide valuable insight into any unique circumstances about the case development process.

> As a national TPL vendor, HMS can draw on experiences nationwide to assist the State in developing successful strategies and legal arguments.

Identification and Referral of Court Cases

During intake of correspondence received, HMS caseworkers identify cases requiring a court appearance or legal representation. Caseworkers review all incoming correspondence carefully and date stamp prior to linking it to the case in Maestro. We escalate all legal documents, other than typical subpoena *duces tecum*, to a supervisor and/or Casualty legal team member for review and handling. When communication is identified that informs HMS about an upcoming hearing, or that indicates the need for a court appearance, it is escalated to the casualty Subrogation Attorney for review and handling. If the Subrogation Attorney is unable to address and resolve the issue in a timely manner, then the Subrogation Attorney will prepare a referral to be escalated to BMS for appropriate next steps.

> We will continue to work with BMS when a referral is necessary under the established protocols or at other times when State involvement may become essential.

Based on our extensive experience performing these services for WV, as well as for Medicaid agencies nationwide, HMS knows that most cases do not require legal representation. We understand that certain cases, however, need to be referred to BMS as it involves interpretation of statutes inconsistent with BMS' interpretation that could have a far-reaching impact on project recoveries or to further protect its right of recovery. For example, when HMS receives a Notice of Hearing on a case in which BMS is named as an interested party, HMS forwards the notice and relevant case information to BMS to be shared with the State Attorney General's office.

Referring Cases to the State

In a new contract term, HMS will continue to identify cases that require escalation and referral to BMS in connection with a court appearance or legal representation and immediately refer these cases to BMS within two business days from the time HMS determines escalation is needed. We will work with the State to confirm referral criteria and that the process meets WV's needs.

We will work with BMS to identify cases that meet BMS-specified criteria. For example, we might refer a case to BMS when:

- The amount of the claim is contested as being unrelated to the injury or; the claim amount should be reduced in accordance with the Supreme Court's decision in *Ahlborn* or for some other reason.
- The member has filed a negative election indicating that he/she will not protect Medicaid claims for which a third-party resource that should be pursued independently exists.
- There is an interpleader of a third-party resource by a defendant and/or as directed by BMS.

We will also provide any necessary supporting documentation and pursue recovery in coordination with the State.

HMS communicates all case-related deadlines with each referral that includes scheduled hearing dates. We understand that this information is vital to BMS' ability to achieve recoveries for litigated cases and other cases referred for action by HMS.

7.1.2.6 TRACKING CAPABILITIES (APP 1, TM049)

As introduced above, HMS uses Maestro to evaluate, track the progress of, report on, and manage cases and workflow throughout the casualty recovery process. We track cases, from initial creation to recovery and case closure, including correspondence to and from members, member's attorneys and liable third parties, as well as telephone calls, court filings, case deadlines, changes in case value, as well as other case-related activities. Built by HMS and designed to specifically support subrogation programs – both for casualty and estate recovery. The system allows for import of all documentation as well as Medicaid eligibility and paid claims data, where users can access it for casualty recovery activities. We Maestro, are continually rolling out enhanced features to Maestro and have seamlessly integrated the system with other innovative tools such as our *Solaris Plus* web portal.

Key features of Maestro include:	
◉ Simplifies and streamlines data entry and tracking	◉ Houses case files and documents/tracks activities with real-time updates, streamlining the case-management process
◉ Leverages an event-driven workflow environment and access to current and accurate claims and eligibility data to facilitate case-valuation and claims-analysis processes	◉ Provides on-demand access to BMS case information and documentation, related correspondence, and status reports
◉ Automates crucial recovery processes and procedures through an event-driven management workflow, configurable at the project level	◉ Allows authorized personnel to monitor staff caseloads, track productivity, and transfer cases as needed
◉ Enables a paperless process through integrated document imaging functionality	◉ Includes notification features that make users aware of deadlines
◉ Interacts with IVR technology and web portal submissions	◉ Features Secure Socket Layer technology using both server authentication and data encryption
◉ Auto generates and stores all outgoing correspondence	◉ Includes 24x7 live, help-desk support

7.1.2.7 REPORTING (APP 1, TM050)

As stated above, HMS offers robust reporting capabilities, and our Account Management team can generate standard status and ad hoc reports from Maestro. Our reports offer timely and valuable project management information regarding recoveries, case-management activities, case status, and other data. **Exhibits 7.1.2-4** and **7.1.2-5** in proposal **Appendix 1** are samples of the current monthly Casualty Reports we provide to BMS, which include number of cases closed, total recoveries along with check details, total posted amount and claim level details.

HMS has the capability to produce fully customized reports within Maestro allowing for reporting on any predefined data field in any subsystem.

Key data captured by Maestro's reporting function includes:	
◉ Case source	◉ Number of SOAP Update Letters sent
◉ Cases opened	◉ Number of web referrals received (cases opened through *Solaris Plus*)
◉ Cases closed	◉ Dollars collected
◉ Number of Casualty letters sent	

As the State's current vendor, we generate reports on a monthly basis and will continue in the upcoming contract term and provide for any new reporting requirements. We understand that BMS' requirements regarding report format, content, and submission frequency are subject to change at any time during the term of the contract.

7.1.2.8 COMMUNICATION PLAN (APP 1, TM051)

Communication is essential in all aspects of the casualty recovery process. From referral telephone calls, to negotiating recoveries, to reporting to BMS, HMS has implemented an effective policy of openness in our regular communication with all stakeholders.

In the new contract, one of our first tasks will be to develop and implement the formal communication plan as one of our project deliverables. This plan will describe the information disseminated throughout the project and list the parties involved. Using the plan will ensure that stakeholders regularly receive project-progress information. Our communication plan will include correspondence on case creation, status, and closure.

Abiding by BMS' contract requirements, we will obtain BMS approval of all communication processes, including distribution of letters and documents to attorneys, members, and insurance companies.

As noted earlier, HMS has a website located at wvrecovery.com that serves as a resource for BMS' and WVCHIP's casualty recovery program. This website is familiar to WV program stakeholders and contains information about the WV Casualty program. In addition to program information regarding legal authority and contact information, stakeholders can download project-specific forms.

We actively work to establish and strengthen relationships with Medicaid casualty lead sources by conducting webinars and presenting at professional association meetings when requested.

By developing relationships with the WV legal and insurance industry community, we are often able to receive leads and open cases in a more efficient manner than soliciting information. Our key staff is available 8:00 a.m. to 5:00 p.m., local time, to accept telephone calls and referrals from members, attorneys, insurance companies, providers, and local welfare offices. This has dramatically increased members' awareness of the casualty recovery program and the number of referrals from Medicaid members themselves.

ESCALATION PROCESS

Should a situation or issue occur pertaining to BMS' casualty recovery program, HMS has established processes in place to escalate issues to expedite resolution. For instance, if a caseworker encounters a problem or issue, he/she first must thoroughly review the case and attempt to resolve it independently. If unsuccessful, the matter is forwarded to the casualty supervisor. If the supervisor is unable to resolve the matter, the file is forwarded to the HMS Project team Account Manager and HMS' subrogation attorney. A final decision will be made on when to engage the client and the attorney designated to the project on a case-by-case basis.

PROJECT STATUS MEETINGS

To maintain regular communication with BMS throughout the contract term, HMS conducts monthly status meetings. These meetings provide a tool to facilitate project management and issue resolution. In addition to monthly communication, we will offer quarterly progress summaries specific to BMS' program services.

These quarterly progress summary reports outline the following components:	
◉ Work accomplished during the reporting period	◉ All communications regarding case initiation, status, and closure
◉ Work to accomplish during the subsequent reporting period	◉ When BMS requests, we also provide ad hoc reports that address project-related issues.
◉ Any significant deviation from previously agreed-on work statements	◉ Problems, both real and anticipated

During monthly status meetings, we provide status updates on tasks associated with our proposed services. Items reviewed include information on completed tasks, tasks in process, and tasks with unanticipated problems that require attention. Action plans developed for any items will undergo continual review to ensure that the remediation steps are producing the desired results. HMS has this process established today with BMS during these meetings.

7.1.2.9 MMIS FUNCTIONALITY REVIEW (APP 1, TM052)

HMS will continue to work with the State's MMIS vendor regarding all data and file transactions between the two entities. We will work closely with BMS and the MMIS vendor to ensure that any required data updates at a case level are performed with extreme care and detail, as is our practice under the current contract. HMS currently has established caseworkers that are fully trained on WV's MMIS to review claims appropriately when evaluating cases. HMS caseworkers will continue to validate all claim details within MMIS in the upcoming contract. Finally, HMS

staff will be available to BMS and the MMIS vendor if they are needed to assist with any changes in MMIS casualty recovery functionality.

7.1.3 ESTATE RECOVERY

Since the beginning of the Medicaid program in 1965, states have had the option to recover long-term care costs from the estates of deceased Medicaid members, under certain circumstances, when that member dies.

Through the West Virginia Estate Recovery program, BMS seeks to recover correctly paid medical assistance from the estates of people who have passed away and received BMS long-term services and supports. With the passage of the Omnibus Budget Reconciliation Act in 1993 (OBRA '93), by federal law, if BMS pays for these services, they are required to recover these payments from the estate of certain Medicaid members under the following circumstances:

- Upon the death of members, age 55 or older, who received services for nursing facility services and/or home and community-based waiver services paid by Medicaid
- Deceased permanently institutionalized members who received services provided in a nursing facility, ICF/MR, or other medical institution

HMS has been assisting states with their design, implementation, and successful operation of Medicaid estate recovery programs since the early 1990s. We have managed successful programs, end to end, across a wide range of policy environments and diverse demographic/cultural settings, which translates into numerous field-tested options for maximizing revenue collections. HMS currently performs estate recovery services in 13 states, including three of the nation's largest Medicaid programs.

Our extensive national Medicaid estate recovery program experience that spans over more than two decades, combined with WV-specific knowledge and experience, makes a difference in our ability to deliver results for BMS now and in the new contract.

Contracted with BMS to provide recovery services for the State's Medicaid Estate Recovery program since 1995, we continually apply our extensive knowledge of national and state estate recovery laws to continue delivering a customized approach. Through our current work, we understand the need to effectively identify the assets of deceased Medicaid members and maximize recovery dollars to support the provision of long-term care services. With our knowledge of WV Medicaid claims and eligibility data, coupled with our third-party death records and asset data matches and searches, we have applied our knowledge of federal and State law to develop a successful Estate Recovery solution for BMS. We have gained a solid understanding of WV's Estate Recovery program as defined by WV Code § 9-5-11c, WV State Plan Amendment section 4.17 and BMS Provider Manual, as well as the WV probate laws.

Over the past 20 years, we have developed and maintained a wide range of valuable stakeholder relationships in WV to help identify recovery opportunities and deliver results. Through these relationships, we have deepened our knowledge, which allows us to develop, implement, and optimize our services that support WV's Estate Recovery program.

Over the past 20 years, we have proven our estate recovery expertise for BMS. Our estate recovery program has generated recoveries for BMS of more than $5.9 million since 2011.

Our experience and success managing the current contract with BMS gives us a unique advantage. Our in-place resources and established relationships with project stakeholders confirm that HMS can provide reliable and immediate results in the contract and throughout the term of the engagement. Most importantly, BMS can continue to trust HMS to provide a thorough and innovative Estate Recovery solution.

PROPOSED ESTATE RECOVERY SOLUTION FOR BMS

For the new contract, our proposed Estate Recovery solution is comprehensive and includes the necessary components to fulfill the project requirements. We bring end-to-end case identification, case management, and recovery services including recommended expansion opportunities, several technical innovations that are underway and will be fully implemented for the new contract, along with program enhancements we will collaborate on with BMS.

Our existing WV referral network, recovery processes, and staff are in place and operational. Accordingly, we are poised to help the State achieve greater estate recovery results on the next contract term, with no delays.

Throughout our process, HMS' objective is to increase estate recoveries for BMS. To help meet this objective, we continually look for areas in our process to innovate and improve.

Our proposed solution includes several new innovative enhancements that will streamline and automate portions of the estate recovery process, which will speed up case creation and subsequent recovery opportunities for BMS. We will review these enhancements with BMS and incorporate them into our WV Estate Recovery solution and workflows in the new contract. We will enhance our existing wvrecovery.com website with functionality that will enable program stakeholders to submit WV Notice of Intent (NOI) questionnaires online as well as self-report new cases/deaths; by linking site users to our **HMS Submissions Portal,** which has capabilities that support both our Casualty-Trauma and Estate Recovery programs.

- **Online Submission of NOI/Estate Recovery Questionnaires.** When HMS sends out a Notice of Intent to File a Claim against the estate, the letter includes a questionnaire that solicits information regarding exemptions/deferrals, reductions or waivers, property, assets, and intent to open probate. The new functionality will allow program stakeholders (e.g. attorneys, decent family members, personal representatives) to submit the completed questionnaire online. Site sers are greeted by an easy-to-use interface when they go to submit the questionnaire online through the HMS Submissions Portal. We have already

begun development of this process and plan to complete the upgrade in the new contract term.

- **Self-Reporting of New Cases/Deaths.** A second new link added to the wvrecovery.site website will route site users to the HMS Submissions Portal to allow program stakeholders to report the passing of a member and request information regarding the estate recovery claim, an exemption/deferral, or an undue hardship waiver as well as obtain real-time confirmation that their request for information has been received. Based on the information provided, a case is opened in Maestro and any documents submitted are attached to the case. This activity will then trigger the Maestro workflow event to alert the caseworker that a new referral or information has been received for them to review and follow up.

Over the years, HMS has been an integral partner in developing the regulations and business approach to support the estate recovery initiative in WV. As a result, we also recommend the following program-related enhancements that can improve and strengthen the WV Estate Recovery program for the new term:

- **Legislative changes to increase recoveries.** A change in WV law to allow for collection on "expanded definition" of estate would result in additional collections to BMS.
- **Recovery threshold change.** In the upcoming contract term, BMS can elect to make the contract coincide with the State Plan and Medicaid regulations. Currently, Medicaid regulations and State Plan state that BMS will pursue recovery on any estate valued at more than $5,000 but this industry best practice is not currently in place under the existing project. Enacting this administrative change to the contract rules in the upcoming contract term could potentially net BMS collections greater than $3 million per year.

7.1.3.1 ESTATE RECOVERY (APP 1, TM016–TM019, TM022)

HMS' solution for managing the WV Estate Recovery program for BMS complies with WV Code 9-5-11c, the State Plan Lien and Adjustments or Recoveries provisions and the West Virginia Probate Code.

Our estate recovery approach leverages HMS' decades of experience, talented staff, and our unique Maestro case management system that allows for a thorough review and accounting for estate recoveries. Through experience, we consistently demonstrate we have the right team, processes, and technologies required to perform estate recovery services effectively, at the highest possible level for BMS.

We manage the estate recovery process end to end, from lead development to case creation and case management through recovery and reporting. We are always sensitive to the nature of estate recovery and use a "high-touch" approach while working through the process with our clients and their members.

- **Project Team.** Our proposed project team for BMS includes qualified, subject-matter experts who apply industry best practices to optimize recovery goals. Our team members understand estate recovery law at the federal and state levels. They remain current on and

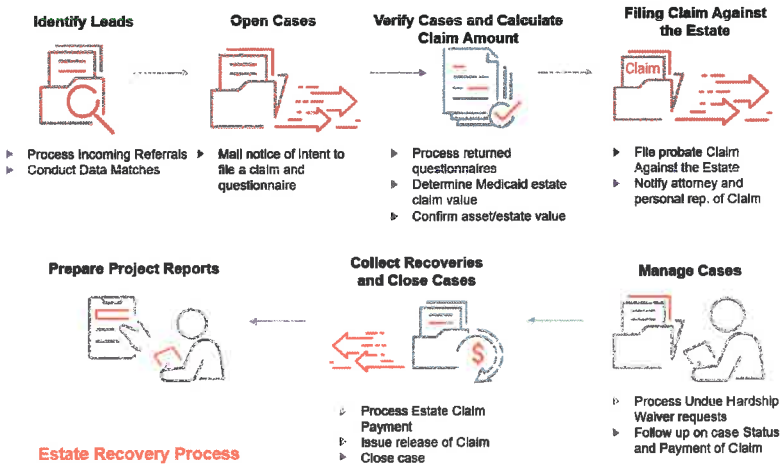
have a working proficiency related to federal and state requirements in order to remain compliant and administer programs that support rapid, maximized recoveries.

- **Processes.** We collaborative with BMS to continually fine-tune our approach and develop and customize processes that meet the State's requirements. Our caseworkers are trained to communicate with empathy to grieving family members of a deceased member and express condolences while still upholding all legal and program requirements.
- **Technologies.** We operate and maintain our web-based estate recovery case tracking and management system, Maestro, the same system utilized for our Casualty Recovery solution, which contains the purpose-built technology and features to carry out the tasks needed to support the WV Estate Recovery program.

Our West Virginia Estate Recovery Process

Our estate recovery process is results-driven and detailed, with each step vetted and examined by our professional team. In this section, we describe this process for managing BMS' estate recovery program. **Exhibit 7.1.3-1** illustrates the process, while the narrative that follows details the activities we perform during each step, along with any processes specific to WV.

Exhibit 7.1.3-1 HMS' Estate Recovery Process
We use our proven estate recovery process to achieve positive results for 13 states nationwide.



Step 1: Identifying Estate Recovery Cases

HMS identifies new estate recovery cases by processing leads through various sources as described below. The accurate processing of new case leads and referrals is critical for the success of an estate recovery program. The sheer volume of referrals and match leads generated by most estate recovery programs necessitates an organized and systematic approach to targeting cases where a recovery is possible due to the availability of recoverable assets and/or non-probate assets.

Identifying Cases Through Referrals

To maximize referrals, HMS works to educate organizations and other stakeholders about the estate recovery program requirements, including the courts, county assessor and recorder offices, elder law and probate attorneys, funeral homes, and nursing home providers. HMS has established a national and state-specific referral network that enhances our identification of estate recovery cases. Through our comprehensive referral network for WV, our Estate Recovery team receives and processes case referrals to identify opportunities for recovery.

Estate recovery referrals can come from any source. BMS currently receives estate recovery referrals from key sources:		
◉ Attorneys	◉ Referrals from local county offices, probate notices, and obituaries	◉ Anonymous sources
◉ Notice to creditors	◉ Families	◉ Government agencies
◉ Casualty referrals/wrongful death cases	◉ Trustees and public trustees	◉ Executors/personal representatives
◉ SSA death match	◉ Annuity Companies	◉ Real estate investors
◉ Long-term care facilities	◉ Guardians/Conservators	◉ Real property research by caseworkers

In addition to referrals, HMS identifies estate recovery opportunities through various outreach and education efforts found in our Communication Plan, which we describe in **Section 7.1.3.3**.

Identifying Cases Through Data Matching

HMS uses advanced data matching logic an analyses to match Medicaid eligibility files against our national death database, comprised of numerous sources indicating a Medicaid member may have passed away. These data matches are performed early in the process to identify opportunities prior to disbursement of estate assets. By proactively identifying cases, rather than waiting to receive notification after recoverable assets may have been sold or transferred from the estate, we protect potential recoveries and maximize results for BMS. We also use these files to track cases in deferral status (e.g., surviving spouse, minor or disabled child) that will expire at the end of an exemption. When the estate recovery deferral status changes, we resume recovery activities against estates that previously qualified for a deferral.

Prior to opening new case leads identified by our data match processes as new cases in Maestro, we review and verify each referral lead when received, confirming the deceased qualifies for the Medicaid estate recovery program by confirming eligibility for estate recovery.

Step 2: Opening Estate Recovery Cases

Assuming the member meets the eligibility requirements for estate recovery, a new case file is opened in Maestro. HMS' estate recovery caseworkers use the newly opened case as the foundation to manage all steps through to recovery.

Notifying Affected Parties of Intent to File Claim

To protect BMS' interest in the estate, upon case opening and claims amount calculation, Maestro generates a series of documents that are sent to the address of the member's personal representative, attorney, or family representative:

- **Notice of Intent (NOI) to File a Claim Against the Estate** – This letter indicates there is a claim against the estate, explains the program, and includes an estate recovery questionnaire.
- **Estate Recovery Questionnaire** –This questionnaire collects information to determine whether to file a claim against the estate, or if there are other recoverable assets. The questionnaire solicits information regarding exemptions/deferrals, reductions or waivers, property, assets, and intent to open probate from the member's personal representative or heirs.
- **Information Sheet and/or FAQ** – The WV FAQ sheet is included to provide background information on the estate recovery process, hardship waivers, deferrals/exemptions, etc.

HMS will work with BMS to review the current project letters and questionnaire and recommend modifications based on best practices used in our estate recovery projects.

In **Exhibit 7.1.3-2** located in proposal **Appendix 1**, we provide an example of the current BMS-approved Notice of Intent to File and Estate Questionnaire.

Step 3: Verifying Estate Recovery Cases, Calculating Claim Amounts, and Determining Ability to Recover Funds Owed to Medicaid

Intake - Processing Returned Estate Recovery Questionnaires

Once a completed estate recovery questionnaire is received by HMS, intake personnel link the questionnaire to the associated case in Maestro. Maestro alerts the caseworker to review the questionnaire responses and any attachments to determine if the case qualifies for a deferral/exemption, possible hardship waiver, claim reduction, or if we can pursue immediate recovery action.

In the new contract, a new link added to the wvrecovery.com website will take users to our HMS Submissions portal where they can submit the NOI questionnaire to HMS online and real time.

Identifying Exemptions/Deferrals and Undue Hardship Waiver Requests

HMS has built customized processes to quickly identify cases eligible for exemption. We base our recovery determinations on current federal and WV laws, which provide for hardship waivers, claim reductions, or exemptions for cases where there exists one or more of the following scenarios as noted in **Exhibit 7.1.3-3**.

Exhibit 7.1.3-3 Definition of Exemptions/Deferrals and Undue Hardship Waivers
Federal and WV laws provide for hardship waivers, claim reductions, or exemptions for cases where there exists one or more certain scenarios.

Scenario	Criteria
Exemptions/Deferrals	◉ A surviving spouse ◉ A surviving child under age 21 ◉ A surviving child of any age who is blind or disabled ◉ A sibling of the member who provided monetary support for his/her sibling for medical care and other necessities prior to the date the sibling became a member.
Undue Hardship Waivers	◉ An adult child who was residing in the Medicaid member's home continuously for at least two years prior to the parent becoming a Medicaid member and provided care that allowed that member to remain at home without Medicaid assistance for at least those two years ◉ An heir, who maintains continuous employment in the family business for a period of time beginning at least one year before the member became a Medicaid member until the time of the member's death, if the property which would otherwise be subject to an estate recovery lien is an integral part of the business and required for the continued viability of the business ◉ An adult child who has maintained a business within the home for at least three years prior to the member becoming a Medicaid member ◉ An adult child provided monetary support for the parent for medical care and other necessities prior to the date the parent became a member ◉ Grandchild whose parents are both deceased prior to the date the grandparent became a member provided monetary support for the grandparent for medical care and other necessities prior to the date the grandparent became a member ◉ A sibling who can present proof of monetary support to his/her sibling for medical care and other necessities prior to the date the sibling became a member. Such support will reduce the medical assistance lien on a dollar-for-dollar basis.

The caseworker analyzes supporting documentation that may be received with the questionnaire.

This documentation includes, but is not limited to:	
◉ Birth certificates (validates child/parent relationships as well as the child's age)	◉ Employment and income records (demonstrates proof of residency)
◉ Marriage and/or Divorce Records (validates existence of surviving spouse)	◉ Utility and bank statements (also used as proof of residency)
◉ Death certificates (validates existence of surviving spouse)	◉ Correspondence from doctors (confirms care provided to member or disability status)
◉ Social Security Administration letters (validates disability status of child)	

Following documentation review and analysis, if it is determined that an exemption or undue hardship criteria applies to the case, a letter is sent notifying the attorney or representative that we have approved the deferred exemption or hardship waiver. When a deferred exemption is granted pursuant to State rules and regulations, the case may be re-opened once we confirm the surviving spouse has passed away or the disabled or minor child situation no longer exists.

VALUING THE CLAIM

To determine the amount of the State's claim on the estate, we use the paid claims file to select all recoverable claim types subject to WV's estate recovery until the member's date of death. We total the appropriate BMS-paid claims incurred during the member's long-term care

enrollment period when the member was age 55 and older or determined permanently institutionalized.

Once the total paid claims are calculated, HMS updates the file in Maestro to include the estate recovery claim amount filed with the probate court. We also generate an itemized claims listing for use in the next step in the recovery process.

IDENTIFYING PROPERTY FOR RECOVERY – CONFIRMING ASSET/ESTATE VALUE

To assess the recovery opportunity, our Estate Recovery team reviews the information in the returned questionnaire and records any self-reported assets in Maestro, then attaches all asset documents in the electronic case file. We also review the addresses in the eligibility file into our case management system for real property ownership verification.

Our team verifies each eligible member's real property ownership, pursues the case for recovery if the asset belongs to the Medicaid member and is not excluded for such reasons as the property value falls below the approved threshold

In addition to identifying self-reported assets, HMS can search and identify assets for thousands of Medicaid members. Our automated asset identification process leverages an online asset search subscription service that compiles information and listings from public sources. Using this tool, we identify assets recorded in the decedent's name and verify the results.

To capture all asset data, we supplement these automated inquiries with manual review and confirmation by our caseworkers. This asset search subscription searches county online databases and identifies assets that have been improperly taken out of the decedent's name. It also verifies results provided through the automated identification process. We can locate property owned by the member out of state that may or may not have been previously disclosed.

If we cannot identify real property of the estate subject to recovery or other assets that can be probated, the questionnaire indicates an absence of assets, and we cannot locate any probate through the courts, we close the case. Additionally, if we determine that the recoverable estate is worth the identified minimum dollar threshold or less, after taking into consideration the outstanding mortgage balance or other lien amounts on the date of death, the interests of the heirs or legatees and the deduction for undivided interests in real property, we close the case. If new information is later obtained on previously undiscovered assets or an open probate case, the case is re-opened at that time and a new review conducted. HMS will record all events related to asset identification in Maestro to create a clear audit trail of all case activity.

Our caseworkers review each case through local assessor office and clerk and recorder databases, along with another industry-leading online asset search subscription.

STEP 4: FILING A PROOF OF CLAIM AGAINST THE ESTATE

After we determine a case is appropriate for recovery, we conduct probate research to verify if an estate has been opened and file a Proof of Claim against the decedent's estate with the appropriate county probate court, on behalf of BMS. We search court docket information online throughout the State and contact county clerks to ascertain whether a probate estate has been opened and to identify whether a Personal Representative or Executor has been appointed for a specific case. We also ask the personal representative about probate plans/attorney involvement on our standard questionnaire to discover potential estates and follow up as needed seeking additional information on the family's plans to open an estate.

As a direct benefit of the relationships we have developed with them over the past 20 years, the probate courts send us a monthly list of all the open probate cases. This increases our visibility into potential estate recovery and speeds up the process.

FILING PROOF OF CLAIM

Once the personal estate representative has opened probate, HMS files a proof of claim against the estate in accordance with WV Probate Code § 44-2-1 et seq. For reference, we provide a sample Proof of Claim in **Exhibit 7.1.3-4** located in **Appendix 1**. We file BMS' claim within 60 days from the date of notice to BMS as an unsecured creditor of the estate. If no notice is given, then we file the BMS' claim at any time prior to the partition and distribution of the estate. The claim on the estate indicates the basis of the claim, the claimant's name and address, and the amount of the claim. Court documents are filed with the appropriate court as well as sent to the personal representative, or, if known, their attorney, per state law. These include the following:

- A copy of the claim
- Notice of Claim letter that explains the estate recovery program and cites all applicable state and federal laws regarding Medicaid estate recovery rights and acts as a "notice" to the of those rights
- Detailed claim listing

If the value of the estate is less than the claim amount, we pursue recovery of the total value of the estate (less prioritized expenses as set forth in State and Federal statutes). Claims filed are classified as and included in the class of debts due the state. As result, the following estate expenses that have priority over the estate recovery claim are; costs and expenses of administration, reasonable funeral expenses, debts and taxes with preference under federal law, and unpaid child support which is due and owing at the time of the decedent's death

If the attorney or administrator for the estate rejects the claim or disputes the validity of the claim, our staff/estate attorney will reach out to the attorney or administrator to attempt to resolve the issue. If we are unable to resolve the dispute, we notify BMS of the issues raised and provide a summary of the pertinent facts and applicable laws and/or rules, copies of relevant documents, present the courses of action that are available and along with our recommendation.

Processing Requests for Claims Deductions and Costs of Care

As required, HMS compiles and processes claim reductions requests for expenses of home maintenance and costs of care. The WV Notice of Intent to File a Claim sent to estate representatives states that all requests for claim reductions must be submitted in writing. If HMS needs additional documentation, our caseworker sends an information request letter directing the estate representative to submit additional documentation.

HMS reviews the documentation and receipts submitted as claim reductions to determine whether claims and supporting documentation were reasonable. These may include maintenance expenses, utilities, and/or property taxes associated with the home of the deceased member along with receipts submitted for costs of care and any statements or letters written by the member's physician stating that such expenses were necessary and delayed the member from receiving Medicaid long-term care services. If approved, these deductions reduce the total amount of the claim.

Step 5: Managing Cases

With our Estate Recovery solution, HMS' goal is to obtain the full amount of Medicaid expenses that the State is entitled to recover because effective case management is an essential part of our approach. An assigned caseworker individually monitors each case to conclusion.

On an ongoing basis, our Estate Recovery team monitors the probate process by requesting case status updates, confirming asset information, and determining the value of the estate subject to recovery. We review the Appraisement and Inventory of Assets, Petitions for Final Discharge, documents from estate proceedings, online property appraisal records, computerized asset searches, and other data resources. Caseworkers also stay in contact with attorneys representing the Personal Representative of the estate to ensure prompt payment and resolution of the claim. In addition, caseworkers review correspondence from heirs and other stakeholders, including deeds to real property, bank statements, property appraisals, or stock information.

Using Maestro to Monitor Case Status

Through Maestro, caseworkers can maintain electronic case files, track cases at all stages, and manage necessary tasks and activities. We update Maestro with each activity performed in a case, such as receipt of an incoming telephone call, documents, emails, and faxes. Maestro also has workflow functionality to create reminders for tasks for follow-up by automatically generating tasks in the ER caseworker's action queue. To assist in meeting deadlines, a tickler system shows the next task along with its completion timeline. Each active case will have at least one upcoming task associated with it until the case is closed.

Maestro's reporting capabilities allow caseworkers to review cases and take necessary action, depending on the status of the case.

For performance monitoring and quality management purposes, supervisors and other management personnel review caseworkers' activities and outstanding case tasks periodically to ensure case review and tasks are performed in a timely manner.

Responding to Telephone Inquiries

HMS maintains a dedicated telephone number for the WV estate recovery program. Our experienced ER caseworkers are logged into the telephone line and available to accept calls between the hours of 7:00 a.m. and 5:00 p.m. Eastern Time, Monday through Friday, excluding State holidays. They answer general questions regarding the program as well as review cases and Maestro and provide case information and status, if authorized, to the caller.

Our estate recovery customer service center also features:	
Supervisory team access to calls	Our supervisory team has access to live and recorded calls, including recorded calls to a caseworker's direct-dial telephone number. This capability assists with our quality assurance and continued training of our caseworkers.
Translation service	HMS employs several bilingual caseworkers who understand and speak both English and Spanish. Using an interpreter service provides HMS with access to translators covering more than 150 languages. This ensures we can address the questions and/or concerns of each caller as well as proves our commitment to customer service excellence.

Using the telephone system's reporting capabilities, we can review call volume and staffing numbers to ensure our performance meets or exceeds contractual commitments.

Should a situation or issue occur pertaining to BMS' estate recovery program, HMS has established processes in place to escalate such matters to expedite resolution. If we are unable to resolve the dispute, we notify BMS of the issues raised and provide a summary of the pertinent facts and applicable laws and/or rules, copies of relevant documents, present the options that are available, and our recommended course of action. We will work with BMS to resolve the issue and provide BMS' decision to the stakeholder. We provide more information on how we handle issues and complaints in **Section 7.1.1 TPL Management.**

Processing Exemptions and Hardship Waivers

An estate representative may request an exemption or hardship waiver to satisfy BMS' claim throughout the case, in situations where one has not been initially identified. For these cases, families are asked to complete and submit the WV questionnaire to put this request in writing along with the applicable documentation. Instructions to request the exemption, reduction or hardship waiver are sent with the Notification Letter. This includes information that the application shall be submitted within 45 days of the proof-of-claims filing and that BMS has 90 days from receipt to issue an approval, denial, or advise the applicant if additional time is required to review the request. An exemption or waiver may be requested through:

- Wvrecovery.com website to download the questionnaire
- WV Estate Recovery Program-dedicated number to call and request the application
- Mailing address to submit a request for exemption or hardship waiver application

- Questionnaires to request the exemption or hardship waiver are also included with the initial Notice of Claim.

After receipt of the completed waiver form, we review the exemption or hardship waiver application for accuracy and completeness. If any information is incomplete or supporting documentation missing, we follow up with the applicant for the additional information and documents. Once all supporting documentation and information is received, we evaluate the application to determine if the request meets the approved waiver or reduction guidelines and send a determination letter to the applicant and/or the applicant's attorney or personal representative.

We will work with BMS to review requests that are outside approved program guidelines for hardship consideration.

STEP 6: COLLECTING RECOVERIES AND CLOSING CASES

EVALUATING ESTATE ASSETS AND VALUE OF ESTATE

We validate the inventory of assets and liabilities provided by the estate representative and then determine the gross value of the estate to confirm that BMS is recovering the full amount of the estate recovery claim allowable under the probate code. In accordance with BMS guidelines, we will not impose recovery on estates below the identified threshold after the estate is admitted to probate. Once we receive the value of the estate from the estate representative and confirm the estate value meets the minimum threshold, we will file a release if the proof of claim is filed and close our case.

We make every effort to obtain the full reimbursement of program expenses that the State is entitled to recover.

POSTING PAYMENTS

When HMS receives payments for an estate case, our estate recovery caseworker reviews the payment thoroughly to verify that the estate tendered the correct payment amount. If the amount is correct, the payment is posted in Maestro and any claim filed against the estate is released and filed as a Satisfaction of Claim with the court. The estate recovery claim is satisfied when HMS, on behalf of the State, receives payment from the estate and proceeds in accordance with the law and priority of payment of all estate claims. In circumstances where the payment received is less than the amount expected, we contact the personal estate representative or attorney to obtain more information about the outstanding payment, logging this activity in Maestro. We retain check copies and supporting documents in Maestro for audit purposes.

We will conduct all banking procedures per BMS guidelines for financial transactions management. Our standard collection process includes:

- Managing payment receipt on all estate claims
- Providing the address and specifying checks should be made payable to "WV Estate Recovery" in our correspondence
- Preparing a monthly report of all deposits and posting activity

The Maestro case management system captures the following data elements required for posting:

- Member's name and ID number
- Check amount and check number
- Date of deposit
- Case settlement type (e.g. probate, annuity recovery, trust)

Posting Payment Disputes

In rare circumstances, the personal representative may dispute an estate claim after payment has been made, or another higher priority creditor may claim that BMS was paid before its higher priority claim. In these cases, the personal representative or the creditor may contact HMS. We forward a refund request along with any supporting documentation to BMS. HMS can make a review and recommendation on the refund request, but BMS must make the final decision. Once a decision has been made, we will communicate it to the requestor.

Closing Cases

We close an estate recovery case when we recover on the claim in its entirety or if the payment received represents the balance of all the available assets. Other reasons for case closure include no assets available, value of the estate is less than the established minimum threshold, no probate filed, or an approved hardship waiver.

We provide our clients with enhanced reporting functions that include generating regularly scheduled and on-demand reports and providing online audit capabilities. We will continue to create customized reports specific to BMS' needs.

Step 7: Reporting

Maestro incorporates automated production of reports and produces all reports required for this project, as well as ad hoc reporting. In proposal **Appendix 1**, we include sample Estate recovery reports we currently provide to BMS as **Exhibits 7.1.3-5 and 7.1.3-6**. Full reporting functionality is in place with access to all estate recovery data and information on cases, including specific payment and claims related data. Under a new contract, HMS will further discuss and address any additional development of BMS' reporting requirements. HMS understands BMS requirements regarding report format, content, and submission frequency are subject to change at any time during the contract.

HMS produces project status reports for BMS including the following:

- **Case Status Report.** Provides the total number of cases opened and closed during the month, including the reason the case was closed
- **Monthly Deposit Report.** Indicates the number of cases where payment is received, amount of payment received, member name, Medicaid identification number, case number, and total amount of claim

HMS produces project status reports for BMS including the following:

- **Case Status Aging Report.** Shows a summary of cases in open status, current case stage and the length of time a case has remained in that stage, as well as associated case value amount
- **Case Source Report.** Indicates the referral source for our cases and can be used to track the effectiveness of outreach activities

In addition to the above-referenced standard reports available, HMS' project team has access to system reporting data to run ad hoc queries and reports against the data to support additional project-specific reporting requests. The flexibility of the system allows reporting on any predefined data field in any subsystem.

RECOMMENDED SPECIAL NEEDS TRUST RECOVERY / ANNUITY SERVICES

One of the many daily challenges faced by every Medicaid agency is how to stretch scarce resources to enable Special Needs Trust (SNT) and Annuity recoveries. An SNT is set up to provide for the extra needs of a disabled person—over and above the basic care provided by government programs. They provide only goods or services not provided by Medicaid and supplement what Medicaid does provide. SNTs, authorized by federal law in 1993, generate significant Medicaid recoveries. Section 1917 of the Social Security Act allows for certain individuals who would otherwise be disqualified for Title XIX, based on resources or income in excess of qualifying guidelines, to place the income/liquid assets in a qualified trust.

Our innovative HMS Trust Services, acknowledged within the industry as the national service benchmark, protects the financial interests of our clients at three essential phases: (1) lien settlement, (2) expenditures during life of the trust, and (3) Medicaid payback at the death of the trust beneficiary and annuity recovery at the death of the Medicaid member.

HMS currently handles Phase (3) Medicaid payback for BMS, which provides for the final stage in the life of a SNT or annuity – payback recovery upon termination of the trust or recovery from an annuity. An effective SNT program produces results. During the Trust Recovery phase, HMS systematically and aggressively pursues SNT payback recovery in the amount of the payback claim or, if less, the remaining balance in the SNT, as well as the term amount of an annuity.

In **Exhibit 7.1.3-7**, we describe the activities we carry out during our SNT recovery process.

Exhibit 7.1.3-7 Steps in HMS' Special Needs Trust and Annuity Service
Our innovative HMS Trust Services protect the financial interests of BMS

Step	Description
Step 1: Receive Death Notices	We typically receive notice of death referrals at the time of the member beneficiary's death. HMS performs data matches monthly of MMIS, SSA, and Vital Statistics Files against the Medicaid Eligibility File to identify deceased members. Medicaid members are required to disclose to the State any interest they or their spouse have in an annuity or trust and the State must be named as the remainder beneficiary or as the second remainder beneficiary after a spouse, minor, or disabled adult child, for an amount at least equal to the amount of Medicaid benefits provided. HMS also receives many self-referrals from Trustees and Annuity companies immediately after the death of the beneficiary. Regardless of the source, HMS' Estate Recovery team processes the opportunity as a potential estate recovery lead. These steps are also taken for annuity cases.
Step 2: Value Medicaid Claim and Notify Trustee or Annuity Company	After we receive the death notice for a trust or annuity beneficiary, our caseworkers value the amount of the Medicaid payback claim. Our caseworkers recognize that different from estate recovery, the value of the payback claim is for all medical assistance received by the beneficiary during their lifetime.
Step 3: Follow Up with the Trustee or Annuity Company for Recovery Payment	As soon as the trust or annuity receives initial valuation, an Initial Notice of Claim is sent to the trustee or annuity company giving notification of the amount of the claim and the steps that need to be taken for making the payback from the trust or annuity. This notice also informs the trustee or annuity company that there is potential for additional provider claims to be received and processed. The final notice provides the finalized amount of the payback claim, restates the steps that need to be taken for making payback, and specifies the time deadline for receipt of the payback payment. For annuity cases, recovery is made against the value of the annuity at the time the recovery claim is made.
Step 4: Obtain and Credit Payments Received	After receipt of trust payback or annuity payments, the payments are processed into the electronic file in Maestro and prepared and sent for deposit in accordance with BMS procedures. As the last part of this process, the HMS caseworkers prepare and send a release to the trustee or annuity company and close the case.

7.1.3.2 TRACKING CAPABILITIES (APP 1, TM021)

HMS uses Maestro, our case tracking and management system to evaluate, track, and manage cases throughout the estate recovery process. Designed by HMS to specifically support subrogation programs – both for estate and casualty recovery – we customized Maestro to support all estate recovery casework for WV. In Maestro, we track cases, from initial creation to recovery and case closure, including correspondence to and from member's attorneys, personal representatives, family members, and other stakeholders as well as telephone calls, court filings, case deadlines, case value changes, and other case-related activities.

Maestro's event history functionality automatically tracks specific actions and date taken, such as:	
◉ Remarks/notes such as the synopsis of any casework-related discussions	◉ User who logged the action
◉ Lien amount for the case once action logged	◉ Payments received
◉ All case-related correspondence received/sent	

7.1.3.3 COMMUNICATION PLAN (APP 1, TM020 AND TM023)

HMS communicates with many stakeholders during the recovery process. The most important communication occurs between HMS and the various referral sources, including nursing homes

and courts and other key stakeholders such as decedent personal representatives, attorneys and decedent family members. As noted in this section, we have developed brochures and outreach programs to educate and provide WV-specific estate recovery program information.

For many of these stakeholders, we have developed and carried out various outreach and education efforts. Most recently, we have:
◉ Supplied educational brochures to all 55 WV counties, in collaboration with the State
◉ Developed posters to increase awareness about the program
◉ Held educational seminars for Eligibility Workers Association, WV Medicaid Ombudsman Advisory Council, WV Hospital Association, large nursing and rehabilitation centers, Social Workers Association, and the Center for Senior Services
◉ Updated WV Estate Recovery Program-specific information on the wvrecovery.com website for online referral solicitation, including an overview and history of the program and links to (1) Notification of Death Form, (2) Estate Recovery Brochure and (3) Hardship Waiver application. We describe this website in **Section 7.1.1 TPL Management.**

In **Exhibit 7.1.3-8** we highlight some of the ongoing outreach efforts we use to regularly promote awareness of the WV Estate Recovery program and generate referrals.

Exhibit 7.1.3-8 Ongoing Outreach and Education
HMS also identifies estate recovery opportunities through various outreach and education efforts for the various stakeholder communities.

Other Case Identification Methods	Description
Provider Mailers	HMS sends mailers to providers, such as nursing home facilities, reminding them to complete and forward a death notification when the death of a member occurs.
Brochures	The project website wvrecovery.com includes a link to the WV estate recovery brochure. Upon request, caseworkers can also send brochures to members as they become eligible for long-term care and to their authorized representatives at enrollment and recertification.
Outreach to Professional Associations	We routinely work with professional associations, including the Bar Association, community associations, and other groups, to disseminate information and to educate their members about the estate recovery program. We are available to present at meetings and seminars attended by members of the WV Bar Association, Probate Judge's Association, area agencies on aging, National Academy of Elder Law Attorneys, and other organizations. These informational sessions describe the importance of estate recovery and the work that HMS performs on behalf of BMS. They also enable us to provide contact information for the submission of referrals, such as death notices.
Training of State and County Eligibility Office Staff	As requested, HMS can provide education and training sessions for relevant staff at State and county eligibility offices to improve the effectiveness of the referral process and improve the information given to the public on estate recovery by county-level staff.

HMS will produce and mail all marketing materials described above at no cost to BMS, in accordance with Department, State, and federal requirements, including those covered in the Electronic Code of Regulations (e-CFR) referenced in the requirement.

7.1.4 TRICARE, MEDICARE, AND COMMERCIAL INSURANCE RECOVERIES

HMS began recovering claim payments from third parties in 1985, our goal remains the same today — to recover payments as quickly, efficiently, and accurately as possible for BMS. Since 1994, we have been identifying, billing, and performing accounts receivable (A/R) management

for claims paid by WV Medicaid but for which HMS subsequently discovered are the legal responsibility of others.

HMS performs post-payment recoveries on a variety of claims in addition to those from commercial insurance, Medicare, and TRICARE. These include casualty/trauma, provider credit balance, and estate recoveries. We describe each of these in the respective sections of this response.

Since the start of our current contract in 2011, in addition to cost savings, we have delivered more than $91 million in recoveries to West Virginia.

PROPOSED POST-PAYMENT TPL RECOVERY SOLUTION FOR BMS

Our current TPL recovery solution is comprehensive and complies with rules for filing claims with third-party resources is flexible enough to accommodate all BMS post-payment recovery requirements.

To support BMS' project goals and objectives, HMS will continue to apply our in-place, proven claims recovery plan and approach, including targeted solution enhancements for the new term, which we call out appropriately throughout our proposal. This will ensure maximum recovery results, while continuing to minimize stakeholder abrasion. With our TPL recovery program for BMS, we pursue recovery of claims from third party entities (TRICARE, Medicare, and commercial insurance) that were erroneously paid by the WV Medicaid program. We will also continue to seek out new opportunities for BMS to enhance recoveries. With our approach, HMS remains committed to maximizing recoveries for BMS and consistently applying a three-year lookback period to further help the State recover the payment of claims.

7.1.4.1 TRICARE, MEDICARE, AND COMMERCIAL INSURANCE IDENTIFICATION (APP 1, TM034 – TM036)

The Vendor should propose a method to identify Medicaid members with other insurance, including, but not limited to, the following:

- Medicare, Tricare, and commercial insurance
- Submission of claims to the appropriate source for recovery

Our TPL program accurately identifies other health coverage for healthcare claims that were, or could be, erroneously paid by our Medicaid clients. For BMS, we currently utilize various data match methods to identify WV Medicaid and WVCHIP members with other health insurance coverage. Data match serves as the foundation for all subsequent activities, including post-payment recoveries. We cover these methods in more detail in our response in **Section 7.1.6 Third Party Adds** for identifying TPL:

- **Commercial insurance.** To identify Medicaid members with other insurance from commercial carriers, we leverage our National Eligibility Data Platform (NEDP), carrier network, and iMatch process.

- **Medicare**. To identify Medicaid members with Medicare insurance, we complete a CMS enrollment data match utilizing the EDB and MMA files.
- **TRICARE**. The Defense Enrollment Eligibility and Reporting System (DEERS) match between CMS and the Department of Defense ceased early in 2017 and remains on hold. HMS continues to identify Medicaid members with TRICARE insurance coverage and perform post payment recoveries through existing data resources we have available.

Once we identify Medicaid members with other insurance coverages, we submit Medicaid Reclamation claims to the appropriate third party resource for recovery, complying with their specific requirements for filing claims. Our goal for post-payment recoveries is to return WV Medicaid payments that were the result of missed cost avoidance opportunities. To do this, we recoup the payments made by BMS through two distinct methods – direct billing and provider disallowance. Our methods are based on accurate data matches and reconciliation between BMS' paid claims (including encounter data, if approved by BMS) and eligibility files. Our proven methods conform to industry-accepted billings standards.

HMS will continue to deliver a report to BMS, which includes a reconciliation of claims billed, including adjudications down to the claim-line level from health insurance carriers or other sources. Upon project initiation, we will work with BMS to review current file layouts, further customize, and determine the frequency of file delivery.

7.1.4.2 Post-Payment Recovery (App 1, TM037)

Our TPL post-payment recovery approach and plan, described in the remaining sections in this document, includes post-payment recovery activities covering commercial insurance; Medicare Parts A, B, D; and TRICARE. With our TPL program for BMS, we pursue recovery of claims erroneously paid by the WV Medicaid program through direct billing or a provider disallowance process. The plan and steps we follow for our direct bill and disallowance processes are described later in this section.

- **Direct billing.** These are comprehensive billings to commercial carriers and other payors using processes and supporting systems that are flexible, scalable, and configurable to support WV Medicaid requirements. This approach involves submitting Medicaid reclamation claims directly to the insurance carrier electronically, through a clearinghouse, or if needed, through paper processes. We currently use this approach to recover on claims from commercial carriers, pharmacy benefit managers (PBMs), Medicare Part D, and TRICARE.
- **Provider disallowance.** As a value-added benefit, this approach engages providers to resolve claim discrepancies where providers have the missing data and/or documentation, that carriers request to complete adjudication. The providers are equipped to furnish the required information and bill the commercial carrier directly, thus resolving any discrepancies, allowing BMS to ultimately recoup funds back from the provider. With our process, HMS provides a list of paid claims to the provider, to facilitate correctly billing the identified third party. After payment from the appropriate carrier or PBM, providers can submit any allowable balance to Medicaid for supplemental payment. Providers are satisfied with the disallowance

process as it reduces administrative burden and often results in higher reimbursement. We currently use this approach to recover on claims from commercial carriers, pharmacies, and Medicare Parts A and B.

Together, these two approaches provide the flexibility necessary to accommodate all of BMS' requirements and ensure maximum recovery. During the new contract, we will continue to work closely with BMS as well as carriers and other payors to further minimize administrative burden and provide support throughout the steps of the recovery process.

Direct Billing for Commercial Insurance, TRICARE, and Medicare Part D Claims

HMS began billing claims to third parties in 1985 and is proficient in achieving recoveries on Fee-for-Service (FFS) claims as well as recovering TPL using MCO encounter data. We understand the importance of pursuing mandatory "pay and chase" claims and have consistently demonstrated the ability to bill liable third parties and carefully manage the process for successfully delivering recovered funds to the state agencies that we serve.

To supplement our direct billing efforts as well as to provide BMS with an opportunity to generate additional recovery dollars, we offer an additional, value-add solution for MCO Come Behind Encounter billing services. We describe this solution in **Section 7.2.5** Additional Value Add Projects.

Our comprehensive direct billing services include billing of claims to liable third parties and subsequent accounts receivable (A/R) management, rebilling of claims to appropriate carriers, and following up on claims billed to carriers. Our direct billing processes also work to make sure that the preparation and submission of Medicaid TPL claims to liable third parties meet state- and federally mandated guidelines and time frames in accordance with the policies and direction established by BMS.

With our direct billing recovery solution, we identify, bill, and collect on claims paid by WV Medicaid which HMS subsequently discovered other healthcare coverage was the responsible payor. We issue a single monthly billing cycle on behalf of BMS for commercial health insurance carriers, PBMs/pharmacies, Medicare Part D plans, and TRICARE.

HMS' Proposed Direct Billing Solution Enhancements

HMS' systematic and detailed direct bill recovery process is recognized industry-wide for accuracy, integrity, and subsequent results. Considering our national footprint in TPL recoveries and pay and chase, the TPL team stays abreast of best practices, policies, and industry standards affecting TPL and our 40+ Medicaid clients. We will continue to share these industry standards and best practices with the State in a new contract term to make sure that its TPL program aligns with current national standards.

Our edit-driven, direct billing process and supporting systems are designed to be flexible. They permit us to modify and customize our billing platforms rapidly and adjust claims- and

population-selection criteria to include additional types of data to meet BMS' timely billing requirements. For example, incorporating State-specific claim-level edits and validation checks to eliminate claim populations identified by BMS as exempt from the recovery process. These edits are flexible across both recovery and cost avoidance rules and can be updated without additional cost to the State.

We program all claim level edits according to client- and carrier-specific requirements and policies. Examples of claim level edits include procedure codes, procedure modifiers, facility types, rate codes, and claims associated with certain members and/or providers. This specificity in our systems confirms billings abide by client- and insurance carrier-specific requirements and policies, such as excluding confidential or sensitive services. For example, we can exclude waiver services and certain client-only procedure codes from our billings to avoid sending insurance carriers an excessive volume of claims they will never pay.

These edits confirm we are selecting claims based on client rules, billing only those claims likely to be paid, and preparing the claims in the correct format for the carrier to process. This helps us target only those claims with a high probability of payment by the third-party coverage, thus increasing client recovery results. Our claim-level checks also prepare the claims in the correct format for the carrier to process and perform validation checks against the Provider Demographic File, National Drug Code listing, and ICD-9/10 code sets, among others, to check that all entities and medical or pharmacy codes are valid.

Our innovative direct billing features help save time and reduce operational cost:

- **Leveraging electronic billing platforms** to quickly validate whether the carrier received the claim. HMS submits more than 90% of carrier billings electronically.
- **Posting 100% of claim payments and electronic denials** for monitoring the timely adjudication of claims and targeting claims for follow-up.
- **Performing comprehensive billing follow up** to collect claim payments at multiple levels and by targeting unpaid claims at the claim level, carrier group level, and carrier level for maximum recovery effectiveness.
- **Administering an image-based, deposit-management system and lockbox** for tighter financial controls and to facilitate account auditing.
- **Using a carrier-preferred billing method** to increase carrier acceptance, accelerate payment, and reduce errors.

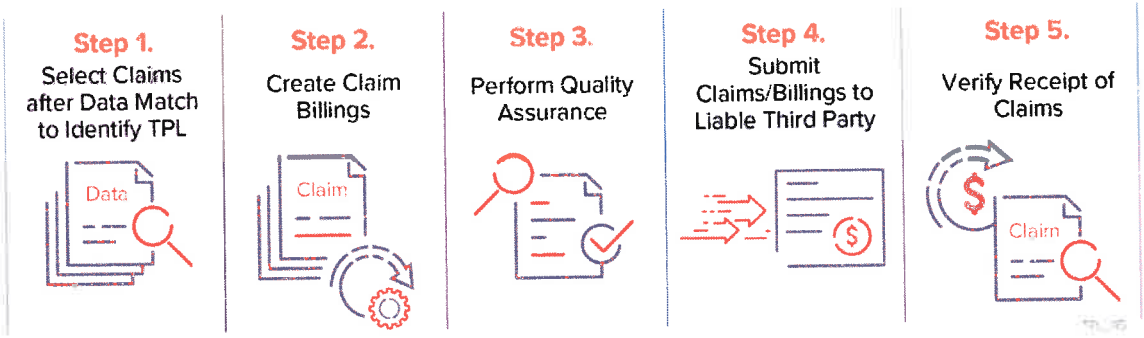
HMS Innovation: Business Rules Management System

Over the past three years, HMS has made a multi-million-dollar investment into an innovative Business Rules Management System (BRMS). While not utilized in WV today, we will incorporate BRMS into the current direct billing solution we provide to BMS in the new contract. When deployed for BMS, BRMS will provide increased visibility into individual direct bill cycles including claim level edits and client action items. BRMS reporting features include trending, benchmarks, and averages for comparative and analytical comparisons, all aimed at providing a transparent view into billing and recovery efforts aligned with modular Medicaid enterprise system delivery.

OUR DIRECT BILLING PROCESS

In **Exhibit** 7.1.4-1 below, we illustrate our direct billing process that ensures claims are submitted to the appropriate source for recovery and in a timely manner.

Exhibit 7.1.4-1 HMS' Direct Billing Process
Through our process, we ensure we submit claims to the appropriate source for recovery and in a timely manner.



We follow this process, with minor variations noted, to perform direct billing for commercial insurance, Medicare Part D, and TRICARE and if approved MCO come-behind recovery. We describe the primary tasks carried out during each of the steps in our process in **Exhibit 7.1.4-2** below.

Exhibit 7.1.4-2 Steps in HMS' Direct Billing Process
Our direct billing process helps minimize billing claims for non-covered services.

Step	Description
Step 1:Select Claims After Data Match to Identify TPL	Using the current results from our data match process and National Eligibility Data Platform (NEDP) to identify TPL, HMS performs another match to the cumulative BMS-paid claims history file, which we modify after receipt of the monthly file. With this process, we can identify claims paid by BMS, for which a third party may be liable during the last three years. HMS can identify all claims paid for an enrollee where there is newly identified third party coverage.
Step 2: Create Claims Billing	After satisfying a detailed list of eligibility and coverage criteria during the data match process, HMS generates billings on behalf of BMS. To minimize billing claims for non-covered services, before submitting claims to payors, we check to confirm the third-party coverage is consistent with the services the member received. We use available coverage codes, data maps, and category-of-service codes from the Paid Claims File. We also work regularly with insurance carriers to identify new ways to detect covered benefits. When the list of claims suitable for recovery is complete, we initiate direct billing. By making sure we bill the correct entity within the appropriate time frame and for the correct amount, we accelerate repayment to BMS. Our billing protocols, using HIPAA-compliant EDI standards, ensure we prepare and submit TPL claims to liable third parties in accordance with all federal and state regulations.
Step 3: Perform Quality Assurance	HMS refines our claim-selection process frequently to guarantee we can accurately identify and bill the maximum number of claims for our clients. To do this, we undertake multiple levels of quality assurance (QA) prior to approving billing cycle releases and submitting claims to liable third parties. After completing the final claims selection process, we produce summary Quality Assurance/Cycle Reports for internal review and approval. The QA team compares the billing to an established internal QA checklist that contains all BMS-specific or payor-specific edits to meet all requirements to bill claims.
Step 4: Submit Claims/Billings to Liable Third Parties	After both our internal QA team and BMS approve the billing cycle for release, we prepare and submit billing to payors using a variety of methods: electronic, clearing house, and mail. We select the most appropriate method per the insurance carrier, ensuring their acceptance and resulting in payment or

	actionable denial. However, **HMS currently submits more than 90% of carrier billings electronically.**
Step 5: Verify Receipt of Claims	Timely adjudication is a cornerstone of HMS' offering. By posting 100% of electronic claim adjudication information, HMS can monitor the timely adjudication of claims and target claims for follow-up through revenue cycle management (as described below), saving time and reducing overall operational cost.

PROVIDER DISALLOWANCE FOR COMMERCIAL INSURANCE, MEDICARE PARTS A AND B, AND PHARMACY CLAIMS

HMS advocates the use of the provider disallowance process as an effective tool in maximizing recoveries. We currently perform provider disallowance and recover on claims which are the liability of another third party, including commercial insurance carriers, pharmacies, and Medicare Parts A and B.

Overall, provider disallowance is the preferred method of TPL recovery and benefits both the State and the provider. In WV, HMS' analysis is used to determine what BMS would like to disallow, depending on what the provider network will support (e.g. certain provider types, certain claim types). Other important provider disallowance benefits include:

The major attraction for disallowance is that BMS establishes a timeline for the provider response, or they will be liable for the claim. The direct bill process is the opposite; we continue to request the carrier pay the claims until it is no longer eligible for recovery. With disallowance, all disallowance claims are reconciled after cycle close to see what was truly disallowed and what was rebutted.

- Higher recovery and provider satisfaction results for the State:
  - For certain claim types, providers can bill carriers more effectively and efficiently than HMS since they have access to additional information necessary to process claims. This results in higher recovery rates for BMS.
- HMS assists providers by identifying and validating other health coverage, increasing payment rates by billing commercial carriers rather than Medicaid.
- Disallowance means faster recoveries for certain claim types, including those that require medical records or other additional information to adjudicate.
- Less provider administrative burden — in many cases, HMS is already interacting with these same providers to obtain medical records and other information needed by carriers to process claims; the recoupment process would eliminate this burden for claims included in the recoupment cycles.
- Minimized provider abrasion – HMS will validate policy coverage for the claims selected for disallowance to mitigate unnecessary work by providers and then loads the data into our Provider Portal to initiate the disallowance billing cycle.

OUR PROVIDER DISALLOWANCE PROCESS

Because the disallowance process places some burden on providers, it is important to select claims in a way that maximizes the chances of payment and minimizes the resource and

administrative burdens placed on providers to comply with WV mandates. Coverage information included in disallowance listings must be accurate, and the services must have a reasonable likelihood of reimbursement. Given our extensive and successful carrier partnerships, our process includes contacting carriers to verify the TPL eligibility prior to launching the provider disallowance process—a crucial step that minimizes provider abrasion.

In **Exhibit 7.1.4-3** below, we illustrate the provider disallowance process that we follow to recover claims for commercial insurance, pharmacy, and Medicare Parts A and B claims.

Exhibit 7.1.4-3 HMS' Provider Disallowance Process
The HMS provider disallowance process maximizes the reccupment of funds for BMS.

Our BMS provider disallowance process, for both commercial insurance and Medicare, follows the same key steps outlined in the direct billing process for claims selection and QA. However, with provider disallowance, instead of billing claims directly to insurance carriers, we create and send a listing of claims for providers to submit for payment to the liable third party. In **Exhibit 7.1.4-4**, we describe the primary tasks we generally perform during each step, with minor variations depending on cycle type.

Exhibit 7.1.4-1 Steps in HMS' Provider Disallowance Process for Commercial Insurance and Medicare
Our provider disallowance process helps to minimize provider abrasion.

Step	Direction
Step 1: Claims Selection	HMS utilizes our NEDP as well as our data match process (**Section 7.1.6 Third Party Adds**) to initiate our claim selection process. In this first step, we generate (or run) disallowance cycles to create matches and then verify eligibility, as described further below. ◉ **Run Cycles to Generate Matches.** We select claims in a similar fashion as with direct bill. We perform a match to the cumulative paid claim history file to generate a file of TPL leads with the member demographic, policy, and claim information. Using that information, we select appropriate claims for inclusion in our disallowance process. **By applying more than 10,000 standard rules—in addition to customized client business rules and edits—our disallowance cycles include only those claims likely to be paid that meet BMS-specific requirements and thresholds.** ◉ **Perform Eligibility Verification.** To mitigate provider administrative burden, after generating the disallowance cycle, we validate policy coverage for all claims selected for provider disallowance.

Step	Direction
	Solid carrier relationships support our ability to obtain eligibility information for verification purposes quickly. To provide the highest quality of information to providers, we verify 100% of the policy coverage information for members prior to including their claims in a disallowance claims listing. We also check to confirm the third party coverage is consistent with services the member received.
Step 2: Create Claims Listings	Once we identify claims for recovery and validate the coverage, we generate the disallowance cycle by compiling claims listings, or report of claims identified for disallowance, for each provider. We then notify providers of the State's intent to recoup any identified Medicaid overpayments. The exception to this is with Medicare Part B claims where providers may submit checks, since the State prefers not to recoup Medicare Part B Claims. The claims listings are an output file of all members with verified policy and coverage information that aligns with the associated claims.
Step 3: Apply Claim Edits and Perform Quality Assurance	Before we transmit any notification and accompanying claims listings to providers, our HMS QA team reviews the documentation, to make sure it meets BMS-specific requirements. We also review the provider address and point of contact, the third party and policy information, and the claims listing information for accuracy.
Step 4: Correspondence- Create and Issue Disallowance Notices and Load to the HMS Portal	After QA approval, HMS initiates the disallowance cycle by notifying the provider of our intent to recover payments, through a BMS-approved Provider Disallowance Letter requesting they rebill the claims to the appropriate third party. Sent electronically through the HMS Portal or by mail, this Letter is accompanied by a detailed claim listing, relevant rules and regulations, HMS' contact information, payment guidelines, and instructions for disputing the disallowance and submitting supporting refuting documentation within the 60-day response period. The Letter also includes a toll-free telephone number that providers can use to speak with an HMS Provider Relations representative, who is knowledgeable of BMS-specific practices and reimbursement rules and can address inquiries and offer other assistance.
Step 5: Collection- Verify Receipt	Within 7-10 days after transmission of the disallowance correspondence to providers, HMS' Provider Relations representatives follow-up with each provider to make sure that the correspondence was received. All follow-up attempts to reach a provider and confirm receipt, are logged by the representative. Providers enrolled in the HMS Portal have the option to acknowledge receipt online in lieu of receiving a telephone call. If during follow up, a provider indicates they did not receive the letter by mail, the HMS Provider Relations representative may fax a copy to the provider.
Step 6: Monitor Recovery and Process Provider Documentation	After HMS confirms providers' receipt of the Provider Disallowance Letter, our Provider Relations representatives carefully manage the rest of the steps in the disallowance process, remaining available during business hours to respond to questions from providers regarding our process.
Step 7: Follow Up with Providers	Our Provider Relations team places a final follow-up telephone call to all unresponsive providers 14-21 days before the end of the BMS-specified response period. We notify these providers of a final close date and time as well as an approximate date on which we will recoup the claims in the listing. This gives providers ample opportunity to participate in the disallowance process. When the cycle closes on the specified date, our representatives close out the cycle, update the cycle status in the HMS Portal, and notify the HMS Project team.
Step 8: Reporting- Generate Claims and Recoupment File	After the disallowance cycle closes and the provider dispute period has ended, HMS begins the process to generate the claims file for BMS to recoup on. This Recoupment file is inclusive of claims that providers received other payment on as well as claims not responded to but received by the providers. We currently deliver this file in a BMS-required format customized for easy upload into the State's claims system and to retract against subsequent claims.

HMS understands we will only receive compensation for commercial, Medicare A & B, and pharmacy insurance disallowance recoveries that meet the following criteria:

- The collection is the result of HMS' effort
- The collection has been applied to the appropriate A/R system
- The commercial insurance exists in the BMS designated system(s) before payment to HMS

To verify the disallowance was a result of HMS action, we track and monitor the disallowance listing sent to the provider and the resulting disallowance date. Recoupments for claims made by providers directly to BMS before receiving the HMS Provider Disallowance Letter will not be invoiced to the State. To confirm that commercial insurance exists prior to HMS receiving the payment or having the disallowance processed, we use BMS' TPL Resource file of known other coverage to perform match off against our overpayment and recoupment information

PHARMACY COMMERCIAL DISALLOWANCE PROCESS

Rising pharmaceutical costs have led many payors to implement stronger plan policies. Following guidance from the Centers for Medicare & Medicaid Services (CMS), many medical plans now process certain medications in-house, instead of outsourcing to the PBM. Additionally, plan policies at PBMs now include more stringent formulary restrictions, step therapy, authorization requirements, limited distribution networks and more. Many of these new plan designs and pre-payment requirements make it more challenging than ever for TPL recoveries to occur in a commercial insurance direct billing process due to the lack of medical documentation and/or patient history. Related post payment recovery denials represent millions in "lost" dollars to the Medicaid program.

Today, we conduct a commercial disallowance process for pharmacy claims in WV. The pharmacy disallowance process provides BMS an opportunity to achieve higher recovery rates on high-cost medications and compound drugs by leveraging patient history, providing direct relationships between pharmacies and prescribing physicians, and identifying specific expertise of the pharmacy providers. In the disallowance process, the pharmacies submit claims for payment directly to the liable third party.

As with medical commercial insurance disallowance, this process is beneficial to both BMS and the provider. BMS typically recognizes on average a 21% higher recovery rate than that of the Commercial Insurance Billing process and the provider can recognize the generally high reimbursement rate that commercial insurance pays above and beyond Medicaid.

SPECIALIZED HMS RESOURCES SUPPORT OUR PROVIDER DISALLOWANCE PROCESS

We have several technical and human resources, available to BMS today, that support our provider disallowance process as highlighted below.

HMS PORTAL

Our secure, web-based HMS Portal allows our team to support providers in managing the recovery process, from assisting them with accessing claims and billing information to answering questions and inquiries in a timely manner. It helps alleviate administrative burden by allowing providers and team members to access listing information, update information, submit extension requests, and view comprehensive Status and Recovery Reports.

The HMS Portal is a comprehensive, cloud-based tool accessed through a secure Internet log-in. With more than 10,000 provider users across our client portfolio, this tool allows authorized users to view both summary and detail information about all aspects of HMS TPL processes.

The HMS Portal also facilitates disallowance cycle management by streamlining tasks. Once our team identifies claims for recovery and generates a disallowance cycle, we send an email notification to providers indicating their claims are ready for review. By logging in to the portal, providers have immediate, secure access to Medicaid reclamation claim information, including identifying information (e.g., control numbers and patient account numbers), comprehensive third-party insurance–billing data, payment information, and payment posting dates. Providers experience no delay and can begin their reviews at once, at their convenience, rather than waiting to receive the information in the mail. This not only provides a higher level of security but also allows providers more time to conduct their reviews and requires less time to process the reviews online than on paper—minimizing the effect on providers.

The benefits of the *HMS Portal to* the providers and BMS to support the disallowance process are displayed in **Exhibit 7.1.4-5.**

We offer user training during provider onboarding as well as on an as-needed basis that covers:

- Establishing and maintaining an HMS Portal account
- Using the portal to communicate with HMS
- Managing the disallowance process

More than 400 WV providers, currently enrolled with BMS, have already signed up and are using the HMS Portal as part of the Provider Disallowance program.

Providers can directly access user documentation from the portal. They also have the option of directly contacting our Provider Relations team through toll-free telephone call, fax, or email to obtain assistance, discuss recovery issues, and receive additional information.

Exhibit 7.1.4-5 HMS Portal Provider Features that Benefit the Provider Disallowance Process
Our HMS Portal enables the WV provider community to engage in the provider disallowance process in a more streamlined fashion and with minimal administrative burden.

We implemented an enhanced HMS Portal for the State in late August 2020. An additional option available is the ability to gain BMS client-level access to the portal to review current cycles along with claim level details.

HMS' Provider Relations Team

Our Provider Relations team is our dedicated customer service team that supports our disallowance process, delivering consistent, high-quality service while ensuring a successful outcome for each post-payment recovery cycle. This team works exclusively with providers, fostering collaboration and building strong relationships with WV's provider community, while guiding them through the recovery process and responding to questions and inquiries.

These healthcare specialists have extensive medical billing knowledge, understand complex billing and reimbursement issues, and know how to handle issues that arise with BMS' post-

HMS' Provider Relations Team

Our Provider Relations team members are adept at managing disallowance cycles from start to finish and experienced at communicating with providers. They continuously answer disallowance process-related questions, resolve issues that arise during the recovery period, provide supplemental data and information, and manage provider correspondence in a timely manner. They are available to answer any questions providers have regarding the disallowance process and can be reached by email, through a toll-free telephone number, or by fax.

The specific tasks our Provider Relations representatives perform include:

- Communicate with providers to make sure that the requirements and documentation are clear and understood
- Inform providers about the time frames they need to respond to the project
- Supply additional information on the claim record as requested
- Review documentation submitted, including payor denials, copies of the fronts and backs of checks that prove the provider has already refunded the payment to BMS, and copies of BMS remittance advices that show a prior void of the claim
- Review and respond to provider requests for extensions of time to respond to Disallowance Notices, as instructed by BMS

payment recovery process. Outreach by this team also requires the ability to efficiently handle a large number of provider contacts.

Communication Plan and Escalation Process

HMS communicates with many stakeholders during the post-payment disallowance recovery process. The most important communication occurs between HMS and the WV provider community. The Provider Relations team manages communications throughout the recoupment process to confirm that providers receive notifications and work claims in a timely manner.

All written communications used in the course of managing the provider disallowance process are approved by BMS prior to their use. For alignment on communications across all parties, HMS incorporates messaging in BMS' preferred manner. HMS adheres to a thorough approval process regarding the revision of correspondence, forms, notices, and other materials used to conduct daily operations. Prior to the distribution of newly developed or revised correspondence and materials, HMS will also seek BMS' review and approval.

Should a situation or issue occur pertaining to BMS' disallowance process, HMS has established processes in place to escalate matters to expedite resolution. If we are unable to resolve the dispute, we notify BMS of the issues raised and provide a summary of the pertinent facts and applicable laws and/or rules, copies of relevant documents, present the courses of action that are available and our recommended course of action. We will work with BMS to resolve the issue and provide BMS' decision to the stakeholder.

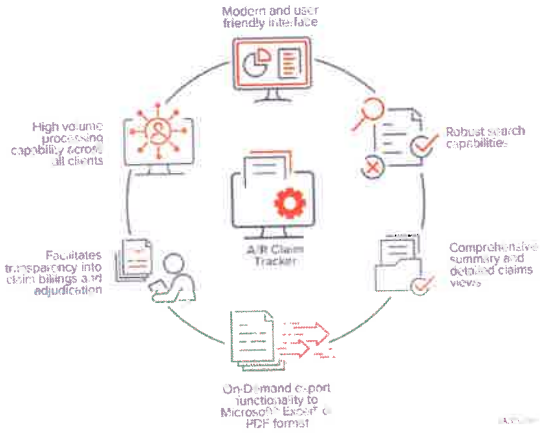
MMIS Transaction Posting Method

While our current process for BMS does not incorporate a reconciliation file that generates a posting transaction to the State's MMIS vendor, we do have an established process for this task that is operational for many other state Medicaid agency TPL contracts. We have the capability to begin this process for BMS with the new contract. This is a simple step to incorporate into our workflows with an additional file that we will submit to BMS through SFTP. We will work with BMS directly to provide sample layouts that HMS currently utilizes for this process and customize this report to fit both BMS' and the MMIS vendor requirements for transmission.

7.1.4.3 Establish, Maintain, and Update an Accounts Receivable File (App 1, TM038 -TM039)

For direct billing recoveries, following our submission of claims and billings to the appropriate insurance carrier, we utilize our comprehensive accounts receivable process (**Exhibit 7.1.4-6**). Customized for BMS, the process includes creating, maintaining, and updating an accounts receivable file to prepare for our subsequent process to manage payment collections. Below, in **Section 7.1.4.4,** we describe our entire process for sending commercial and Medicare disallowance files to BMS monthly.

Exhibit 7.1.4-6 A/R Claim Tracker
Our complete A/R process is driven by A/R Claim Tracker.



HMS has a process established today for transmitting all disallowance recoupment files regularly, which we will continue in the new contract. This includes the transmission of the recoupment file, once our cycles close, to the fiscal agent as described in Step 8 of **Exhibit 7.1.4-4,** above. These finalized files utilized for invoicing are included in our monthly back-up and contain claim level details for each cycle as described in Step 5 in **Exhibit 7.1.4-9,** below.

HMS agrees to transfer the BMS-specific accounts receivable file to the State at its request or at the termination of the contracting resulting from this RFP.

A/R Claim Tracker Facilities Recovery Tracking

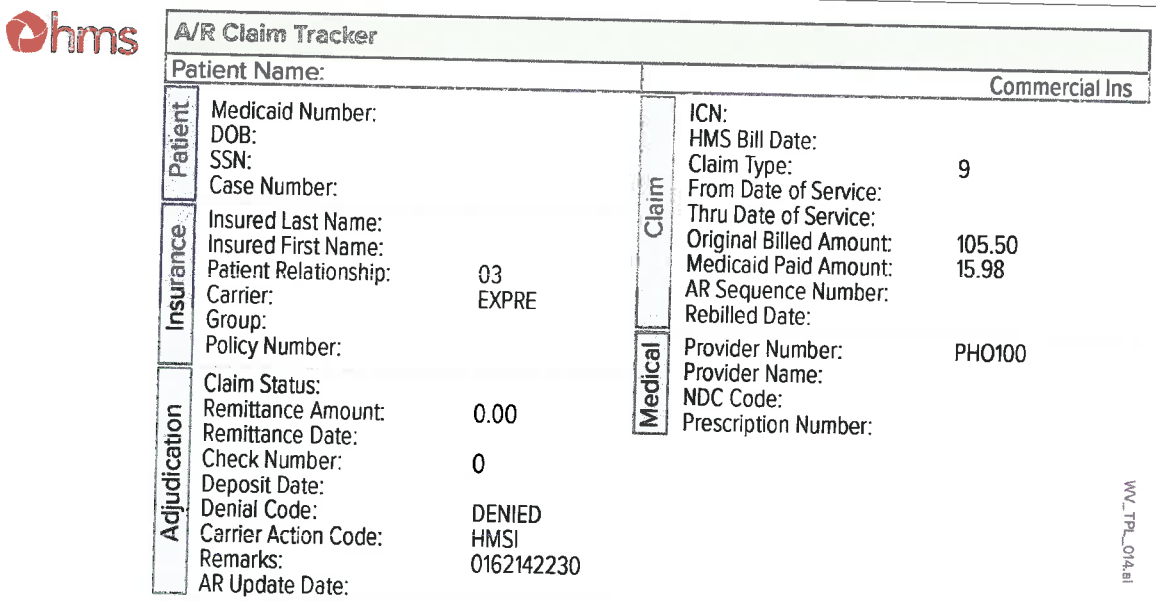
HMS has a secure, stable accounts receivable (A/R) system to house all claims billed to third-party payors along with their adjudication results. This system, known as A/R Claim Tracker, is the result of years of ongoing investment in new technology to support our billing, collections management, and follow-up activities as well as provide effective and accurate reporting for our clients, including BMS.

BMS will continue to have access to our A/R Claim Tracker tool, through our HMS Portal, to review claim-level details on any HMS sent out to recover through our direct billing or disallowance cycles.

We update the A/R, manually or electronically, with remittance data (payments and denials) that we receive from carriers, providers, and fiscal intermediaries. To ensure we post remittance information accurately, we have programmed our system with complex logic that includes hundreds of universal and carrier-specific posting rules. Recent upgrades in our A/R and case-management systems provide enhanced posting, document imaging, reconciling, import/export functionality, and web-based reporting.

Exhibit 7.1.4-7 illustrates the claim-level detail viewable in A/R Claim Tracker.

Exhibit 7.1.4-7 HMS' A/R Claim Tracker: Claim Details
Our A/R Claim Tracker application allows users to view claim payment and denial status.



A/R Claim Tracker allows for effective financial controls and complete tracking and reporting capabilities. By maintaining a record for every claim billed on BMS' behalf in our A/R system, along with posting claims activity (payments and denials) at the claim level, we create a comprehensive audit trail for State and federal documentation requirements that provides the adjudication status—and subsequent follow-up activity—through closing of each claim.

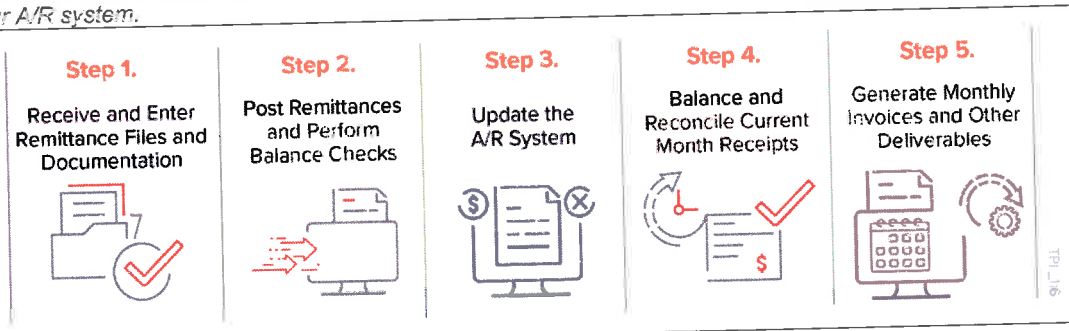
7.1.4.4 Posting Recovery Payments (App 1, TM040 – TM043)

As introduced in **Section 7.1.4.3** above, we have a specialized, integrated solution to manage the accounts receivable file and collections. This process drives the timely processing of remittances post carrier adjudication, including posting, tracking, and reconciling all payments and denials resulting from HMS-generated billings.

Our Collections Process

HMS follows Generally Accepted Accounting Principles (GAAP). We maintain separate accounting and financial records for individual clients and for each separate contract in those instances where we provide services to multiple agencies within one state. Records related to the BMS TPL project will remain separate and independent of our other accounting records. In **Exhibit 7.1.4-8**, we provide a visual representation of our process for handling A/R collections.

Exhibit 7.1.4-8 HMS' Accounts Receivable Collections Process
HMS has developed hundreds of posting rules and logic for this process, ensuring that we post the correct records on our A/R system.



To process the carrier payments, our systematic process leverages our A/R system and includes the following steps detailed in the table in **Exhibit 7.1.4-9**.

Exhibit 7.1.4-9 HMS' Collections Process
Our systematic collections process leverages A/R Claim Tracker.

Step	Description
Step 1: Receive and Enter Remittance Files and Documentation	For the forthcoming contract, will continue to use BMS' established lockbox through BB&T, to manage the receipt of recoveries for the State from third party resources. We will offer an HMS-managed lockbox as an option, preferred by most state clients. We receive remittance information, including payments and Explanation of Benefit (EOB) documentation, through the project lockbox, or directly as electronic files. To process the documentation, we: ◉ Pull the payment images and deposit file from BB&T daily to validate the deposit information ◉ Provide the weekly deposit files to BMS for subsequent review and reconciliation.
Step 2: Post Remittances and Perform Balance Checks	Within 24 hours of receiving remittance information and processing the documents, our Data Entry team keys all line items associated with each check for that batch, capturing the check number, payor name, amount, and date. We then: ◉ Ensure each EOB balances to the check amount, and the batch balances to the deposit total. Note: we identify checks and deposits that are out of balance due to a carrier retraction, partial/missing EOB, electronic payor, etc., and report them as part of our monthly reconciliation process ◉ Identify and report any checks that appear to be unrelated to HMS activity as a part of our monthly reconciliation process ◉ Validate that the total matches the bank deposit summary ◉ Transmit validated detailed records through Secure FTP to our Electronic Data Interchange (EDI) site. Simultaneously, our A/R team updates our document repository (DocDNA), our system for keeping scanned images for the specific deposit. We also identify and report any bank errors to BMS, and the bank, for correction.
Step 3: Update the HMS Internal A/R System	After entering and posting remittances and performing balance checks, HMS updates A/R Claim Tracker with claims adjudication results, including payments and denials. We run batch-posting jobs nightly to reconcile the records from the BMS-specific repository to search for the claim associated with the remit record and post that record to the correct A/R. Then we: ◉ Change the status of these claims on the A/R from OPEN to PAID ◉ Update the record with all check and payment information keyed for that specific claim If the batch-posting logic fails to find an appropriate claim in the A/R system, we will place the remits in an UNMATCHED status, and our Invoicing team will manually key the records. The lockbox used for the payment of billed claims for BMS also receives denials and nonpayment documents. HMS has two distinct procedures for managing payor payments and non-payments/denials. While we process and enter non-payments/denials into the A/R system in a

Step	Description
	manner similar to that used for processing payments, we instead update the status from OPEN to DENIED, with the specific denial-reason code indicated. HMS distributes the Exception Reports for the denials to our Denial Follow-Up team members who determine and execute appropriate actions. If we cannot identify a claim on our A/R system for payment posting, we do not invoice BMS for a recovery contingency fee on that payment.
Step 4: Balance and Reconcile Current Month Receipts	HMS balances and reconciles all current month receipts on a daily deposit-date basis, which we report upon monthly. Throughout the month, the invoicing analyst balances deposits as we receive them. Project analysts also contact carriers for missing EOBs in an attempt to obtain the information for timely posting. Our invoicing team reviews the payment exception reports, generated by batch posting, daily to incorporate these unposted items to our A/R system. This may involve viewing a scanned image of the EOB or searching for the claim in our internal system. If our A/R team fails to identify the claim(s) to which the payment should apply, we categorize the recovery as NOT FOUND/ UNIDENTIFIED PAYMENT and report this information to BMS as part of the monthly invoice. Our cash-management process uses a balanced combination of technology and manual verification to post, track, and reconcile checks from initial receipt to monthly invoicing.
Step 5: Generate Monthly Invoices and Other BMS Deliverables	HMS submits monthly invoices to BMS, based on finalized recoveries. After our operations analyst validates the postings are accurate and complete, we generate a BMS Invoice Report. The analyst creates an invoice, including the attachments for recoveries in a NOT FOUND/UNIDENTIFIED PAYMENT status, deposit summary by date, and the Refund Reconciliation Report. The HMS Finance team reviews all invoice documents, assigns a unique invoice number, and generates an Invoice Report with all contract-specific deliverables (such as required reports) attached. Under the current contract, HMS provides six reports to BMS such as: ◉ For Direct Bill: WVCI, WVT_Recoveries. ◉ For Disallowance: Disallowance through WV Lockbox, Reversal Import Files. HMS understands that BMS requirements regarding report format, content, and submission frequency are subject to change at any time during the term of the contract. We have provided report samples in **Exhibits 7.1.4-10 through XX** located in proposal **Appendix 1.**

7.1.4.5 Investigating Reasons for Non-Payment and Resubmitting Claims (App 1, TM044)

HMS monitors the timely adjudication of claims and targets unresolved billed claims for follow-up. We do this to investigate reasons for non-payment by third party payors and resubmit claims when appropriate. We understand that specific reasons for non-payment must be included in the accounts receivable file described previously.

In 2019, the additional recoveries from revenue cycle management follow-up activities HMS performed nationally totaled more than 30% of all commercial carrier recoveries – increasing our recovery yields for all States.

Known as our revenue cycle management process, additional steps in our billing process enable us to track and follow up on every claim through to final adjudication for BMS. Whereas our competitors may use a singular approach to recover payments, HMS's multi-faceted approach tends to recover more for our clients.

We monitor carrier responses to identify unresolved claims submitted to insurance carriers that appear most likely to be able to be resolved and paid from a targeted follow-up approach. We analyze, correct, and resubmit inappropriately rejected and denied claims as well as all claims that remain open on the A/R within six months from the initial billing.

- **Follow-up on Denied Claims.** Many claims initially denied by carriers are actually eligible for recovery. HMS' Denial Management staff can follow up on those that do not comply with state or federal law (e.g. timely filing). The staff will work with the carrier to resolve compliance issues, or issues such as missing information that would prevent a carrier from repaying a claim to the State.

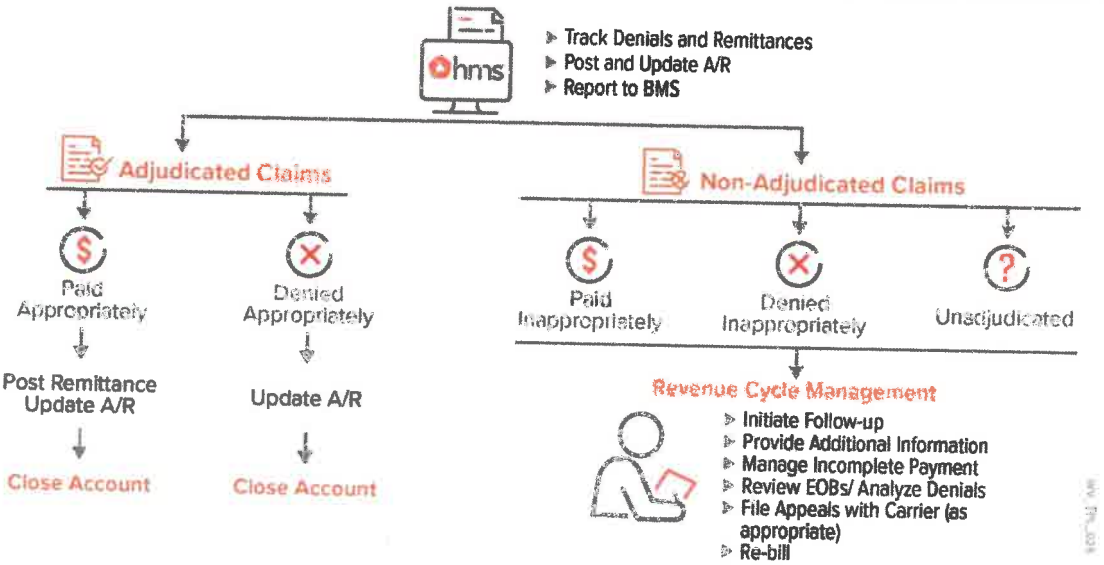
Through our revenue cycle management process, we reprocess claims continuously, until they are billed or past timely filing. In most states, this period is three years- HMS "attempts" to find a match and bill a claim upwards of 36 total times.

- **Follow-up on Open, Unadjudicated Claims.** To the extent possible, HMS will identify claims that have been billed to a commercial or Medicare Part D carrier but have not been paid or denied. We will load these claims into our A/R system for appropriate action including re-billing or carrier follow-up by a carrier account representative.

We engage multiple HMS teams to routinely follow up with carriers on the workable open and denied claims, targeting the claims at the claim level, carrier level, and carrier group level. Our follow-up protocols include denial analysis, correct payor analysis, and obtaining additional claim information.

As depicted in **Exhibit 10**, we actively monitor the processing of claims submitted to third parties. Our A/R system generates reports that we use to monitor adjudication rates, identify unadjudicated claim populations, file appeals with carriers (as appropriate), and rebill open and denied claims. HMS uses this information to target carriers that might need additional follow-up to increase their adjudication rates.

Exhibit 10 HMS Claim Status Monitoring
We aggressively track the status of each bill, so that each is resolved to the satisfaction of BMS.



Our teams coordinate efforts and use the most effective methods to follow up, rebill, and resubmit claims, as appropriate, to recover every dollar owed to BMS. We ensure that our rebilling and follow-up activities do not overlap with those of the State or its MMIS vendor for any type of other health coverage activity (e.g., commercial insurance and Medicare). Our methods for follow-up, collection, and reporting provide an effective and efficient process to avoid duplication of BMS' automated billings. We have developed multiple protocols to ensure the non-duplication of effort between BMS and HMS. This has enabled BMS to pursue recovery on their identified claims while our process provides supplemental identification and recovery. The implementation of these protocols by another vendor would take multiple attempts and likely result in confusion and overlapping claim pursuit.

7.1.4.6 SEEKING REIMBURSEMENT (APP 1, TM045)

Throughout our proposal, we have described our approach, plan, and process for seeking reimbursement, or recoveries, from liable third parties on all claims in which we determine the amount reasonably expected to recover will be greater than the cost of the recovery itself. We affirm that we will suspend or terminate recovery efforts on a specific claim, or set of claims, if they are not cost-effective as specified by BMS.

7.1.5 CREDIT BALANCE AUDITS

HMS began offering Credit Balance Audit (CBA) services to our government healthcare clients in the mid-2000s and successfully performs them today for more than 20 clients. Over the past five years, on average, our CBA recoveries have drawn an average of $74 million per year, nationally. We are well-versed in the different CBA service requirements, levels of effort, and

resources required for various types of contracts. For an impactful provider experience, we also maintain positive provider relationships through education and consistent communication to reduce future overpayments and collaborative working arrangements to ease provider burden.

Under the current contract with BMS for CBA services, which began in September of 2011, **our efforts have resulted in more than $4 million in recovered payments for West Virginia Medicaid.** Through our extensive TPL and CBA work in the State over the past 20 years, we have established solid working relationships with many providers, including Charleston Area Medical Center (CAMC). Based on the strong relationship established with CAMC, HMS has secure remote-based access to their financial system to review credits on a regular basis.

During the most recent BMS engagement, we have performed audits on more than 134 providers (including 85 providers that report as desk audits/remote audits and 49 amnesty providers), while successfully minimizing provider abrasion for the State.

HMS has knowledgeable audit staff with years of direct experience with the WV's Medicaid environment, program, and requirements. They are also familiar with the Medicaid populations, stakeholders, data, BMS' recovery methods, overpayment and payback policies, and the provider systems and limitations. We look forward to continuing to generate credit balance identification and recoveries for WV Medicaid due in large part to our established working relationships with providers and the training and systems access HMS provides to them.

Proposed CBA Solution for BMS

Our proposed solution for BMS includes our CBA provider audits, currently, and for the new contract we recommend BMS consider expanding the current scope of work to include managed care encounter data and onsite CBA reviews to facilitate recovery increases for the WV Medicaid program. Our systems are ready to incorporate managed care encounter data into our CBA workflows. The HMS CBA team conducts Managed Care Organization (MCO) reviews for a number of our state clients and can seamlessly incoporate these reviews into our process. As the majority of Medicaid lives are in the MCO plans, the expected volume of claims to review could necessitate the need for onsite audits. **Inclusion of the managed care claims will help ensure the maximum number of overpayments are identified and recovered by BMS.**

7.1.5.1 Identifying and Recovering Overpayments (App 1, TM013 and TM015)

Our CBA work is provider-sensitive and distinguished by our ability to integrate this work with other projects to identify overpayments of which the provider is not aware. Because we perform this scope of work for BMS today, we can easily continue provider credit balance audits with the TPL services scope of work requested by BMS in this RFP.

Our CBA services work to achieve four goals:

- Identify the greatest number of overpayments
- Recover funds due to BMS quickly and efficiently
- Provide valuable cost avoidance data to BMS to help minimize future overpayments
- Educate providers to minimize overpayments from occurring, where appropriate

OUR CBA APPROACH

The flexibility of our CBA approach sets us apart:

- We perform different types of audits, as described below, and can expand service scope to additional audit types, if needed.
- Our HMS audit staff has expertise in all major provider auditing environments, including hospitals, mental health facilities, dialysis clinics, and physician groups.
- We support both Fee-for-Service (FFS) and MCO encounter data; our systems are ready to support both populations.

Within our CBA service portfolio, HMS can perform one or multiple audit types to identify and validate potential credit balances, which drive recovery of overpayments. Generally, the audit type is determined by the number of credits reported by the provider and/or any of the other factors described within each of the following audit scenarios.

Scenario	Description
Desktop Audits	After a provider sends the Aged Trial Balance (ATB) report, the HMS auditor analyzes the ATB report to determine which claims should be subject to further review. For providers with space issues and/or lower claim volume, HMS requests providers to submit uniform billings (UBs), Accounts Receivable system screenshots (e.g., Demographics, Payments/Adjustments, Summary of Charges, Relevant Notes), and copies of explanation of benefits (EOBs) to HMS. These audits typically require two weeks to complete, depending on volume.
Onsite Audits	We select providers for onsite audits based on criteria developed by BMS and the HMS CBA team. In addition to providers with high claim volumes, other reasons why a provider may undergo an onsite audit include large provider size, historically large refund amounts, known payment issues, and large payment amounts. We request that providers make appropriate personnel available to HMS for interviews regarding billing practices and behaviors. Information gathered from these interviews is used when performing an analytical review of transactions related to the financial accounts of targeted Medicaid recipients. Our onsite audits typically require one to four days to complete, depending on volume.

Scenario	Scenario
Amnesty Audits	Typically targeting all provider types and providers with a low credit balance claim volume or other attributes, amnesty audits are designed to identify all overpayments. Working with BMS to identify the target provider population, we send annual request letters to selected providers; the provider then returns a self-reporting file disclosing all credit balances. Thereafter, HMS enters the identified claims into our claims platform (InVision). We accept agreed-on payment, typically a refund check from the provider, and then submit all findings to BMS with the approved self-report template and refund payments.
Dialysis Audits	We have established positive working relationships with the two largest national dialysis networks (DaVita and Fresenius Medical Care). We have both national and local relationships with these networks and have developed processes to make the audits effective and efficient. These providers send a self-reporting file disclosing all credit balances and provide all documentation needed for HMS to conduct the audit. HMS then validates the payment in BMS's claim system to eliminate duplication. The dialysis provider submits the detailed report and refund check to BMS.

ADDITIONAL BENEFITS FROM HMS' CBA APPROACH

Beyond flexibility and easy integration, our CBA solution provides additional benefits.

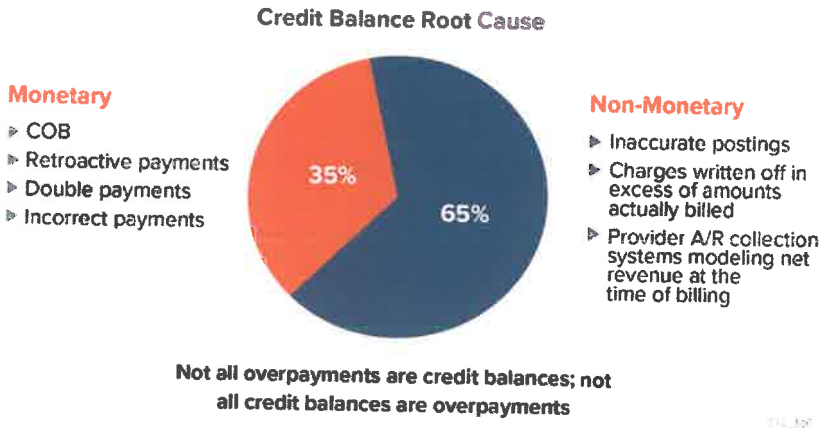
DETERMINING ROOT CAUSE ANALYSIS

By understanding the underlying reason(s) for the existence of a credit balance, providers can prevent them from recurring.

To enhance the value of our CBA services, our approach not only identifies and recovers existing overpayments, but also seeks to identify the root causes of the credit balances and to assist providers in correcting potential system issues. We do not rely solely on reporting submitted by providers and/or facilities to identify overpayments. We also perform specialized claims analysis on the available claims and payment data to identify additional overpayment targets that providers may not be aware of at the time. We also use data analytics to identify other recovery opportunities that may not be identified as "credit balances" in provider accounting systems. Our analyses are iterative and comply with state-specific and national regulations. Our experience has shown that while many states have generic issues causing overpayments (e.g., incorrect coordination of benefits, retroactive TPL coverage), many other causes stem from state-specific billing issues associated with the providers. Our credit balance process can identify issues specific to BMS, and we can target claims with criteria consistent with these overpayments.

Credit Balances occur for a variety of reasons, both monetary and non-monetary. **Exhibit 7.1.5-1** shows the national results of HMS' CBA Root Cause program.

Exhibit 7.1.5-2 Highlights of HMS' Credit Balance Root Cause Program
Monetary refund reasons vs Non-Monetary: 65% of what we identify ends up being non-monetary.



Using Data Analytics to Identify Additional Recovery Opportunities

In addition to reviewing claims submitted on provider Aged Trial Balance (ATB) reports, HMS will use data analytics to identify additional recovery opportunities that may not be identified as "credit balances" in provider accounting systems. As our credit balance process identifies issues specific to BMS, we target claims with criteria consistent with these specific overpayments.

Following are examples of our data-mining targets:

Target	Description
Zeroed-Out Accounts	In a new contract term, HMS will review provider debit adjustments on BMS' paid accounts to verify that A/R systems are not improperly posting debit adjustments to offset credit balances. "Zeroing out" accounts is a widespread accounting practice intended to clean up accounts before the provider completes financial reporting. In nearly all cases, providers that apply this offset do so with good intentions. However, this seemingly innocuous practice masks overpayments by incorrectly "flipping" accounts that are in credit balance status to accounts with a zero balance. By analyzing debit adjustments, we can successfully identify overpayments where providers were unaware and correct system settings that providers did not realize were in place.
Incorrectly Reported Coinsurance /Deductible	We can identify claims in which the coinsurance/deductible amount reported to BMS is either inaccurate or suspect. An unusually large coinsurance amount may result in an overpayment, or it may be the result of exhausted benefits or another appropriate reason.
Inconsistent TPL Information	We will identify claims in which the reported TPL information is inconsistent, for example, where TPL is listed on the claim but there is no payment, or no TPL but a payment is listed and unusually small. These types of inconsistencies are characteristic of potential overpayments, and HMS will review the claims to identify refunds to BMS.

Preventing Future Credits Owed to BMS Through Provider Education

As appropriate, HMS educates providers on issues identified during the review resulting in overpayments to eliminate or minimize issues that result in BMS overpayments. We often use the Exit Conference in Step 6 of our CBA process as an opportunity to educate providers on

underlying or systemic overpayment issues that we identify. For Medicaid claim reimbursement issues identified by HMS that affect numerous providers, we work with provider associations to educate the association and/or multiple providers simultaneously.

OUR CBA PROCESS

To identify targets with potential credit balance overpayments, where appropriate, we start with the information self-reported by providers. Providers will mail listings of claims and overpayments along with a check to the state to refund those payments. While some states have a self-disclosure portal in place, providers typically submit listings of claims in a credit balance status on their Aged Trial Balance (ATB) reports.

Instead of relying solely on the reporting submitted by the providers, we also perform specialized claims analysis to identify additional targets. **This is a key differentiator of our solution—we analyze the voluminous claims and payment data that we possess to identify overpayments of where providers may not be aware.**

To conduct desk audits on the identified targets, or onsite audits if contracted, HMS leverages an established, well-tuned provider CBA process. **Exhibit 7.1.5-2** illustrates the BMS-approved credit balance audit work plan.

Exhibit 7.1.5-2 HMS' Provider Credit Balance Audit Process
Eight distinct tasks make up the audit process.

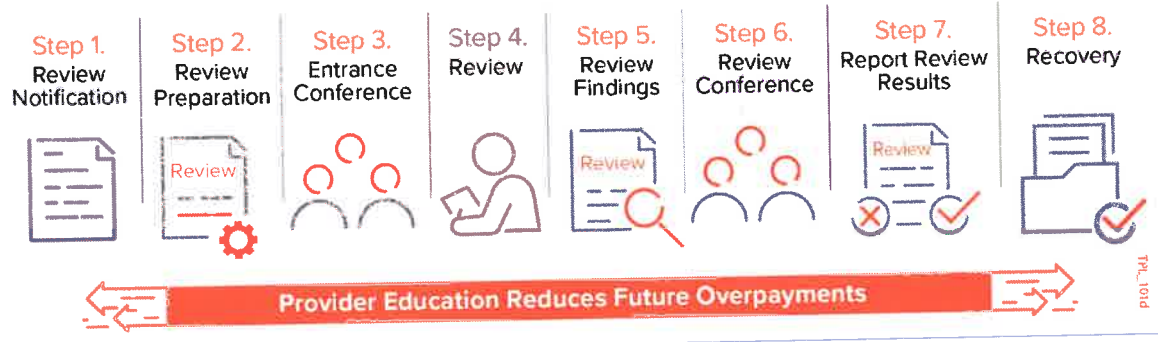


Exhibit 7.1.5-3 subsequently provides a description of the key tasks we carry out during each step of our CBA process.

Exhibit 7.1.5-3 Description of the Tasks Carried Out During HMS' CBA Process
HMS leverages an established, well-tuned provider CBA process for WV.

Step	Description
Step 1: Notify Provider of Audit	We begin our audit process by notifying the provider of the forthcoming audit via these methods: ◉ **Pre-audit conversation.** Our CBA personnel conduct an entrance conference with the provider by telephone, introducing them to HMS and our audit process. ◉ **Review Notification Letter.** We generate and mail through USPS a Review Notification Letter (sample provided as **Exhibit 7.1.5-4** located in proposal **Appendix 1**) to the provider's known Patient Accounts Manager or Chief Financial Officer approximately 30 days prior to the expected audit start date. As part of the notification process, we request that the provider submit the following documentation to HMS before the audit start date:

Step	Description
	◦ Detailed listing of all credit balances with BMS activity ◦ Accounting system used (e.g., EPIC, MediTech) ◦ Names/details of other entities billing for the provider ◦ Billing collection and credit policies
Step 2: Prepare for Audit	To prepare for the audit, we ◉ **Review requested data.** Our team uses the data received from the documentation request to determine the scope of the audit, address logistical considerations, respond to preliminary questions, and provide a general overview of the audit scope to the provider. ◉ **Determine how the audit will be conducted.** The audit will either be conducted as an onsite or desk audit. ◉ **Select accounts for audit.** HMS reviews accounts identified as having outstanding or closed credit balances, or those claims with characteristics of overpayments
Step 3: Conduct Entrance Conference	During the Entrance Conference, we: ◉ Describe the purpose of the audit. ◉ Identify key provider representative. ◉ Determine and describe the duration of the audit. ◉ Describe audit procedures. ◉ Obtain requested documents and billing systems access. ◉ Request explanation for details of any unusual billing/reimbursement practices. ◉ Discuss exit conference.
Step 4: Perform the Audit	Our provider audits consist of meeting with the provider patient accounts personnel and conducting an analytical review of documented transactions affecting the financial accounts of selected BMS recipients. Specifically, we review: ◉ Medicaid credit balance accounts ◉ Medicaid paid accounts where a debit adjustment has occurred within the last six months ◉ Selected Medicaid accounts identified by HMS. To complete the audit, we require access to the following items: ◦ Detailed claim information, including Explanation of Benefits ◦ Patient accounts receivable information, including payment and adjustment screen shots, account history and notes ◦ Medicaid Remittance Advices (RA) or system screen shots ◉ We also perform credit balance reconciliation, where our team reviews accounts in a credit status to determine if an overpayment is due to BMS.
Step 5: Document Audit Findings	◉ Once it has been determined that a refund is due to BMS, the claim is entered into the HMS system ◉ All supporting backup documentation is scanned and attached to the claim. ◉ A worksheet is generated for each claim identified as having an overpayment, which provides claim-level detail and the reason for the overpayment and the amount due back to BMS. ◉ We require sign-off on each account the provider agrees. Accounts with discrepancies include findings from both the provider and HMS. Providers have the option to sign hardcopy worksheets or to review and approve claims online within our secure Provider Portal.
Step 6: Conduct Audit Exit Conference	During the exit conference, we review all findings and resolve discrepancies with authorized provider personnel. During this meeting, based on volume, we attempt to receive provider consensus and sign-off on the credit balance worksheet prior to the conclusion of the audit. If a provider requests additional time for approval and attestation, we work with them to make sure that the approvals are provided within a timely window or as directed by BMS. This provider sign-off process is an important quality step to ensure the provider is aware of all refunds.
Step 7: Report Audit Results	HMS' CBA system and tools feature comprehensive reporting capabilities. All supporting documentation is scanned into our system. We apply our established process for promptly reporting to BMS the audit findings and overpayments, including the BMS-required reimbursement process. We provide further details about our reporting process and sample audit reports and other documentation **Section 7.1.5.3.**

Step	Description
Step 8: Initiate Recovery	Once we obtain written approval from the provider, HMS initiates recovery of the credit balance overpayment, specific to BMS requirements. We provide further details around our accounts receivable process in **Section 7.1.5.3.**

SUPPORTING SYSTEMS

We use several systems to support our credit balance audits as well as facilitate tracking and reporting, namely our internal InVision credit balance audit management application and two CBA-specific portals, which link with InVision and enable automation of tasks and communication between the systems.

- **InVision Credit Balance Audit Application.** HMS uses our InVision credit balance audit management repository to enter detailed information on all overpayments identified, track audit findings, monitor claim aging, store appropriate backup documentation and to generate audit worksheets and reports for provider approval. By compiling audit data in a secure, easy-to-use interface, InVision facilitates effective audit management. We capture every relevant data point for each overpayment, including the Medicaid Recipient Number, Internal Control Number for the claim, reason for the overpayment, provider information, and other data points, as well as a link to the associated claim documentation. Key features of the InVision system include data security, efficient data aggregation, documentation tracking, preload of claim information, audit note capture, quality assurance, online syncing, and audit data customization.
- **HMS' CBA Provider Portal.** HMS is currently launching a CBA Provider Portal for BMS, which is also linked with our InVision system and enables automation of tasks and communication between the systems. This portal is an approval tool used by provider staff to review, approve, or request additional details on audits. It also enables providers to review supportive documentation for claims that are identified by our reviewers as overpayments due back to BMS.

7.1.5.2 IDENTIFICATION OF ALL REFUNDS (APP 1, TM014)

As the incumbent CBA service provider for WV, HMS has established processes for responding to refund requests made by insurance carriers or other third party payors. Carrier refunds may occur for several reasons: carrier allowance exceeds Medicaid payment, duplicate refund, member not covered by carrier, service not covered, or BMS received a payment in error Not all refund requests received deserve a refund or have the supporting documents to prove the refund is due. Upon receipt of a notification from a carrier requesting reimbursement due to an overpayment on their part, the HMS Carrier Relations specialists review the request to ensure its validity and that all proper documentation is attached. As per BMS guidelines, we request that the following items be included at their review before a refund is approved: Letter requesting a refund, Explanation of Benefits (EOBs)/reason for overpayment and Copy of payment check.

When all the required documentation is received from the carrier, HMS conducts the following work steps:	
Step 1	◉ Complete Carrier Refund Request Form and memorandum to include the appropriate claim-specific information and submit it to BMS
Step 2	◉ Scan/retain appropriate documentation and email it to the HMS project manager
Step 3	◉ Complete review (HMS project manager) of documentation for accuracy; if accurate, sign the form and forward hard copy documentation to BMS for approval
Step 4	◉ Enter data on the Adjustment tab of the electronic invoice; carrier refunds are included as a negative adjustment on the invoice
Step 5	◉ Receive refund processing approval from BMS, which cuts a check by the State for repayment to the carrier.

CREDIT BALANCE AUDIT REPORT (APP 1, TM007)

As introduced earlier in Steps 7 and 8 of our CBA process, we provide the requested details around our reporting and accounts receivable work in the following narrative.

At the end of each audit and following the Exit Conference, we will generate and send out the following materials: provider letter with sample and claim list, Credit balance worksheet (CBW), and Final report (also known as an adjustment/recoupment report). In addition to our detailed project reports, we provide at BMS' request all back-up documentation supporting the overpayment finding and the provider's attestation. Through our current scope of work with the State, we have reports already developed and utilized for CBA services. We provide sample CBA reports as **Exhibits 7.1.5-5 and 7.1.5-6** in proposal **Appendix 1.** During implementation, we will work with the State to customize our standard reports and/or develop new reports for use with CBA. HMS understands that BMS requirements regarding report format, content, and submission frequency are subject to change at any time during the term of the contract.

Our final report typically includes the following data on each claim determined to be an overpayment but could be customized according to BMS requirements:	
◉ Provider name and number	◉ Medicaid Payment date
◉ Date of service to and from	◉ Amount paid by Medicaid
◉ Patient first and last name	◉ Amount of identified overpayment to be refunded to Medicaid
◉ Medicaid number (i.e., unique recipient identification number)	◉ Claim control number (ICN, TCN).

To enhance the value of our CBAs, and as described earlier in the Exit Conference step of our process, we not only identify and recover existing overpayments but also seek to identify the causes of credits owed to the client, including provider accounting system issues. This approach increases cost savings by preventing future overpayments.

In the final step of our process, we proceed with accounts receivable management and recovery of the overpayments. Depending on client and providers preference, the following recoupment methods can be used:

- HMS can submit a file for retractions
- Providers can adjust or void overpaid claims online (preferable)
- Providers can issue a check for identified overpayments.

7.1.6 Third Party Adds

Within this section, we respond to all the RFP requirements associated with cost avoidance and provide a comprehensive description of how each of the functions work together effectively to deliver a robust cost avoidance solution for BMS. These functions include:

- **Third Party Adds** through our data match and verification processes (**Section 7.1.6.1**)
- **File Maintenance** of the WV TPL Resource File (**Section 7.1.6.2**)
- **Third Party Referral (TPR)** services for escalated verifications (**Section 7.1.6.2**)
- **Reverification** of active coverage record information (**Section 7.1.6.3**)
- **COB on Demand** for near real-time verifications (**Section 7.1.6.5**)

For details on each function, please refer to the noted proposal section.

Overall, cost avoidance is still the most efficient and cost-effective means of ensuring that WV Medicaid and WVCHIP remain the payors of last resort, as it allows them to deny the full amount covered by other health insurance. The purpose behind cost avoidance is for the WV Medicaid and WVCHIP to reject claims where other primary health coverage exists and should therefore be responsible for payment of the claims. To be effective and for cost avoidance to occur, the policy must be in the State of West Virginia's MMIS prior to claims processing.

As HMS continues to develop innovations in cost avoidance, we are committed to working with BMS to expand opportunities to capture all known "other health coverage" along the payment continuum and work in partnership to ensure WV Medicaid and WVCHIP remain the payors of last resort.

HMS Has Produced Tangible Results for WV

For more than 26 years, the HMS solution has produced exceptional value for WV with our cost avoidance approach. We support BMS' initiatives to contain costs for payment accuracy, so WV can continue providing essential healthcare coverage to its most vulnerable populations. We have continually collaborated with BMS to tap into every opportunity to save money for the State. Our approach provides exceptional value and is the key to ensuring WV does not spend money when it should not.

During the current contract term that began in September 2011, we have identified and verified more than 757,000 insurance TPL policies, resulting in more than $1.3 billion in total savings for the State through cost avoidance.

Proposed Cost Avoidance Solution for BMS

Our proposed cost avoidance solution is comprehensive. It combines the TPL data match and policy verification, file maintenance, reverification, and TPR services we provide currently to BMS, along with several innovative enhancements that are underway and will be fully implemented for the new contract.

HMS' solution is already in place for BMS—we have the required data, established carrier relationships, and customized workflows required to perform the requested cost avoidance work. HMS currently performs a data match against **Medical, Dental, Pharmacy, and Vision** claims and delivers the verified insurance policy information to BMS on a weekly basis. Our **COB on Demand** service for both medical and pharmacy claims is currently in a pilot with BMS, while our online Third Party Referral (TPR) web portals, **eValidate** and **eReferral**, were recently deployed and made available for use. These HMS innovations work with and enhance our existing cost avoidance solution to increase cost savings by quickly providing cost avoidance information further upstream to help prevent payments by WV Medicaid and WVCHIP that are the responsibility of third parties. The services will be fully implemented for the new contract and we describe each in greater detail in proposal **Sections 7.1.6.5 and 7.1.6.2,** respectively.

Because our process to deliver cost avoidance information is approved and already in place, there will be no interruption to cost avoidance savings at the onset of the new contract. BMS will also avoid the risks associated with transitioning to a new TPL vendor.

Together, these solution components enable HMS to deliver daily, weekly, monthly, and quarterly cost avoidance deliverables for BMS, which ensures we provide the most accurate, up-to-date TPL information possible for the State to use to cost avoid future claims.

7.1.6.1 Insurance Policy Verification (App 1, TM032)

HMS' approach to cost avoidance is multi-faceted. It begins with identifying legally liable third parties of other health insurance, unknown to BMS and not captured in the State's MMIS. We then verify the newly identified policies, before delivering them to BMS for WV Medicaid and WVCHIP to cost avoid claims and reduce future payments. We are also responsible for contacting the insurance carriers and arranging for data matches as described in proposal **Section 7.1.6.2** further below.

For effective insurance policy verification, we leverage several HMS-built capabilities that we present in **Exhibit 7.1.6-1**. These include our National Eligibility Data Platform (NEDP), vast data sharing carrier network, highly accurate iMatch data match process, and our **COB***Connect* verification engine.

Exhibit 7.1.6-1 The Unique Capabilities Behind our Cost Avoidance Solution
We leverage several HMS-built capabilities to perform TPL identification and verification

National Eligibility Data Platform (NEDP)
- One of the largest commercial datasets in the U.S.
- Houses 1.98 billion carrier eligibility records from 1,300+ payers

Vast Data Sharing Carrier Network
- Extends well beyond the top commercial carriers in WV
- Currently receives eligibility data from carriers covering more than 97% of West Virginia's insured residents
- Carrier Relations team actively working to onboard additional carriers, which will boost coverage to more than 99% in new contract

Highly Accurate Data Match Process
- Iterative iMatch methodology
- Combines the best of traditional probabilistic matching and advanced analytics, NLP, and ML match techniques
- Produces a unique, powerful match that achieves 99.99% accuracy and finds matches other solutions miss

COB*Connect* Verification Engine
- Filters out data not valuable to BMS in its cost avoidance efforts
- Employs a mix of automated and manual verification techniques
- Integrates with our TPR service to enhance verification efforts and operations

However, what truly differentiates HMS from other TPL vendors are these capabilities combined with how we use the data we acquire with our methods for TPL identification and insurance policy verification.

- **TPL Identification.** The basis of a successful cost avoidance program lies with matching eligibility data from a multitude of sources with WV Medicaid and WVCHIP eligibility data, accurately and consistently, to identify TPL. Our adept ability to engage third-party payers, amass their eligibility data into a national data platform, match WV Medicaid and WVCHIP program data to this resource, and identify both exact (e.g., five-point matches) and near-matches underlies BMS' success in identifying new coverage for program members.

  Because we often have a carrier's complete eligibility prior to the member getting Medicaid coverage, our process accelerates the identification of TPL. Provider-based leads only occur once the member has Medicaid and then receives medical service.

- **Insurance Policy Verification**. To enhance the accuracy and quality of our data match results, we use our **COB*Connect*** infrastructure and insurance policy verification techniques to confirm that the information received on the carrier's eligibility file is the most up to date and accurate. We follow up and verify each insurance policy directly with payors, through our various techniques, before delivering the results to BMS. **HMS' TPL verification process reduces the potential for match errors and inaccurate information.** We make every effort to provide accurate policies that generate a return on investment for the people of WV. If we cannot fully verify the information, we do not deliver the policy to BMS for cost avoidance use.

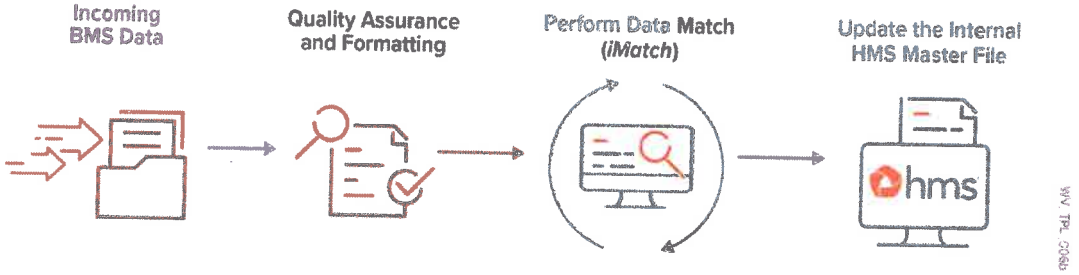
IDENTIFYING TPL USING OUR DATA MATCH PROCESS

With HMS' data match process; we go beyond just following up on referrals from outside sources. Our goal is to link as many Medicaid members as possible with coverage information contained in our platform that we use to match member eligibility data, tailoring each individual match to accommodate the unique characteristics of the source data that we use. In addition, our data analytics and machine learning capabilities allow us to assess the integrity of each match and investigate near-matches, either confirming or discarding them. Unlike other vendors that may only match on medical and pharmacy, we can match other sources of healthcare coverage eligibility such as Medicare, dental, and vision.

As a result of ongoing BMS feedback and collaboration, HMS recently built out an automated, WV-specific intake process to ingest referrals from both pharmacy and provider referral reports, received weekly. As a result, HMS can now generate automated BMS-specific weekly reports validating leads for BMS. Our TPR team processes these reports for further research or to ingest for immediate use in updating eligibility within BMS' MMIS.

With our data match process to identify legally liable third parties, HMS performs a complex series of electronic data matches that identify coverage not yet detected by BMS. Once we receive, validate, and load third-party payer enrollment and coverage data into our NEDP, we perform data matching to identify WV Medicaid and WVCHIP members with other health insurance coverage. We illustrate this process in **Exhibit 7.1.6-2**.

Exhibit 7.1.6-2 HMS' Data Match Process to Identify TPL
HMS' industry-best data match resources maximize TPL identification for BMS.



In **Exhibit 7.1.6-3**, we further describe the primary activities we carry out during each of the steps noted in our data match process.

Exhibit 7.1.6-3 Description of the Steps in our HMS Data Match Process to Identify TPL
With our data match process to identify legally liable third parties, HMS performs a complex series of electronic data matches that identify coverage not yet detected by BMS.

Step	Description
Step 1: Receive Incoming BMS Data	HMS currently receives Medicaid eligibility and TPL resource files (known TPL) from BMS, through an established Secure File Transfer Protocol (SFTP), so no additional reformatting or reprogramming will be necessary.

Step 2: Conduct Quality Assurance and Formatting	Throughout the data match process, HMS incorporates quality assurance (QA) measures, from conducting quality checks on carrier data before integration with our NEDP to performing a final review of all deliverables before submitting to BMS for approval. We understand incorrect information will ultimately lead to carrier and provider abrasion, increasing the difficulty of operating an efficient TPL project for BMS. HMS upholds the highest standards to prevent this from occurring and has QA processes in place to prevent incorrect information from entering the workflow.
Step 3: Perform Data Match	We use our iMatch data match process to identify Medicaid members with other third party health insurance coverage. HMS deploys data matching technology on commercial insurance carrier and Medicaid eligibility data, comparing the two datasets for like individuals. Using multiple, successively applied match logic algorithms, we will determine and confirm TPL coverage information with a high level of confidence despite the data discrepancies that frequently exist in records on the same individual in various files. Our multi-tiered approach reduces the risk BMS may encounter by using an untested TPL services contractor that does not have this technology or approach. After performing the initial Medicaid-carrier match, we review the results, segregating matches identified for Medicaid members with minor policy coverage, such as pharmacy, vision, and dental. Please refer to the section below on **Using Data Match to Determine the Legal Liabilities of Different Payor Types**, where we describe the various minor insurance policy coverage types that we perform data match on for BMS.
Step 4: Add to and Update HMS' Master File of TPL Leads	HMS' internal Master File represents the final output of our data match process. This file is where we maintain third party insurance coverage information (both current and previous) for all the State's Medicaid members with one or more TPL policies identified through the data match process. Our BMS-specific Master File then serves as the source of coverage identification for a variety of subsequent solution activities, such as cost avoidance and post payment TPL recovery billing.

USING DATA MATCH TO IDENTIFY OTHER SOURCES OF COVERAGE

HMS performs enrollment and eligibility (including Medicaid member data) matches with numerous entities, as required by BMS, to identify the appropriate third parties responsible for paying Medicaid claims. In addition to identifying and recruiting carriers that provide major medical insurance benefits, we have worked with BMS to identify other sources of healthcare coverage eligibility.

Without a robust process to identify carriers, BMS risks paying millions of dollars in claims that a commercial healthcare carrier covers.

- **Private commercial health insurance matches, including those with specialty carriers** (e.g. pharmacy, dental, vision) to identify Medicaid members with access to other health insurance and determine benefit coverage.
- **Special health coverage plans** such as TPAs, long-term care (LTC), and union plan matches. While coverage from some groups might overlap, our NEDP includes information from a variety of specialty health coverage plans.
- **TRICARE matches** to identify Medicaid members with access to coverage through TRICARE and determine benefit coverage
- **CMS enrollment matches to identify Medicaid members eligible for Medicare coverage** using BMS-specified data source and determine benefit coverage

- Medicare data matches, including the Enrollment Data Base (EDB) and Medicare Modernization Act (MMA) files

In the following narrative, we provide more details around how we approach identifying TPL for many of these payor types.

HMS Has Extensive Data Match Capabilities with Specialty Carriers

After performing the initial Medicaid-carrier match, we review the results, segregating matches identified for Medicaid members with minor policy coverage, such as pharmacy, vision, and dental. Because many employers use more than one insurance carrier to provide different types of coverage for their employees, we compare minor policy records against the information in the NEDP to determine if a companion policy with medical coverage exists. If no corresponding record exists, we perform additional analyses to try to construct a valid match, cross-referencing and matching records using Employer Group Numbers. For example, HMS may use United Healthcare employer group data to identify members with OptumRx pharmacy benefits, supplementing the direct carrier feed and subsequent data match from OptumRx itself. HMS has data exchange agreements in place with these entities as well as with other PBMs to confirm access to this critical data source and recovery of the highest possible number of pharmacy-related overpayments for BMS. Depending on the quality of the minor or specialty insurance policy data, HMS can at times assume valid major medical coverage, identify the policy information, and bill out medical claims to the appropriate liable party and/or route the information through our verification process.

The majority of WV's third party pharmacy coverage is through Express Scripts, Optum Rx, Caremark, SS&C, and Prime Therapeutics. These top PBMs in the state represent 90% of pharmacy coverage in the nation, and HMS has data exchange agreements in place.

Most of the third-party dental coverage in WV, residing with Delta Dental and Cigna Dental, which are included in our data match network. Dental claims represent more than $5 billion nationwide in Medicaid expenditures each year and will continue to grow in 2020 because of the passage of Senate Bill 97 (Chapter 52, Statutes of 2017) that fully restored adult optional dental benefits (e.g., periodontal services, partial dentures, denture adjustments, repairs, and relines).

Data Match for Identifying TRICARE Coverage

Our HMS NEDP also includes eligibility data from TRICARE, formerly the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA™). TRICARE and CHAMPVA are types of healthcare coverage provided to certain military personnel and their families.

The United States Department of Defense (DoD) has a Defense Enrollment Eligibility Reporting System (DEERS), which is a database that contains information for each uniformed service member (active duty, retired, or a member of a Reserve component), US-sponsored foreign military, DoD and uniformed services civilians, other personnel as directed by the DoD, and their eligible family members. DEERS has not been available to any TPL vendor to perform data

matches for more than three years. HMS has supported states across the country in the effort to have the match reinstated as well as to improve the overall coordination of benefits (COB) process with TRICARE.

When permitted again by TRICARE, HMS will resume matching eligibility files, to identify Medicaid members with TRICARE coverage, through the annual match available with DEERS. We mine and verify the data to determine Medicaid recipients who are eligible for TRICARE coverage. We conduct this process according to the schedule provided by CMS, which is every July for the WV match. We have tailored our data match processes to accommodate the unique method in which the Department of Defense (DoD) provides information, which is different from the process used to identify coverage by commercial insurance carriers.

We obtain this annual match of WV and TRICARE eligibility information by preparing and submitting a WV Medicaid eligibility file to DEERS, that checks to make sure all possible matches are discovered and included in the file forwarded to the DoD. When the DoD returns the DEERS match results, HMS will then process them through our own data mining algorithms to eliminate potential mismatches that may be returned by DEERS. We will also process the data through the same iMatch analyses used in our commercial health insurance match process and remove policies that do not meet BMS' validation requirements. BMS and HMS will make sure the necessary agreements are in place with DoD for HMS to perform TRICARE data matching, verification, and billing for BMS.

HMS IS WORKING TO REINSTATE THE DEERS DATA MATCH FOR WV

Since the DEERS match ceased between CMS and the Department of Defense in 2017, our reinstatement efforts have been ongoing. These efforts include the following:

- Qualifying the impact of the cessation for clients
- Submitting letters to CMS and Congress that describe the value of the DEERS data match on behalf of multiple states
- Working with two state legislatures to enact resolutions calling on Congress to intervene
- Partnering with important stakeholders, such as the Medicaid and Chip Payment and Access Commission (MACPAC), who have been working the issue recently (Spring 2020) with resulting recommendations
- The MACPAC Commissioners voted to recommend two actions:
  - The Centers for Medicare and Medicaid Services (CMS) should facilitate Medicaid agency COB with the TRICARE program by working with the DoD to develop a mechanism for routinely sharing eligibility and coverage data between Medicaid agencies and the Defense Health Agency
  - To protect Medicaid from improper payment of claims that are the responsibility of a third party and improve COB for persons who have coverage through both Medicaid and TRICARE, Congress should direct the DoD to require its carriers to implement the same third party liability policies as other health insurers, as defined in section 1902(a)(25) of the Social Security Act.

Additionally, we will add policies to the HMS Master File that meet BMS' requirements to include in our recovery and cost avoidance processes. For now, as we receive additional eligibility data (for new Medicaid enrollees), we will compare the data with the historical TRICARE coverage

information we have compiled. We will update our NEDP throughout the year as we obtain new or updated information from other data sources, such as the TRICARE PBM.

HMS' Data Match Process for Identifying Medicare Coverage

The Medicare/Medicaid dual-eligible population is a significant driver of state healthcare program costs as members of this population often use more and higher-cost services than the wider Medicaid-only population. Indicators such as member age, disability, and a record of a crossover paid claim for a Medicaid member by BMS may imply Medicare enrollment.

The Enrollment Database (EDB) file is a subset of CMS' Health Insurance Master Record. Enrollees in both traditional Medicare and Medicare managed care organizations are included with identification data fields within the EDB file.

HMS currently delivers cost avoidance information to BMS for Medicare Part C only and has an established process to identify members of the WV Medicaid program that also have Medicare Part C coverage. We receive the Enrollment Database (EDB) file monthly, with existing data structures and logic to incorporate the data from this standard file and load it into our NEDP.

Similar as our process for matching with commercial insurance information, we use the information from this file to match against the WV Medicaid Eligibility File and identify members covered by both Medicaid and Medicare Part C.

Although we just deliver Medicare cost avoidance information for Medicare Part C, HMS has the flexibility and capability to do the same for Medicare Parts A, B, and D as well. Identifying Medicare enrollment/coverage across multiple parts involves unique challenges as numerous sources of Medicare data are available (e.g. Buy-in Data, BENDEX, Enrollment Database/EDB, TBQ, and MMA files); no single source contains comprehensive enrollment and coverage information on all Medicare members. As we do for other TPL Services clients, HMS can easily overcome these limitations of individual Medicare files by aggregating the data from various files to assemble a single comprehensive database of Medicare enrollment/coverage information with complete data records for Medicaid members, who appear likely to have Medicare coverage. In fact, we already receive an MMA file for Part D. Through our experience in using this data, we can identify and verify precisely what types of coverage a Medicare beneficiary possesses.

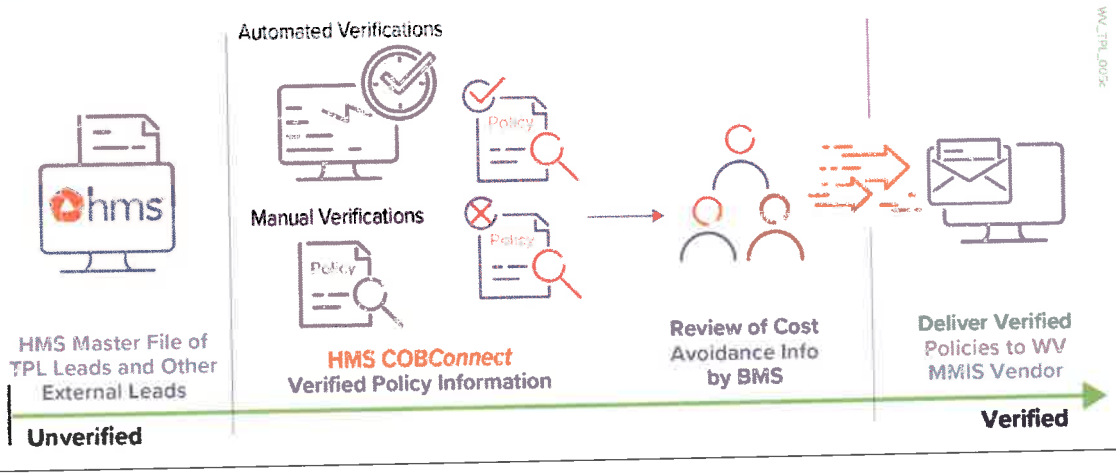
Through data matches and data extracts with Medicare files and databases, HMS identifies claims to process for Medicare recovery before they expire under timely filing limitations.

Verifying Insurance Policies Using Our COB*Connect* Process

Our approach to cost avoidance involves using the coverage information we obtain through data matches and other leads, verifying this information using a combination of techniques, and then ultimately delivering verified information to BMS to maximize savings results. Our verification services not only function to confirm reported third party coverage but also to enhance the value

of our data-match results for BMS. We illustrate HMS' verification process for cost avoidance in **Exhibit 7.1.6-4.**

Exhibit 7.1.6-4 HMS' Verification Process for Cost Avoidance
HMS' industry-best automated and manual verification resources maximize cost avoidance value for BMS



In **Exhibit 7.1.6-5**, we further describe our TPL verification process, including the primary activities we carry out during each step. Our process reduces the potential for third party lead and match errors and inaccurate information. We deliver to BMS only those records that pass-through HMS' rigorous quality assurance evaluation. The quality of the verified TPL information we deliver means that we do not place unnecessary administrative burden on stakeholders.

Exhibit 7.1.6-5 Description of HMS' TPL Verification Process for Cost Avoidance
Our verification services confirm reported third party coverage and enhance the value of our data match results.

Step	Description
Step 1: Leveraging HMS' Internal Master File of TPL Leads for BMS	As introduced earlier, the internal HMS Master File is where we maintain third party insurance coverage information (both current and previous) for all the State's Medicaid members with major and minor TPL policies identified through our data match process. We send the Master File to our Verification team to route the file through our **COB***Connect* engine and process, described in Step 2 below.
Step 2: Verifying Other Health Coverage Using Our COB*Connect* Infrastructure and Techniques	We use our robust **COB***Connect* infrastructure and techniques to verify other health coverage with third parties and deliver complete and accurate policy information that the State can use to cost avoid claim payments at the point of adjudication. **COB***Connect* supports all payor types, regardless of their electronic-transmittal capabilities, helps filter out data not valuable to BMS for cost avoidance purposes. We use a combination of direct and automated techniques to verify insurance eligibility information, storing the information being worked by the automatic or manual verifiers in the engine's database. Using multiple methods, enables HMS to develop a complete policy profile for each member. These techniques **include direct outreach, 270/271 transactions, group validation and eWorker**. We apply the most-appropriate verification technique to deliver results that comply with BMS requirements for quality, timeliness, and other factors. **The techniques work in concert to return reliable, complete information for BMS as quickly as possible.** To customize the verification engine for BMS, we use a Cost Avoidance Requirements Document (CARD), that captures BMS-specific policies and business rules associated with eligibility and determination. We have built more than 100

	customizable rules and edits to verify that BMS only receives the data they want to receive when they want to receive it. We use sophisticated matching logic to compare our data with what BMS already has available to supplement or enhance the data they already know to ensure they are always using the most up-to-date accurate information. Our collaborative approach often leads payors to offer additional verification tools, such as direct access to their eligibility systems through restricted websites or more frequent data updates, for our use. After verification, we create a cost avoidance file for BMS of all members with verified policy and coverage information that aligns with the associated claims (e.g., medical, pharmacy).
Step 3: Send Weekly Cost Avoidance Information to BMS for Review	BMS requires manual review of cost avoidance information each week. This occurs prior to sending the file to the State's fiscal agent via SFTP for upload into the MMIS. , In this deliverable, HMS provides the most current TPL information (e.g. adding or updating third party insurance segments, using results from ongoing data matches as well as manual and automated verification findings) to BMS to optimize the State's cost avoidance efforts.
Step 4: Deliver Cost Avoidance File of Verified Policies Weekly to the MMIS Vendor for Upload	Upon completion of BMS' review, HMS updates the file as needed, then transfers the TPL Add and Update file of verified policies through SFTP to the State's fiscal agent for upload into the MMIS. We transmit the file through an agreed-on TPL file layout (including the Medicaid ID (MAID), using the fiscal agent's SFTP server to protect the security and integrity of the data. After the files are received, and the TPL data is verified and determined to meet state requirements, it is added, updated, or terminated on the MMIS and becomes available for cost avoidance. HMS monitors the loads (Accept and Reject files) into the MMIS through load and error reports and reviews the reports for correction and reload opportunities and invoicing purposes.

RIGOROUS QA PROCESSES AND STANDARDS FOR VERIFICATION

HMS applies quality assurance (QA) measures throughout the verification process, devoting QA resources to BMS' verification function. Our QA standards, both pre- and post-verification, help generate accurate and complete results. Our data validation process (**Exhibit 7.1.6-6**) enables us to assess the integrity of each match and take the steps necessary to investigate near-matches for confirmation or elimination. This ensures the information we deliver to BMS is:

- **Reliable.** Our processes are fully tested and operational in more than 40 states
- **Fully verified.** Without complete verification, match errors would cause many problems: incorrect information sent to providers, errors in the processing of retroactive claims, erroneous rejections, and added burden and frustration on the part of all stakeholders.

Exhibit 7.1.6-6 HMS' QA Process Features
HMS applies QA measures throughout the verification process

Selection.
Before loading policies to our system, we carefully review the selected batches, choosing only policies with sufficient data to warrant verification.

Monitoring.
Our monitoring capability allows supervisors to monitor results at a field-specific level (e.g., scan previously entered fields, concentrate on specific fields, and edit previous fields).

Audit trail.
We maintain a complete audit trail of the quality audits, when they were performed, and by whom.

Revalidation.
After completing verifications, verification QA analysts perform data-analysis processes to identify a percentage of policies to revalidate. ***COB****Connect* allows supervisors to focus on particular carriers or the work of particular team members responsible for reverification, as appropriate.

CAV file deliverable check.
Once all the business rules have been applied and the deliverable is in BMS' format, our QA team compares all the data to BMS' requirements documents using a combination of automated and visual techniques to provide the highest level of quality before delivery.

7.1.6.2 Maintenance of TPL Info (App 1, TM024–TM031)

Through the course of our TPL work, we access, maintain, and update eligibility files from insurance carriers, paid claims files, non-custodial parent files, and perform data mining tasks to enter and maintain accurate TPL data for West Virginia. After TPL data has been verified and is determined to meet state specified requirements for cost avoidance, it is added, updated or terminated on the MMIS.

In addition to our weekly cost avoidance file deliverable (TPL Add and Update file) for BMS, we also perform ongoing maintenance of the TPL policy and carrier information housed in our internal resources (e.g. NEDP, internal HMS Master File) to ensure the quality of the cost avoidance solution we deliver. HMS receives new data from all carriers every month, ingesting this data into our systems. It is important to continuously maintain the TPL data in our systems, to help us identify new policies, updates, and terminations for BMS.

HMS uses various methods to maintain TPL information policy and carrier information, as described within each required category below.

Term Dates, Changes in Coverage, Group Information, and Carrier Information

In addition to insurance policy adds, we maintain updates (e.g. coverage changes, group and carrier information) and insurance policy termination dates through our HMS insurance policy verification process and weekly cost avoidance deliverable for BMS. For details on our TPL identification and verification process, please refer to proposal **Section 7.1.6.1** above for details.

MASS TPL AND/OR CARRIER UPDATES DUE TO CHANGES IN CARRIER STATUS, SPONSOR, GROUP NUMBER AND/OR POLICY NUMBER

HMS receives new data (e.g. eligibility and other files) from all carriers every month through our data match process as described in above proposal **Section 7.1.6.1**, to keep our NEDP as up-to-date as possible.

Our success in identifying the availability of other coverage for WV Medicaid and WVCHIP lies in our ability to obtain eligibility information from our vast data-sharing network, built through data-sharing agreements with payors that allow HMS to use the information we compile to match against our Medicaid client eligibility files.

Our data sharing network extends well beyond the top commercial insurance carriers in WV. This data repository supports large data sets and exponential growth in total database size over the life of the BMS contract. We have also worked closely with BMS to identify other specialty sources of healthcare coverage eligibility such as: local, regional and national commercial payors including minor coverage; third party administrators, pharmacy benefit managers (PBMs), and federal programs such as TRICARE and Medicare. We work diligently to obtain eligibility information from these sources. By recruiting specialty insurers, we can frequently infer and then confirm primary medical insurance coverage that was previously unknown based on information within a specialty insurer's eligibility records. We reverse engineer our data match process to determine major policies based on minor insurance coverage (e.g. pharmacy, vision, dental). For instance, we can often link a pharmacy carrier to a large medical insurer.

Because HMS already has carrier data for 97% of WV lives, we will not incur additional implementation time to account for onboarding these carriers. We are "ready to go" with matching on these lives immediately once the contract begins.

In comparison, Pennsylvania has been contracted with another vendor since April of 2020 with a 90-day implementation timeline ongoing for eight months and recovery efforts not yet begun.

Currently, HMS receives eligibility data from carriers covering more than 97% of WV's insured residents. This percentage is based on blending carrier data and industry reports to develop a representation of insured lives within the state, which best represents HMS' carrier market share for Medicaid lives. By digging deeper into the coverage network and adding data sharing partners – including those with a smaller footprint in a state – we can maximize TPL identification and recovery for the State. Because we receive both regional and national data, our database includes out-of-state policyholders, such as noncustodial parents, which represent more than 25% of other health insurance coverage in many states. **Exhibit 7.1.6-7** provides a sample of our relationships with the top health insurance payors that cover WV residents.

Exhibit 7.1.6-7 WV Healthcare Insurers in HMS' TPL Data Match Network
HMS currently receives enrollment data for 97% of insured WV residents.

Entity	Segments/Lives
BlueCross® BlueShield® WV Highmark***	239,998
United Healthcare™	205,580
Aetna®	191,190

Entity	Segments/Lives
HealthSmart®	159,995
The Health Plan (Health Plan of Upper Ohio Valley)	131,967
Humana®	121,370
Federal Employee Program® (FEP)	63,599
CIGNA®	47,329
Anthem® West (Unicare, Blue Cross® CA, BlueCross® BlueShield® GA, BlueCross® BlueShield® CO)	44,478
United Mine Workers of America® (Medicare Advantage)	16,825
BlueCross® BlueShield® MD Carefirst (restricted to MD,DC, VA)	16,770
American Benefit Corporation**	16,000
Benefit Assistance Corporation	12,685
BlueCross® BlueShield® AR	8,805
Highmark Health®	6,414
BlueCross® BlueShield® TN	6,176
BlueCross® BlueShield® AL*	5,449
Government Employee Hospital Association (GEHA℠)	4,350
Ameriben Solutions	4,347
BlueCross BlueShield of New Jersey (Horizon)	3,603
Total Lives	**1,306,930**

Sources: Atlantic Information Systems Directory of Health Plans – 2020, WV DOI - Annual Report 2019, 2019 SPBA Directory of Third Party Administrators, AM Best- Best's Third Party Administrators
**In progress **Under recruitment ***BCBS of WV no longer under Highmark umbrella, in progress to obtain file directly through BCBS of WV*

In the healthcare industry, new eligibility data is being generated every minute, and we work extremely hard to capture it. HMS is responsible for contacting the insurance organizations and arranging for data matches. As a result, we have existing relationships and data usage agreements (DUAs) with 97% of the insurance carriers in WV. Our established process for building and maintaining our NEDP includes growing the network and continually maintaining these valuable relationships.

Building / Maintaining our NEDP
Obtaining updated eligibility data for the NEDP requires significant time and effort, yet our services place less of the burden for programming on carriers and do not require carriers to pay a fee to participate in our network, resulting in more cooperation.

Our dedicated Carrier Relations team works closely with commercial insurance carriers to negotiate and implement new Data Usage Agreements (DUAs), which explicitly allow the use of carrier data to support Medicaid TPL services. When HMS recruits a carrier into our data sharing network, we follow a multi-level process that starts by educating that carrier regarding their obligations to share data with our clients. A new data sharing agreement can involve many factors – including legal, compliance, operational and technical issues – and the HMS team works diligently to resolve them. We also require a thorough testing of all data to make sure it's accurate and meets our system requirements.

While designed to be as efficient as possible, the process has its challenges. Often, carriers need several months to review the requirements necessary to implement a data exchange. Even when HMS establishes a signed agreement quickly, it can still take many months to create a data exchange. To help expedite this process, we don't require carriers to provide this eligibility data in a specific format – we only ask that we receive a minimum data set necessary to perform the data match.

While DRA legislation provides HMS with the authority to obtain the data on behalf of our clients, it often doesn't include any timelines or penalties for not providing data within a certain timeframe, contributing to delays in obtaining eligibility data. HMS works diligently with each carrier to assist in development completion and accelerate data exchanges when possible.

HMS Assists Carriers with DRA Compliance

HMS' data sharing network recruitment process begins with carrier education. Our Carrier Relations team works with our HMS legal staff to analyze state-DRA legislation requirements and develop materials to educate carriers about their legal obligations to share data with clients.

Occasionally, an insurance carrier may interpret legal requirements to share data with Medicaid agencies differently than HMS or our clients, taking the stance that they are not legally required to comply with the statutes of a state where they are not headquartered or licensed to do business, or in other cases they argue that they are not covered by DRA requirements. When a carrier under recruitment declines to share information, our attorneys help to draft correspondence and determine options for moving forward and outlining carrier obligations pursuant to the DRA and state statutes.

Negotiating initial DUAs is only part of making the NEDP as comprehensive and useful as possible. Our Carrier Relations team also maintains the NEDP by working continuously with existing carriers in our data sharing network. Our team members have established relationships with all major carriers providing health insurance coverage in the State and ensure that all eligibility information HMS receives is current and consistent with prior data feeds. After all, a large factor in our industry-leading match results is our investment in obtaining accurate and comprehensive coverage information directly from carriers. That's why we take measures to:

- Increase the frequency of data files obtained, hoping for daily eligibility data feeds
- Expand the data we receive to use for data matching
- Improve the quality of the data

Tracking Mechanisms

We use numerous methods to track the ongoing changes made to TPL information during the course of performing TPL work; these are the methods described throughout this section. One major way we track and ensure the changes made to policies, as well as avoid duplication of policies, is through the TPL Resource File we receive from BMS weekly and intake into our WV-specific HMS internal Master File.

The TPL Resource File, which is a subset of the State's MMIS, shows what TPL is presently in the State's MMIS. For this reason, coordinating our efforts with those of the MMIS vendor is critical to providing the most value for BMS and other stakeholders.

HMS' dedicated **Carrier Relations team** proactively works with payors to implement new data sharing agreements, expand the data we receive in our NEDP, and improve the quality of information provided for data matching with the WV Medicaid eligibility file to identify other available coverage from third parties.

Working with the TPL Resource File

We currently use the TPL Resource File to ensure that the newly identified TPL segments added to WV MMIS were not previously known to BMS, by comparing our data match and verification results with the TPL Resource File. HMS helps to maintain the TPL Resource File by loading verified updates and terminations to the State's MMIS system. We regularly update the State's MMIS with the most current potential TPL information (e.g. adding or updating third party insurance segments, using results from ongoing data matches as well as manual and automated verification findings) and provide to BMS in order to optimize the State's cost avoidance efforts. We also make changes to the TPL Resource File information, as identified, through referral information provided by provider billing offices and through members.

Avoiding Duplication

Throughout our solution, HMS provides seamless coordination between other systems including, but not limited to, the MMIS. We employ several methods across the file maintenance and recovery continuum that help us avoid duplicating data and efforts. Below is one method used for file maintenance, which is the carrier-code review and crosswalk.

The value of the TPL Resource File is directly tied to the accuracy of the Carrier Code File. Without appropriate maintenance, the MMIS Carrier Code File can rapidly become duplicative and outdated, resulting in incorrect TPL postings. **As a best practice and because this file contains elements that are member, provider and other key stakeholder facing, it is a crucial starting point in the file-maintenance process.** HMS is uniquely positioned to continue to seek out and eliminate duplicate entries, validate entries, and remove carrier codes of companies that have been acquired. For this, we will perform tasks that include:

- Cleaning duplicate carrier codes from the MMIS TPL subsystem and removing all outdated codes.
- Crosswalk carriers that have multiple insurance codes in MMIS to one code.
- Provide updated carrier cross walk listing to BMS' MCOs, HIPP and CSRU.

Once completed, the file will contain current claims mailing addresses and contact information for active carriers. County workers, providers, and TPL personnel will have accurate carrier entries for posting or reviewing TPL information.

After identifying duplicate carrier codes and prior to consolidation, HMS will identify all members affected by the change. We will crosswalk members under the old code to the new carrier code (i.e., referential-integrity process) to verify that all members have correct carrier codes.

Interfaces with the Medicaid Management Information System

We currently exchange numerous files back and forth with BMS – daily, weekly, and monthly. This is handled through established interfaces with the Medicaid Management Information System (MMIS), specifically import and extract files transmitted through secure file transfer

protocol (SFTP). We also maintain write-access to the MMIS TPL screens in order to interface and update TPL policy information real-time when an escalation occurs.

REPORTING CAPABILITIES

Our weekly cost avoidance reflects any policy adds, updates, or terms obtained through our TPL verification process, third party referral service, and/or COB on Demand service. Each month, during our invoice process, BMS will receive multiple cost avoidance reports serving as back-up documentation that encompasses all weekly deliverables provided throughout the month to BMS. We understand that BMS requirements regarding report format, content, and submission frequency are subject to change at any time during the term of the contract. We have provided sample monthly cost avoidance reports as **Exhibits 7.1.6-8 through 7.1.6-10** in proposal **Appendix 1**.

METHODS FOR CORRECTION – THIRD PARTY REFERRAL SERVICES

In addition to the methods and resources described above, HMS has additional methods used to correct previously transmitted information found to be erroneous. The primary method we use for this is our third-party referral (TPR) services, described below.

State Medicaid agencies, such as BMS, experience constant change within their member populations. The causes vary but can include a member's loss of employer-sponsored coverage, transition to another plan, reaching retirement age and changes to a spouse's or other family member's coverage. Other circumstances may include carrier updates to internal systems and databases, or client edits that block the coverage from being included in our weekly cost avoidance deliverable. Because these changes are frequent and occur in high volumes, the most recent coverage data accessible by providers does not always reflect the latest changes to an individual's status. Members affected by coverage changes may discover last minute —at the point of care—their coverage information is incorrect, sometimes resulting in a demand for co-payment or denial of service.

Being real-time, TPR helps provide clients with more accurate and timely coverage, loaded and available in the MMIS.

As part of our cost avoidance solution for BMS, we provide a **Third Party Referral (TPR)** service that delivers cost avoidance data at a higher frequency and faster – including near-real time for escalated coverage verifications. In this section, we describe our current TPR solution for BMS as well as call out the recently implemented **eReferral** and **eValidate** features available to our cost avoidance clients.

HMS receives ongoing leads identified from sources other than our weekly, or even daily COB on Demand, data match process. Whether the need is to verify incorrect or conflicting coverage information, or address a missing policy altogether, our team ensures leads are promptly updated in the State's MMIS, so the most updated coverage information is always available.

We receive leads in varying formats and levels of detail – telephone, fax, email, and even through special requests that come in from the State directly to our assigned project manager.

TPR is HMS' process for verifying these non-data match cost avoidance leads that are referred by BMS, providers, members, or other data sources, including in real-time at the point of care or sale, such as when a recipient is at the pharmacy. TPR acts as a point of contact for stakeholders, which include BMS, its providers and members, for the prompt verification of these non-data match cost avoidance leads that allows users seeking policy re-verification to quickly add, terminate, or update commercial insurance coverage in real-time to ensure proper coordination of benefits.

- **Policy adds** are new insurance policies that HMS does not have on file in our NEDP, or that are blocked from our weekly cost avoidance file due to client-specific business rules/edits
- **Policy terms** reflect knowing a recipient's coverage has been terminated but that change is not yet reflected in the MMIS
- **Policy updates** are an adjustment to a specific policy (e.g. time span change).

Our approach to using TPR in WV is to support:	
Real-Time Verifications or Escalations	Used to receive and process policy verification requests, as well as update the MMIS, in real-time for use at the point of care or service. If a verification request is an escalation, such as live at the pharmacy point of sale, our HMS team can log into the WV MMIS and look to see the information before calling the carrier to verify. Our team updates the MMIS, to sync with the provider, and log it into our internal system for reporting purposes and to ensure duplication of future matches does not occur
Non-Data Match Leads or Non-Escalations	Used to receive and process non-data match leads for the purpose of updating our weekly cost avoidance deliverable for BMS. If the verification is not an escalated request, such as a non-data match lead, our HMS team reviews the request and then logs and enters the valid policy lead into our internal system manually. These policies are pulled in as adds/updates/terms in our next weekly cost avoidance file deliverable for BMS.

With our standard cost avoidance efforts, we maintain various modes of lead receipt and verification, along with TPR, to enhance our verification solution for BMS and respond expeditiously when access to care or service is impacted due to incorrect or outdated information on the State's MMIS. TPR will address the challenge of point-of-care coverage information when it does not always reflect recent changes.

TPR is designed to interoperate with our existing cost avoidance engine and processes. We receive both types of requests through various methods, as approved for use by BMS, and route them appropriately, based on the defined delivery pathway, allowing for seamless the transfer of records.

These methods are as follows:	
Email and Fax	Our TPR team intakes requests submitted by BMS and providers through the established WV-specific TPL email address or fax and reviews the information. The updates are then either entered directly into MMIS or delivered on their weekly cost avoidance deliverable.
TPR Call Center	◉ The call center is primarily used by WV Medicaid and WVCHIP members at the point of care or service. While providers may rely more on the email method, they may also submit a request for verification through the call center. Similarly, clients rely more on the email or online methods but may use our call center to inform HMS of policies that we may not be aware of or have in our NEDP. ◉ Our TPR call center may be accessed through a toll-free, BMS-dedicated phone line from 8 a.m. through 5:30 p.m. local time, to take coverage inquiries from Medicaid recipients, providers, clients, and other stakeholders. ◉ We are committed to the highest standards of client service, including rapid response to all TPR calls and quick resolution of the caller's coverage question. We provide staffing levels that not only meet the needs of the program, but also incorporate a built-in "tolerance" level so that our client service team is able to receive and process referrals quickly, even during the busiest times.
Online Portals	HMS recently deployed two additional lead receipt methods for BMS, which will be fully implemented for the new contract. These self-service web portals used by our clients, and in some cases providers, help to further streamline the requests we receive to quickly and efficiently triage leads and respond expeditiously when access to care is impacted due to incorrect or outdated information on the client MMIS. ◉ **eValidate** is a web portal that BMS can use to re-verify cost avoidance records, previously delivered by HMS, that conflict with what is in the MMIS. Our HMS team receives BMS' request submitted through the portal and reverifies the policy within 3 business days to ensure the most accurate information is available to BMS. The updated record is then transmitted on the next cost avoidance deliverable. ◉ **eReferral** is a second web portal that BMS can use to submit policy leads that we have not yet delivered to the State through our weekly cost avoidance file; it is also used to inform HMS. These are policies that we may not have coverage information on in our NEDP; or, we may have the coverage, but BMS has specific edits in place that prevent our team from delivering the coverage in our cost avoidance file.

7.1.6.3 REVERIFICATION (APP 1, TM005)

Another component of our cost avoidance solution is reverification, which involves checking the State's TPL Resource file data to make sure what we show on our end is accurately reflected on the TPL Resource file. While we provide TPR services for BMS, by regularly updating policies with accurate coverage or termination dates, we reduce the number of one-off requests from individuals to terminate or modify of policies for a WV Medicaid or WV CHIP member to receive medical treatment or medication.

Under the current contract, we conduct reverification of the State's entire TPL Resource File, every three months, on a rolling three-month cycle based on the last verification date. We will continue providing this service for BMS as we do today, or on another timetable, as defined by BMS.

Reverification of active coverage record information is key to keeping the data current and accurate. This helps to maintain the integrity of the data on the BMS-specific TPL Resource File to secure smooth claim processing as well as decrease provider and member abrasion. Although HMS strives to capture as many of the enrollment changes as we can through the ongoing termination process, it is not always possible due to life circumstances, including job changes, marital status changes, births, and deaths; inaccurate data entered at the point of eligibility determination; or inaccurate carrier source data. A reverification effort reveals what that the standard process does not.

In a revalidation effort, we can:

- Look closer at policies
- Dedicate additional time to determining coverage specifications
- Research information such as policy and group numbers

A clean file results in fewer claims pended for inaccurate TPL edits and less frustration to end users (e.g., members and providers). By continuing this initiative as part of our CAV solution, we will enhance BMS' billing of claims and opportunity for recovery. There will be fewer claims billed and denied due to coverage not being in effect, and processing of recoveries will be faster if the carrier information is accurate. In addition, BMS will achieve additional cost savings through increased cost avoidance.

7.1.6.4 Transferring TPL Data to BMS (TM006)

Through our initial verification, reverification, and TPR solutions, we provide verified insurance, including updates to BMS electronically, in the established BMS TPL file layout (including the MAID), and inclusive of the insurance carrier identification information, as follows in **Exhibit 7.1.6-11.**

Exhibit 7.1.6-11 Transfer of Verified Insurance Information to BMS
HMS' process for transferring TPL data to BMS is flexible and can be modified, as needed by BMS.

Type	Frequency	Delivery Method
Initial Verification	Weekly	SFTP
Reverification	Every 3 months, on a rolling 3-month cycle, based on the last verification date.	SFTP
One-off Verification Requests (TPR)	As needed	Manual entry into the MMIS or through the weekly cost avoidance delivery

7.1.6.5 Transmitting Pharmacy Policies in Real Time to POS (App 1, TM033)

As previously noted, HMS has data match capabilities with PBMs. We use our COB on Demand service to transmit the pharmacy policies in real time to BMS' point of sale (POS) system, in addition to our Third Party Referral (TPR) support solution for both pharmacy and major medical policy resolution, which we describe further below in this section.

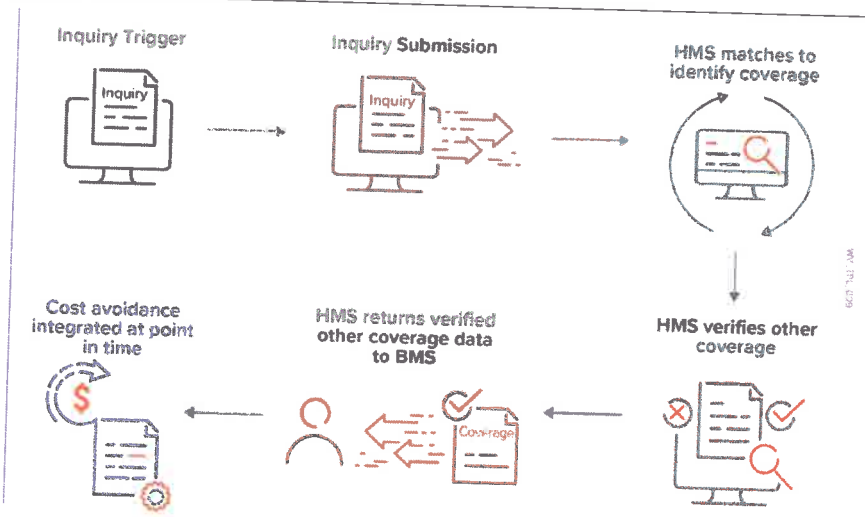
HMS' COB on Demand service is near real-time cost avoidance information injected at various points of the members' eligibility or claims cycle for higher frequency and faster delivery of cost avoidance data and at cost beneficial points in the healthcare continuum. Complementing our existing cost avoidance solution, COB on Demand will identify, verify and communicate existing other coverage at any point in the healthcare continuum – as early as the point of enrollment, point of authorization, or point of pharmacy sale – all within 24 hours.

COB on Demand moves cost avoidance upstream, preventing both medical and pharmacy claims from being billed and paid inappropriately by Medicaid in the first place.

With our standard cost avoidance services, we receive monthly eligibility files from BMS and perform data match and verification weekly against these files. With COB on Demand, we receive a daily eligibility file from BMS that includes any new WV Medicaid members who have become eligible in the past 24 hours. We then run data matches off those new "eligible," and send back a file of cost avoidance records to BMS daily through SFTP to be added into the State's MMIS. **We will continue both services and will check for duplicates on the weekly cost avoidance file that as part of our standard deliverable for the State.**

This enhanced cost avoidance service enables the delivery of cost avoidance segments at the appropriate points in time. Following data receipt, HMS matches, verifies, and provides positively identified third party insurance, as shown in **Exhibit 7.1.6-12.**

Exhibit 7.1.6-12 HMS' COB on Demand Process
COB on Demand enhances our cost avoidance services.



Powered by HMS' NEDP, iMatch process, and verification payor connectivity, COB on Demand uses a daily batch connectivity option, with a 24-hour response. The service also allows for the insertion of business rules that dictate the coverage types, plan types, and other specifics around the results that should be delivered.

7.2 OPTIONAL PROJECTS

7.2.0 TPL OPTIONAL SERVICES

In addition to providing all TPL Mandatory Services, our comprehensive solution offering for BMS also includes all TPL Optional Services requested in the RFP, which encompass a mix of existing and new scopes of work for HMS in the new contract.

- Recovery Audit Contractor (RAC) Services (new scope of work)
- Premium Reimbursement Program administration and support services for:
  - Premium Reimbursement (existing scope of work)
  - Work Incentive/Premium (existing scope of work)
  - Medicare Buy-in (new scope of work – prior service provider in WV)

HMS has extensive experience delivering the services requested in the RFP, including those that fall under the TPL Optional Services. As noted above, HMS currently operates two out of the four TPL Optional Services requested for BMS today. In addition to Premium Reimbursement and Work Incentive/Premium, we were a prior vendor delivering the Medicare Buy-in service for BMS and have existing knowledge and understanding of that program, providing value for re-implementing this program for the new term.

For the services in place and generating cost savings for WV today, we will work with BMS during project kickoff in a new contract term to:

- Carefully review all WV Premium Reimbursement and Work Incentive/Premium TPL program requirements described in the RFP and confirm compliance with new requirements, business rule changes, and integration requirements
- Review current processes to ensure any adjustments required by BMS are incorporated into our final Work Plan and schedule for implementation and operations

The administration of our customized Work Plan will continue to produce value for BMS while implementing new processes and adjusting existing processes to ensure no decrease in financial value for BMS. During the initial phase of contract operations, we look forward to providing a detailed description of our demonstrated methodologies as well as innovative ideas that we are confident respond to the current and future needs of the State.

For the existing TPL Optional Services, and as described in each proposal section, we bring the same level of innovation and full-service scope of work expertise as we do for the TPL Mandatory Services. In proposal **Sections 7.2.1** through **7.2.3**, we provide our proposed solutions for the three premium reimbursement programs, which includes our responses to the RFP Appendix 1: Detailed Specifications.

HMS' Premium Reimbursement Program Management Experience

As access to private insurance increases, premium assistance programs like West Virginia's can become even more effective in containing Medicaid program costs. Changes resulting from recent reforms that might also affect growth include the following:

- More Medicaid members or families might have access to ESI as employer mandates to extend health insurance coverage to all eligible full-time employees or pay a penalty become effective.
- As policies become more affordable to individuals through state exchanges, more families might be able to obtain coverage that includes dependents who are Medicaid members.

We continue to monitor employer health plan–offering trends as well as State and federal legislative and program activity related to state premium assistance/reimbursement programs.

HMS began administering premium reimbursement programs for our clients in 1996. We regularly work with Medicaid programs, including West Virginia, to evaluate referrals and enroll their eligible members into these programs (HIPP, Medicare Buy-in, and the WV-specific M-WIN program), which subsequently enrolls them into the ESI; passing the resultant savings back to the State. Our work processes and systems support our clients and help maximize premium reimbursement opportunities by identifying potential program enrollees through market outreach and our internal data-mining process; partnering with healthcare providers, insurers, employers and community groups; and reviewing referral leads. We support the program application process, determine the cost-effectiveness of initial and continued enrollment, and provide the information needed to interact effectively with all stakeholders by educating them and answering questions about the program.

HMS' Program Integrity Experience

For the new Medicaid RAC Services scope of work, presented in proposal **Section 7.2.4**, HMS brings more than 35 years of experience providing comprehensive program integrity (PI) solutions to public and private healthcare programs. From this experience, as well as our position in this government program integrity space, we know that the most effective RAC service providers have deep and relevant experience combined with expert clinical and technical capabilities, knowledge of industry best practices, and innovative ideas to best serve clients and meet their program needs. Since 2005, HMS has worked continuously with CMS to help contain costs and provide program integrity for our nation's public healthcare programs.

HMS was the first RAC to identify and correct more than $1 billion in inappropriate Medicare payments, and we continue to be a consistent top performer in quality and total corrections identified.

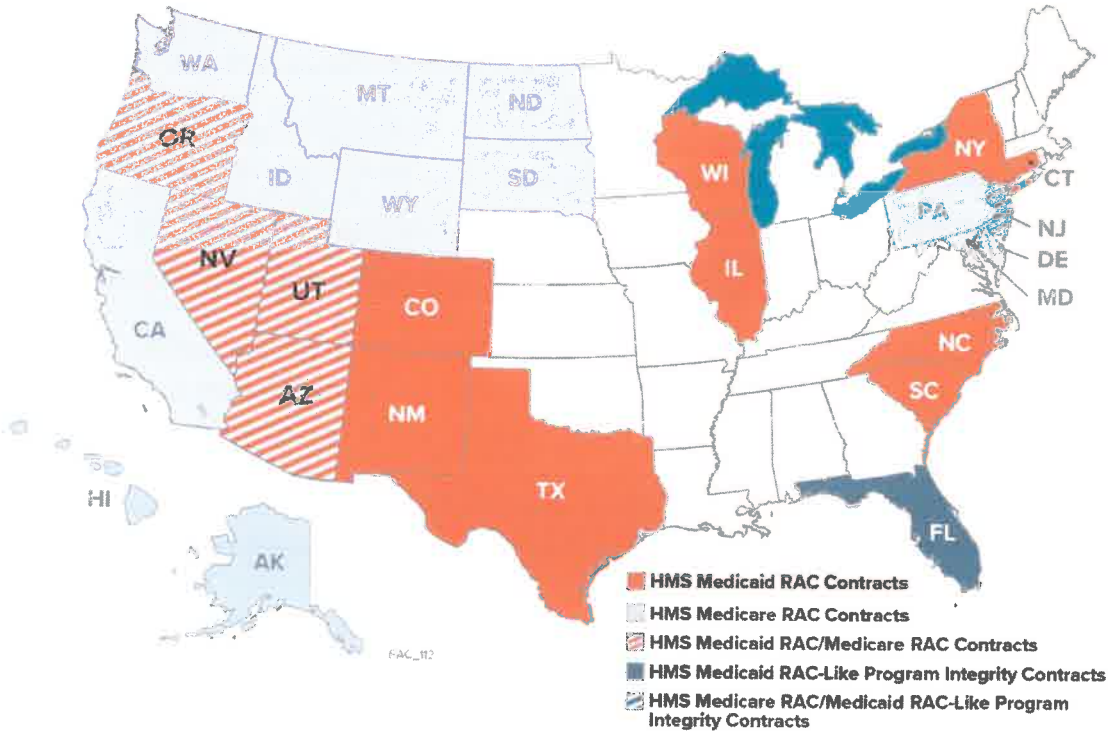
When the RAC program was expanded to Medicaid in 2010, HMS began working with states to implement the Medicaid RAC programs required under the Patient Protection and Affordable Care Act (ACA); we set forth this initiative with the launch of Tennessee RAC in 2011.

HMS quickly became the leading Medicaid Recovery Audit Contractor in the country, for both CMS and state Medicaid agencies. Today, HMS is considered both an industry innovator and leading contractor for government healthcare program integrity nationwide with a robust client portfolio comprised of our continued involvement with CMS on their Medicare RAC in Region 4, the Veterans Administration (VA) RAC, 13 state Medicaid RACs, two additional state agencies with RAC-like program integrity services, and dozens of Medicaid managed care plans.

We serve more Medicaid agencies for Recovery Audit contracts than any other contractor, covering 26% of the nation; our competitors serve one or two RACs.

We have developed a unique understanding of our nation's healthcare system and the challenges faced by public healthcare programs. Each of our clients benefit from the knowledge and insight we have gained by working with similar programs nationwide. **Exhibit 7.2-1** below shows the extent of HMS' combined State Medicaid, CMS Medicare RAC, and related state PI experience.

Exhibit 7.2-1 HMS' Combined Medicare and State Medicaid RAC Experience
HMS currently serves 1 Medicare region (Region 4) and 13 state Medicaid RAC programs nationwide.



Working diligently on behalf of our clients to successfully identify, review, and recover improper Medicaid payments, **HMS has identified more than $370 million in overpayments for our state RAC clients since 2018. We have recovered more than $26 million for CMS in Region 4,** according to the most recent 2018 published reports; **our Medicare RAC Region 4 recoveries are the highest in the Medicare RAC program.**

With our wide-spread national experience, we not only identify what works in other states but identify what does not work. We are constantly evolving our program and approach to provide maximum benefit to our clients, both operationally and financially.

ADDITIONAL VALUE-ADD PROJECTS

In addition to the TPL Optional Services proposed for the new contract, HMS offers BMS several optional, value-added projects that align with BMS' vision to help West Virginians. These proposed ideas, which are new to BMS and beyond the services requested in this procurement, provide an opportunity for BMS to review additional opportunities for expanding cost savings, recoveries, and adding value to the Medicaid program. We provide more information about these projects in proposal **Section 7.2.5 Additional Value Add Projects**.

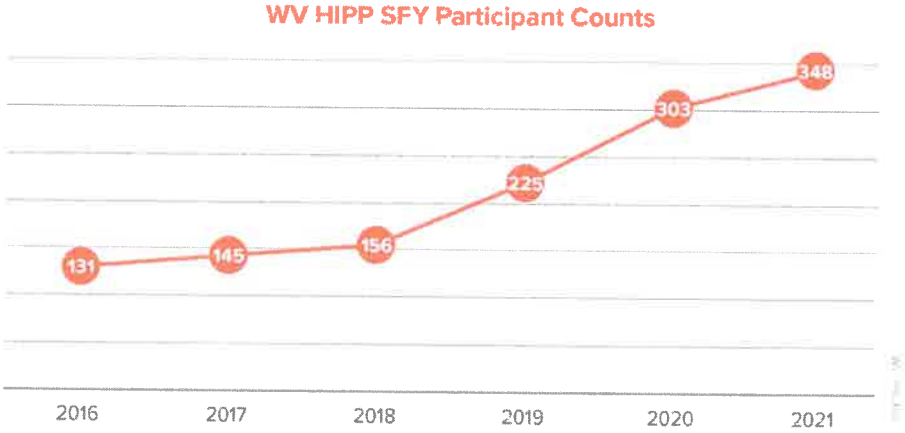
7.2.1 PREMIUM REIMBURSEMENT PROGRAM

The West Virginia Health Insurance Premium Payment (WV HIPP) program is a state-funded premium reimbursement program for qualifying WV Medicaid members and their families, who have access to health insurance that is either self-funded, available through an employer, or through COBRA. WV HIPP is designed to offset the rising cost associated with healthcare by determining if eligible Medicaid members are either enrolled in or have access to Employer Sponsored Insurance (ESI).

Serving 10 clients currently, HMS has assisted states in administering their health insurance premium reimbursement programs since 1996.

Since the establishment of the HIPP program in 1996, BMS and HMS have worked collaboratively to create this program and implement continual enhancements to streamline the processing of applications, ensure the integrity of the data, and provide accurate and timely payments. Since the start of our current contract in 2011, **we have processed more than 14,000 premium payments, with a total value of more than $63 million, and saving BMS $550 million.** In addition to these significant cost savings, **we also increased WV HIPP participant enrollment by 250%** (from 100 to 350 cases, as of September 2020). We have maintained a continual year-over-year increase in savings at an impressive rate, a direct result of this increase in program enrollments (**Exhibit 7.2-2**).

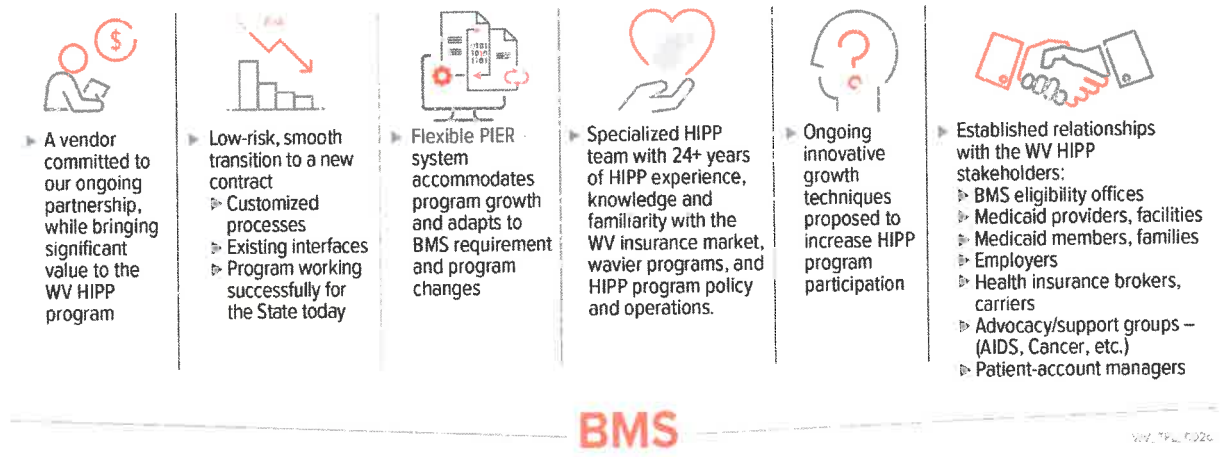
Exhibit 7.2-2 WV HIPP Average Participant Enrollment Over the Past Five State Fiscal Years (SFYs)
Greater participant enrollment caseloads translate directly into greater cost savings for BMS.



This significant program growth has been the direct outcome from the partnerships HMS created within the State community, including relationships with organizations that oversee the Medicaid waiver program. HMS has worked closely with these organizations to determine which members may be eligible for the HIPP program to produce cost savings for BMS. We have since expanded these relationships to include other advocate groups within the State (e.g. Sill Builders, Families First, and Children's Home Society of West Virginia), which has facilitated increased enrollments and savings. We will continue to leverage these existing relationships and expand to others in the upcoming contract period.

In addition to the financial impact, BMS has realized many other benefits with HMS as the State's WV HIPP administrator, as illustrated in **Exhibit 7.2-3.**

Exhibit 7.2-3 Ongoing Benefits Recognized by BMS Through Partnership with HMS
HMS' administration of the WV HIPP program also produces many non-monetary benefits for BMS.



7.2.1.1 Our Premium Reimbursement Program Approach (App 1, OS001)

The WV HIPP program offsets the rising cost associated with healthcare by determining if eligible Medicaid members are either enrolled in or have access to Employer-sponsored insurance (ESI). If so, we determine if enabling BMS to purchase health insurance, under the authority of Section 1905(a) of the Social Security Act (SSA), is cost-effective and would make better use of Medicaid program dollars.

In this section, we provide our proposed solution for BMS as well as describe our approach to operating the State's premium reimbursement program.

Proposed Premium Reimbursement Solution for WV HIPP

With our proposed premium reimbursement solution for BMS, HMS will continue to administer all aspects of WV HIPP end to end, as we have done successfully for more than 24 years. Our established solution provides WV HIPP with effective processes and systems, customized for the State, that identify potential WV HIPP program participants. The solution also validates and determines eligibility and automatically calculates the cost-effectiveness of enrolling an individual in the program. Using our robust case management system, the solution performs participant reimbursement and premium management, and periodic program evaluation. We are proud of the work and collaboration we have achieved with BMS to build and grow an effective WV HIPP program that benefits participants and their families, while maintaining the fiscal integrity of the WV Medicaid program.

During the current contract, we developed and implemented several system applications, databases, and innovative operational components specifically customized for the WV HIPP program **at no additional cost**. Our PIER case management system generates application-to-potential participants based on customizable data mining algorithms, using TPL data (e.g. TPL

Resource File, Carrier File, and Paid Claims File) on high-cost members as well as data from other lead sources, if available. We mine the data to identify members who fit the specified criteria, then do further analysis to see if that member has access to commercial insurance. To further supplement our current processes, we recommend several additional file types for WV to enhance the current lead sources. We summarize these enhancement opportunities that we can implement for BMS during the forthcoming engagement in **Exhibit 7.2-4**. Development on these is already underway, and we will collaborate with BMS on implementing them for WV HIPP.

Exhibit 7.2-4 Recommended Supplemental File Types for BMS
To supplement what is in place, we recommend additional file types to enhance current lead sources.

File Type	Description
Dependent File	The Dependent File is created to target policyholders who have enrolled themselves in ESI, but not their eligible dependent children. A HIPP advisor will determine how much the participant and their dependent(s) are eligible for by using the cost-effective evaluation calculation built into the PIER system. They will then work with the participant and their employer to assist them in enrolling their dependent(s) into their employer's health insurance.
Pregnant Women File	The Pregnant Women File is created to assist pregnant women and newborns in enrolling in WV HIPP. If the pregnant mother has eligible Medicaid coverage, a HIPP advisor will reach out to assist them in getting enrolled in ESI. After enrollment, the HIPP advisor will process the expecting mother's case within our internal PIER system and the participant will begin receiving monthly premium reimbursements. Once the child is born, a HIPP advisor will reach out again to assist them in enrolling their newborn into ESI. Once enrolled, the HIPP advisor will process the case within our internal PIER system. The participant will begin receiving monthly premium reimbursements for themselves (if still eligible for Medicaid coverage) and their newborn.
COBRA-Eligible Members	As unemployment has risen with the impacts of COVID-19, HMS has developed a robust algorithm to identify members whose ESI coverage has terminated and the member has had a claim within 60 days of the ESI termination. This process will not only allow BMS to cost avoid for future claims the member may accumulate, but it will also allow BMS a chance to recover any claims paid by the agency that cannot be passed back to the COBRA plan.

Our Approach

Our approach to operating the WV HIPP program is comprehensive, flexible, efficient, and proven successful in WV as well as in nine other states nationwide covering more than 5,800 lives. Our effective model for evaluating cases and determining the cost-effectiveness for each participant assists BMS in realizing maximum Medicaid cost savings. HMS' advanced algorithms determine if enrolling a member in the program would be advantageous. Estimated medical expenditures are based on various factors—age, gender, geography, disability, and special medical conditions. The HMS team thoroughly tests each case for cost-effectiveness before enrollment in the program.

HMS prides itself on having the flexibility and scalability to accommodate the specific requirements of each of our clients as well as adjust our solution and PIER system to accommodate any program changes and/or react to unforeseen events that may occur.

For example, we understand the process changes needed to meet the nationwide CMS guidance on the timing for submitting premium reimbursements to WV HIPP program participants. Right now, participants provide proof of payment before we reimburse them, however, CMS is looking to have states reimburse prior to obtaining proof of payment. Our PIER

system can be modified to allow for payments to be issued in advance of the premiums being taken out of the participant's paystub. Our trained caseworkers will continue to validate the participant's Medicaid eligibility and help ensure that the ESI policy remains active prior to issuing any advance payment to the participant.

This new guidance from CMS may lead to an increase in overpayments made by BMS. HMS will use the data we have within our National Eligibility Database Platform (NEDP) and PIER systems to validate that the ESI policy remains active prior to BMS making a payment.

PROVEN FLEXIBILITY

One instance that demonstrates our flexibility surrounds the COVID-19 outbreak and changes we have implemented within the WV HIPP program. HMS implemented a new procedure in March 2020 that aimed to address the change in many of our HIPP members' work lives. Items that may have been easy to obtain previously, such as pay stubs or health insurance premium rate sheets, suddenly became obstacles.

Keeping this in mind, our HIPP caseworkers performed more outreaches on the member's behalf. These outreach calls were targeted towards gathering information that may have been missing at the time of application. This allowed us to enroll as many members' in the HIPP programs as possible, while also reducing the burden on the members and offering additional cost savings back to BMS. HMS will continue to bring this flexibility and innovative thinking to BMS in the new contract period.

HMS' CASE MANAGEMENT SYSTEM (PIER)

Our approach includes use of our secure, web-based Premium Identification, Evaluation, and Reimbursement (PIER) Case Management System, specifically designed for Medicaid HIPP programs. Pier helps us manage all aspects of the WV HIPP program, from enrollment through premium reimbursement, including case management and reporting. PIER's system functionality enables effective HIPP program administration through many useful features:

- Integrated data mining from various sources designed to select Medicaid members that offer the greatest savings for BMS
- Expedited referral and application processing through online program application support
- Rapid, automatic review of all active cases to verify Medicaid and ESI eligibility before processing payments or reimbursements.
- Report generation
- Automated program-eligibility and cost-effectiveness determinations
- Rules-driven workflow management to track each case through various stages and manage HIPP caseloads
- Automated triggers and reminders based on BMS-specific requirements that prompt caseworkers to take the appropriate action at the right time
- Reimbursement tracking and facilitation of timely, accurate payments, including use of fiscal-management controls

Using PIER, we can process applications; review participant plan, and policy information; review case notes; evaluate cases; set up workflows; and generate correspondence. At each stage of the process, *PIER* adds a layer of project control, which supports sound program management

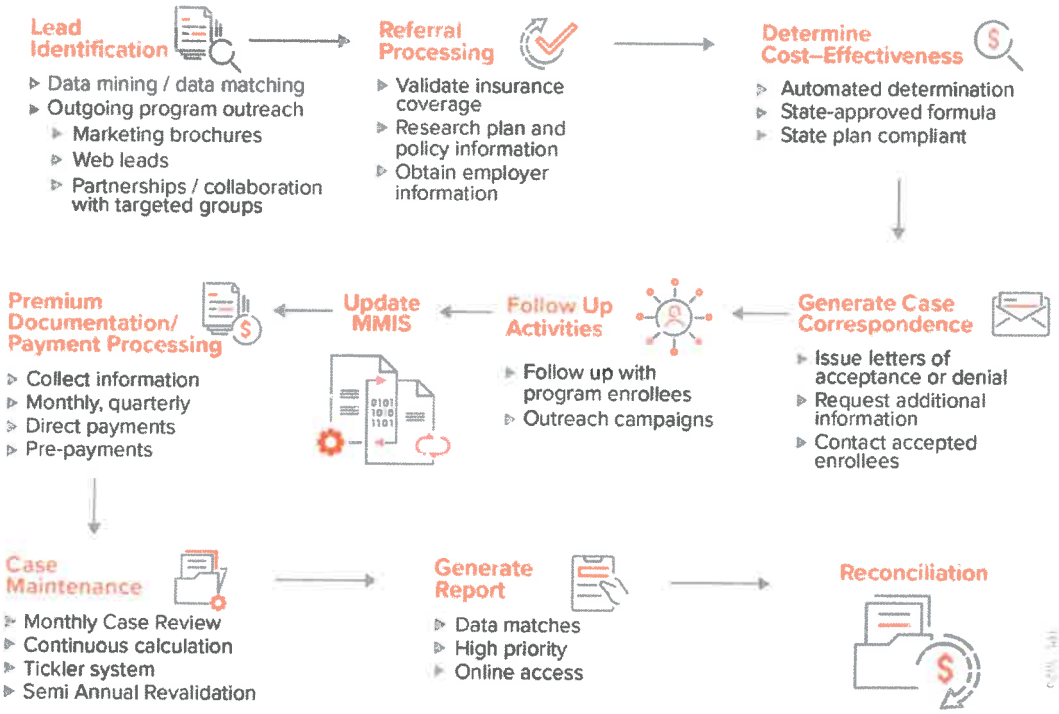
Our proposed premium reimbursement solution includes a systematic process that addresses all service requirements to best serve BMS' Medicaid members who qualify for this valuable program. In our response to requirements **OS002** through **OS014** below, we describe our step-by-step process and activities we will perform to manage the WV HIPP program.

7.2.1.2 Our WV HIPP Process (App 1, OS002-OS014)

In **Exhibit 7.2-5** below, we visually identify the various phases and tasks included in our comprehensive and proven process that we leverage to manage the WV HIPP program. A description of each step follows immediately below, including a reference to where each of the activities in this requirement falls within the process.

Although not part of our current process, on an as-needed basis, we can also provide BMS with a "premium reimbursement program Business Rule" file, documenting all requirements as agreed upon with BMS for the program. This is easily accomplished using our PIER system.

Exhibit 7.2-5 HMS' End-to-End Process for Managing the WV HIPP Program
Our process addresses all service requirements to best serve BMS' Medicaid members who qualify for this valuable program.



Step 1: Identifying Leads

Addresses marketing and outreach; operating a web portal.

Like most clients, WV does not have an automatic stream of incoming referral sources. Because of this, HMS leverages various data sources to identify potential WV HIPP program participants to continually increase program cost savings. We generate program leads and referrals by

identifying potential participants through data matching with enrollment/eligibility and employment data as well as through marketing and outreach to targeted Medicaid members and surrounding communities. Our extensive data-mining techniques, predictive-analysis technology, online-application tools, and targeted, large-scale direct-outreach campaigns arm us with the right tools to help us increase WV HIPP program participation.

Through data mining we can identify employed FFS members, compare current costs by the case, and determine if outreach regarding HIPP is warranted.

- **Data Mining/Data Matching.** Our data-mining techniques target high-potential participants across the WV Medicaid Fee-for-Service (FFS) population and enroll them in the program. PIER systematically generates applications to send to WV Medicaid members based on customizable data mining algorithms, using TPL data on high-cost members and supplemental data files. We also use data mining and predictive analysis to identify potential participants from certain populations for targeted outreach and promotional campaigns. Once an application is generated and mailed, our HIPP caseworkers perform additional outreach to the member informing them of the program and detailing what information is needed to process the application

- **Web Leads.** We have multiple modalities available for prospective participants to obtain program information. This includes the WV HIPP website (https:/www.wvhipp.com), available 24/7/365) and specific to our HMS-administered HIPP program for BMS. This online interface simplifies the enrollment process and enables real-time direct transmission of application data to PIER. This minimizes errors from data entry or incomplete responses while expediting the enrollment process.

Our real-world HIPP processing experience has shown that most program applicants prefer the convenience of enrolling online rather than faxing and/or mailing an application.

- **Outgoing Program Outreach.** To drive program growth, we promote awareness to targeted groups through various methods, including distribution of marketing materials, awareness campaigns, web leads, and through partnerships with targeted associations and groups. Our outreach will be focused on the following stakeholders: BMS Eligibility offices, WV Medicaid providers, WV Medicaid members and their families, health insurance brokers and carriers, advocacy groups, patient-account managers, children's hospitals, birthing centers, support groups for AIDS, cancer, and more.
  - **Awareness Campaigns.** We work with BMS stakeholders to develop outreach campaigns and supporting materials, update application forms, distribute information statewide to prospective participants, primary care physicians, eligibility

By engaging stakeholders and focusing HIPP outreach on the appropriate partners and enrolling individuals who require high-cost or extensive services, we increase program awareness, drive program enrollment, and ultimately maximize the value of HIPP. We implement and improve upon these growth techniques until the WV HIPP program reaches its optimum size.

technicians, acute care providers, and other community entities.

- **Partnerships.** We also promote WV HIPP through our partnerships and collaboration with targeted associations and other groups. In 2020, HMS initiated outreach to groups that assist members through the waiver program as well as other advocate groups. Our goal was to create a partnership where we could educate the workers of the WV HIPP program, highlighting who is eligible for the program and what information is needed to apply and the benefits to the member once they are enrolled in the program. We are also working with the stakeholder groups listed above on creating informational sessions that would provide one-on-one support to potential members with our trained caseworkers to determine if they would be eligible for the program.

To support all these promotion efforts, we create, tailor, and distribute supporting materials (e.g. brochures) at no additional cost to BMS. Prior to updating or releasing materials, HMS will provide them to BMS for review and approval. These materials direct potential applicants to the WV HIPP website, where they can access an online application and apply for the program. Please refer to **Exhibit 7.2.1-5** in proposal **Appendix 1** for a sample of our newly updated HIPP brochure, which was finalized in November 2020.

STEP 2: PROCESSING REFERRALS AND APPLICATIONS

Addresses verifying member eligibility for WV Medicaid and validating insurance coverage and premium payment amounts to ensure eligibility.

After receiving a completed application from a Medicaid member or employer, either by paper or through electronic means, our HIPP caseworker reviews the documentation and determines if all required information has been received or if additional outreach is needed. Case data is uploaded into PIER and an electronic case file is created. For paper applications, we scan and index the documentation, attaching it to the case.

VALIDATING INSURANCE COVERAGE

We queue cases in our system based on whether the applicant has identified health insurance coverage or does not currently have coverage but has access to it. If the applicant supplies active policy information, we verify the health insurance policy and premium data with the policyholder's employer and insurance carrier. We perform telephone, fax, and batch verification processes with applicable carriers. In cases where the employer cannot verbally release information, we use employer correspondence to contact Human Resources personnel to obtain both premium and coverage data. This information is critical for cost-effectiveness determinations. If an applicant indicates potential access to insurance, we work with the policyholder and employer to identify options to enroll the Medicaid member and his/her family into a cost-effective plan.

To assist in managing the WV HIPP enrollment process, we maintain an employer database in PIER that includes the largest employers in WV. The employer database enables rapid identification of insurance coverage and benefit plans offered by employers across the nation, which allows us to process applications more quickly. Given that we update employer

information as frequently as daily, we can track cost avoidance data that might affect HIPP program administration.

RESEARCHING PLAN AND POLICY INFORMATION

Using certain criteria helps us verify that health insurance carriers' policies meet the basic BMS-required benefit levels so that Medicaid pays the minimum as a secondary payer. Our HIPP caseworkers obtain detailed information regarding policy limitations, exclusions to enrollment, covered services (e.g., pharmacy services, practitioner services, Durable Medical Equipment, inpatient hospital services, home health services), benefit limits for nonessential services, coinsurance, deductibles, co-payments, and Out of Pocket (OOP) maximums.

We collect and maintain relevant plan data, including tier (e.g., individual, individual plus spouse, individual plus children), rate, employer size, employer and employee contributions, and open-enrollment dates, in PIER. Retaining comprehensive employer-plan data in a repository limits our need to contact an employer for updated plan information to once per year, during the Open Enrollment period.

If our team needs additional information to process a potential participant's application, a caseworker will ask the applicant to provide additional documentation, including identification number (ID), employer information, policy coverage, and premium costs. Please refer to **Exhibit 7.2.1-6** in **Appendix 1** for a sample HIPP Program Missing Enrollment Information Letter that we send to request this information.

STEP 3: DETERMINING COST-EFFECTIVENESS

Addresses verifying cost effectiveness.

After the required information has been entered in PIER, we perform the cost-effective determination to see if the member/household should be enrolled in the HIPP program. We rely on integrated cost-effective algorithms, programmed in PIER to meet BMS' project requirements, and the automated calculations to determine if the applicant should be accepted into the WV HIPP program. The cost-effective equation for WV has an added complexity given that both FFS and managed care organizations (MCO) members are eligible for the HIPP program, which currently resides in our PIER system.

To determine the cost-effectiveness of enrolling an individual in the WV HIPP program, we will compare the estimated cost of the insurance policy with the estimated medical costs of participants on the case. If the estimated policy costs are less than the estimated medical expenditures plus any administrative fees, we designate the case to be cost-effective and the applicant to be eligible for the HIPP program.

An accurate assessment of a participant's medical needs is essential in deriving estimates for cost savings. To do this, we request documentation from treating providers to confirm the participant's medical condition. We also request copies of Explanation of Benefits (EOBs) from third-party carriers or a Special Condition Letter from a provider as additional documentation of

medical need. These additional data elements are only used after the participant is determined not to be cost-effective based on the estimated medical expenditures.

We update cost-of-care rates on an annual basis, or as required by the State, to reflect the current actuarial data calculated for WV's population. Leveraging our knowledge of Medicaid and our repository of historical paid claim data allows us to recalculate the Average Annual Medical Cost (AAMC) for each demographic and cost category using claims from the most recent state fiscal year. In a new contract, we will update the calculation and present the AAMC to BMS for approval and load the data into PIER to value the case. HMS also requests that BMS pass along updated MCO capitation rates as they change so that this information can be updated within PIER.

Step 4: Generating Case Correspondence

Once the case has been either enrolled or denied for the WV HIPP program, the HMS HIPP caseworker will issue the appropriate correspondence to the participant. This provides the participant with the outcome of their case review and offers contact information should they have any questions. Based on the cost-effectiveness calculation results, from Step 2 above, our HIPP caseworker takes one of the following actions to generate case correspondence in PIER:

- For cases considered cost-effective, we generate an Acceptance Letter to the applicant. The letter notifies the applicant of the decision and the ongoing reimbursement that they will receive or of the direct payment to the employer or carrier, as applicable. In addition to mailing the Acceptance Letter, we make "Welcome" telephone calls. Please refer to **Exhibit 7.2.1-7** in proposal **Appendix 1** for a sample WV HIPP Acceptance Letter.
- For cases not considered cost-effective, we generate a Denial Notice to the applicant. The notice indicates specific reasons documenting why we did not approve the case and provides a toll-free telephone number through which the applicant can contact us for additional information. Please refer to **Exhibit 7.2.1-8** in **Appendix 1** for a sample WV HIPP Denial Letter.

In addition to the Acceptance Letters and Denial Notices, we generate other correspondence to manage open-enrollment opportunities, obtain missing information, and communicate with employers to obtain enrollment information, as necessary. The PIER system allows users to select a programmed letter template to generate system correspondence.

PIER allows eligibility advisors to generate approved communications directly from the system. For tracking purposes, the tool will automatically maintain an electronic image of each correspondence generated. To certify consistency and accuracy, we employ fully automated case development, requiring only minimal data inputs from eligibility advisors.

Step 5: Following Up With Participants

Addresses handling all correspondence and inquiries regarding the program.

Either during or following enrollment, we perform outreach and follow up with participants. We recommend the following touchpoints to ensure effective and timely caseload management:

1. Follow up on applications sent to prospective participants
2. Follow up with applicants who return an incomplete program application
3. A monthly text message (or by other means) reminder to the HIPP participant to submit the necessary pay stub verification
4. Reminder to submit the annual Renewal Form

We typically perform follow-up activities through email, telephone call, interactive voice response (IVR) campaigns, or text messaging.

We also can bolster the effectiveness of our outreach and follow-up activity with *Eliza*®, our member engagement solution. We discuss *Eliza* and how it can benefit outreach for BMS in **Section 7.2.5 Additional Value Add Projects.**

STEP 6: UPDATING THE MMIS

Addresses forwarding health insurance with all types of coverage per approved members to BMS to be added to the MMIS and coordinating benefits with the TPL program.

PIER will seamlessly transmit policy information to BMS' MMIS for the purpose of cost avoidance. During implementation, we will meet with BMS to determine updates to the current file layouts and reconfirm our secure process to transmit this data.

STEP 7: PROCESSING PREMIUM DOCUMENTATION AND PAYMENTS

A key success measure of a HIPP program is the ability to generate accurate, prompt premium reimbursements to members or direct payments to insurance carriers, employers, ESI plans, and COBRA administrators. Members are more willing to participate in the program when the HIPP Program Administrator processes their reimbursement checks in a timely manner.

In the upcoming contract period, HMS would look to continue the proven process we have created with BMS for processing premium payments. This process includes generating a funding request for BMS to approve batching of checks. BMS requests funding of just the check amount from the State Controller's Office, and then the State Controller's Office funds the State bank account. After funding, checks are printed, and the Positive Pay File is created and loaded into the online banking system. Checks are then released and sent to participants. The Positive Pay File contains all the checks for that week's check cycle. As BMS is requiring the contractor to prefund the account for reimbursements, we will still follow the process of presenting a funding request to the State so that BMS is aware and agrees with the premiums being reimbursed. Once approved, HMS will fund the account and distribute reimbursements.

In addition to the monthly check runs scheduled near the first of each month, another check run occurs on the fifteenth of each month to help ensure direct payment of premium payments to employers, ESI plans, and COBRA administrators and to help ensure payment for cases pended and released later in the month. Direct payments are scheduled for release two weeks prior to the official premium due dates to avoid late payments or interruptions in coverage. On an ad hoc basis, HMS can issue checks to pay participants for insurance premiums within three days of receipt of supporting documentation, as requested in the RFP.

Because Medicaid and third-party insurance coverage fluctuates over time, HMS reviews the data for changes prior to generating a check request. As noted in our discussion of HIPP case management, we will leverage real-time access to eligibility data and other databases to validate Medicaid and BMS' eligibility, as well as insurance coverage, before issuing payments to participants. Loss of eligibility automatically suspends the case with a specified reason, which triggers an investigation. We do not issue a payment if we have not verified eligibility or have not received evidence of a premium payment from a participant before the time of check-write.

HMS generates a funding request for batching of the checks. When we send the check, PIER receives Acknowledgement Files and loads them to the check histories. The logic in the PIER financial subsystem prevents the production of multiple premium checks for the same benefit period without manual supervisory approval and intervention. For compliance, we incorporate the following BMS requirements into our HIPP/PIER project controls:

- HMS will requisition the approved amount to the designated HIPP program checking account to ensure funds are available.
- We will send a Positive Pay File to the bank to prevent alterations of the check amounts issued.
- HMS will provide BMS with appropriate documentation to confirm payment of premiums.

We attach financial transactions to case files to maintain complete transaction history and for monitoring HIPP program activity and process.

HMS is pleased to offer an additional functionality, ACH payments (direct deposit), to both BMS and HIPP members. This added benefit not only allows members to receive this HIPP reimbursement directly in their checking or savings account, but it also offers enhanced security for BMS. There are often delays with members depositing paper checks received via the post office. By implementing direct deposit into the WV HIPP program, BMS will see a drastic reduction in the number of outstanding payments waiting to be deposited. HMS recently implemented this feature for one of our southern HIPP states and over 80% of the HIPP membership signed up for direct deposit payments within 3 months.

The payment process described previously would not change with the addition of direct deposit payments for BMS. Rather, HMS would make a simple change to our process to capture the member's bank information and send an additional file to the bank for processing. The bank also has safeguards in place that alert HMS if an error was made during the data entry of the member's bank information. If either the routing or bank account information is entered incorrectly, JPMorgan Chase will send HMS an email alert detailing what payments failed and why. Our trained payment specialists review these failures the same day they arrive to determine if the bank information within PIER needs to be updated or if an additional outreach call to the member is needed.

Direct Deposit payments also provide HIPP members insight into when their payment will be issued. Direct Deposit payments are processed the next business day by the bank and the funds are usually available the same day in the member's bank account. This routine leads to

fewer calls and escalations from members inquiring on check status and reduces unnecessary voids and reissues of paper checks because it was lost in the mail or misplaced by the member.

Fiscal Controls

PIER automatically reviews all active cases to verify Medicaid and ESI eligibility before processing payments or reimbursements. It creates workflow events that prompt the HIPP caseworker to validate that the correct policyholders receive their payments. Similarly, we review payment stubs to confirm the correct reimbursement amount owed to members, employers, and insurance carriers. HMS has fiscal controls within our system to help ensure payments are accurate and made in a timely manner. They also direct how the system reduces any unnecessary overpayments. These controls include system edits, operational controls, a QA review, and the following additional controls:

- User-access controls limit those who can perform special processing (e.g., PIER will issue only one payment per benefit period for each case without supervisory approval.)
- PIER allows only supervisors to authorize payments that are more than three months retroactive.
- Premium recovery functionality is available in PIER to allow for recoupment or refund processing. By direction of BMS, we do not currently perform this function in WV.
- PIER has automated functionality to suspend cases when eligibility, policy, or payment dates or activities stall. This functionality allows clear visibility of cases that require additional consideration from the HIPP Case Management team.
- Security safeguards within PIER limit the number of users who can change payment address data as well as the number of users who can create Payment Request Files.
- During final review, a QA specialist reviews new cases or renewals to check the accuracy of the member, policy, cost-effectiveness result, and payment setup.

Step 8: Maintaining HIPP Cases

Addresses performing an annual comprehensive analysis and recertification of each enrolled member to ensure continued cost effectiveness.

HMS uses PIER to manage all aspects of the WV HIPP program administration, including processing applications, researching cases, calculating cost-effectiveness, storing case documentation, processing payments, and generating reports.

Our HIPP caseworker reviews each case monthly before submitting reimbursement to help ensure the participant remains eligible for the program. This review includes confirming the payroll deduction on the participant's pay stub, Medicaid eligibility, and the case remains cost-effective for reimbursement.

We understand that effective management of insurance changes ensures that State and Federal funds are utilized effectively and efficiently. In addition to reviewing Medicaid eligibility and other case details, we use the information from our monthly data matching with insurers when identifying changes in health insurance coverage for active HIPP households. We also review each case on an annual basis, or as often as needed, to re-verify insurance information and ensure the continued cost-effectiveness of the HIPP case. Should an overpayment on the case occur, we suspend future premium payments to offset the overpayment. Alternatively, we can work with the HIPP participant to make repayments each month until satisfying the amount owed to BMS.

HMS caseworkers review policy coverage dates as part of the payment processing, as described elsewhere in this section. On a semiannual basis, we will perform a redetermination of each active member's case to evaluate if the participant continues to meet BMS HIPP program requirements. Once we re-determine the cost-effectiveness of the HIPP case, we notify participants by sending out a Renewal Notice. It is imperative that communication with employers is ongoing to identify changes in open-enrollment periods or the policy anniversary date in the case record. Caseworkers will use this information to schedule timely case reviews.

Ongoing Case Maintenance and Review

Based on criteria such as medical condition, activation date, and Open Enrollment periods, we assign to each case a review or follow-up date that meets BMS' requirements. Within 30 days of the review date, we reevaluate the entire case for the HIPP program. Cases that remain cost-effective remain active. We close cases deemed not to be cost-effective. Our HIPP team promptly mails notices to terminated program participants that indicate the reasons for termination of eligibility as well as the termination date.

Minimizing overpayments is one of our HIPP program goals. The PIER system maintains a record of overpayments, which we can make available for monitoring or auditing purposes. As we receive reimbursement payments, HIPP team members update the system to reflect the current amount owed. Our eligibility advisors follow the steps indicated by BMS for checks received. Our monthly Payment Report includes recovery payments for full reconciliation.

Step 9: Generating WV HIPP Reports

Addresses notifying BMS of all approved and denied applicants, providing reports with actual cost savings to the State, and providing documentation.

Our WV HIPP service capabilities will include detailed, flexible reporting that provides information on our program activities. Our reports will include accurate, detailed accounting of WV HIPP participants and dollars expended. PIER can generate a file listing all denied, terminated, and active WV HIPP cases as well as current insurance coverage data, carrier codes, and policy information validated during the application-verification process.

All our project reports will comply with WV HIPP's program requirements regarding content, format, and frequency of delivery. We understand that BMS requirements regarding report format, content, and submission frequency are subject to change at any time during the term of the contract. Currently, we provide HIPP-related reporting, customized for the State's program, in the Monthly Invoice Report. This report provides monthly statistics for the WV HIPP program including:

- Number of active cases
- Case ID (Medicaid ID or Social Security Number of the policyholder
- Policyholder name
- Activation date
- Case status
- Premium amount
- Number of months covered

Please refer to **Exhibit 7.2.1-9** in **Appendix 1** for a sample PIER report for the WV HIPP program.

STEP 10: PERFORMING PAYMENT RECONCILIATION

HMS maintains a record of financial transactions as part of the case history, providing an audit trail and account reconciliation. We can coordinate and report payment reconciliation with BMS on a monthly or quarterly basis as required by the State. To support reconciliation of payments, we extract historical Payment Records and case details from the PIER system.

PIER maintains a record of overpayments, which we can make available for monitoring or auditing purposes. As we receive reimbursement payments, BMS team members will update the system to reflect the current amount owed.

7.2.2 WORK INCENTIVE PREMIUM PROGRAM

7.2.2.1 WORK INCENTIVE PROGRAM (APP 1, OS036-OS043)

The West Virginia Medicaid Work Incentive Network (M-WIN) program creates an incentive for individuals with disabilities to obtain employment and earn healthcare coverage by eliminating a major barrier to employment: losing current healthcare benefits when an individual with a disability returns to work.

OUR WORK INCENTIVE PROGRAM EXPERIENCE IN WEST VIRGINIA

HMS was instrumental in the initial development and deployment of this vital program in 2003 and are uniquely qualified to continue supporting the State's M-WIN program. The program currently supports an average of 1,100 WV Medicaid members enrolled on a monthly basis. We understand the system requirements to maintain and track program "eligibles" and have effective processes in place for the collection and administration of premiums for individuals "buying into" the Medicaid program.

Our experience with West Virginia's Medicaid program, providers, and members has enabled us to successfully support this important program, which serves as an important link to offering healthcare to the uninsured of WV. Our team's knowledge of the population, employer space, and program ensures our focus on providing exceptional customer service as well as effectively supporting program participants and their needs.

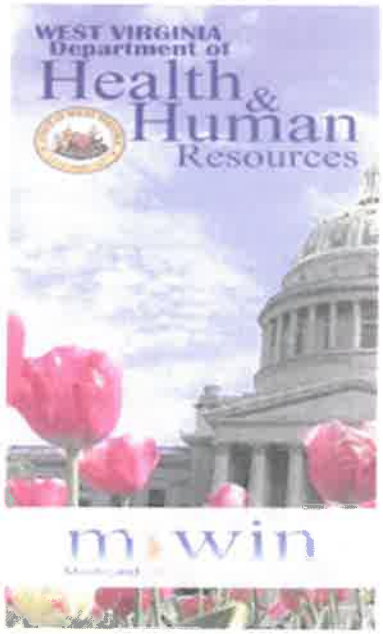
During the time we have been operating the program, we have also established solid working relationships with the Local Welfare Offices (LWOs) that refer the program participants. This keeps us aware of who is enrolled in the program to properly manage the premiums due.

We provide a high level of customer service to M-WIN members. In West Virginia, M-WIN premiums currently range from $15 to $120 per month. The exact premium amount is determined by the individual's average monthly gross income. HMS is the only vendor with experience managing the WV Medicaid work incentive program.

Current M-WIN Solution in WV

HMS' project team actively manages the State's M-WIN program our experience has been invaluable to the growth of the program. Our solution is comprised of the following components that enable our effective support of the WV M-WIN program:

- Formal Introduction experience geared toward new participants to make sure they are properly enrolled in the M-WIN program
- Clear procedures to manage processing of enrollment fees and monthly premium notices
- Established lockbox, streamlining the handling of checks or money orders
- Scalable operational process capable of handling the continued program growth
- M-WIN program staff with work incentive experience as well as interactions with State caseworkers and WV Medicaid members
- Fully functional case management tracking system, with the relevant technical capabilities to manage and report on program outcomes



- Regularly scheduled reporting that includes meaningful and actionable information.

Proposed Innovative Solution Enhancement

HMS will continue using our established and effective processes with M-WIN to offer healthcare to the uninsured. While currently the processing of M-WIN program applications for the State is currently managed by the LWOs, BMS is requiring a web portal for prospective member access for electronic application processing.

HMS will offer this capability for the M-WIN scope of work as an enhancement to our current solution through the PIER system that we use currently for the West Virginia Health Insurance Premium Payment (WV HIPP) program. HMS will create a website specific to our HMS-administered M-WIN program that would be available 24/7/365 for all Medicaid members to use to contact us or view M-WIN program information. This online interface simplifies the enrollment process and enables real-time direct transmission of application data electronically to the *PIER system*. This minimizes errors from data entry or incomplete responses while expediting the enrollment process. We describe the PIER system further in proposal **Section 7.2.1 Premium Reimbursement Program.**

Program Staffing Plan and Technical Support

Our WV-based, dedicated resources (i.e. caseworker, project team) are in place, currently perform the work requested, and have supported the program for the past several years to provide M-WIN related assistance to the State, LWOs, and program participants. This team is very familiar with the M-WIN operational requirements and have established effective, collaborative working relationships with the LWOs involved in the program. For program continuity, we propose using our current resources to support this program in the upcoming contract. We describe these resources more in proposal **Section 7.3.3 Staffing Management Plan**.

Our team remains dedicated to BMS and the M-WIN program, and we stand ready on Day 1 of the new contract to ensure the ongoing success of M-WIN without requiring additional training.

We will also incorporate case management system technology enhancements into the program through use of our existing Premium, Identification, Evaluation, and Reimbursement (PIER) case management system. PIER is specially designed to support premium assistance programs.

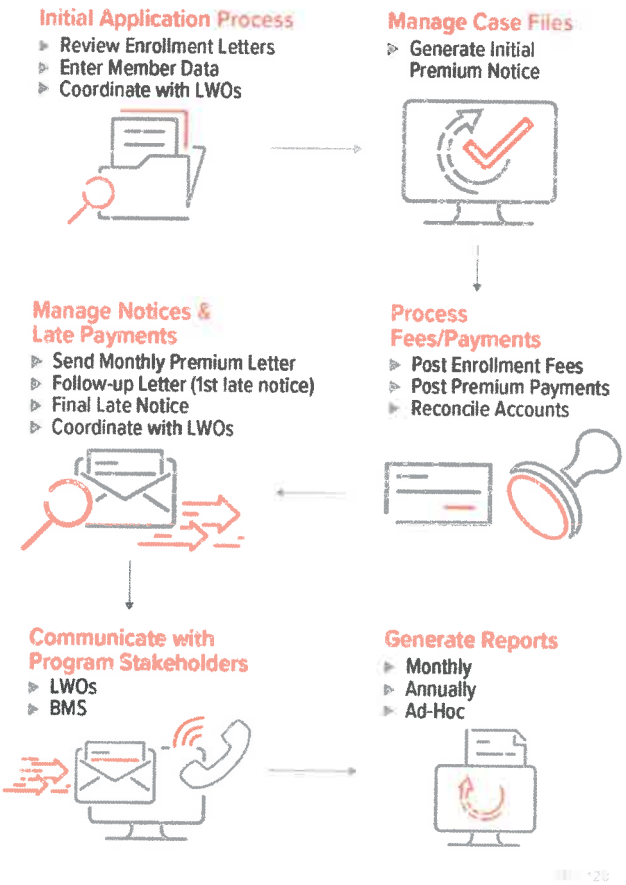
Individuals with questions regarding their participation in the M-WIN program may contact HMS through a toll-free, dedicated telephone line that directs them to our program-specific customer service center/caseworker for assistance. When there are technical issues specific to the PIER application, our Project team works in tandem with HMS' Programming and Technical staff to quickly and efficiently solve any system or process problems to return PIER to full functionality with minimal interruption of service. HMS keeps BMS staff informed of the status of active technical issues through to resolution and will continue to openly communicate with BMS in the upcoming contract.

During the Initial application process, the LWOs handle cost effectiveness determinations. This involves performing automatic recalculations when a member moves from one age group and/or cost category, to another; they simply notify HMS when premiums are increased. HMS has this capability, through our PIER system, if BMS would like to discuss a change to the current process.

HMS' M-WIN Operational Process

HMS has an established, fully operational, and customized process supporting the State's M-WIN program today. We will transition to the new contract term without any interruption in service to BMS or M-WIN program participants. After project initiation, we will review our current process, program materials, correspondence, and surveys with BMS stakeholders and make any necessary program enhancements/ adjustments per BMS' request. **Exhibit 7.2-6** illustrates the tasks HMS performs for WV's M-WIN program.

Exhibit 7.2-6 HMS' Process for Managing the WV Work Incentive Program
Our in-place process is established and highly effective for the State.



In **Exhibit 7.2-7,** we describe the primary tasks we carry out during each of the steps in our process. In these steps, we call out our recommendations for further automating and streamlining the current M-WIN process.

Exhibit 7.2-7 Description of the M-WIN Process Steps
Upon project initiation, we will review the steps in our current process with BMS to determine if they would like to make our recommended adjustments for the new contract.

Steps	Description
Step 1: Initial Application Process	To enroll in the program, an individual must apply and complete an enrollment application and must either visit a local LWO office in-person or access an application online through the M-WIN-specific website proposed above. After they complete and submit the application, the LWO notifies HMS that there is a new enrollee in the program. During the application process, the LWOs determine the cost effectiveness figures and notify HMS when premiums are increased. For the new contract term, **HMS recommends use of our existing online application process, as described in Section 7.2.1 Premium Reimbursement Program, in which applications will be fed directly to our PIER case management system to then follow programmed cost-effectiveness determinations.**

Steps	Description
Step 2: Manage Case Files	We generate an initial monthly premium notice for the newly enrolled program participant, which includes the premium amount and instructions for them to follow when forwarding their payment via check or money order. HMS staff maintain the case files daily, entering information on new enrollees, updating premium amounts, managing payment information, and closing cases. For the new contract term, **HMS proposes streamlining tasks through our PIER system, which will automate the release of letters and track all case file information**. PIER will also retain records associated with each case, should a state caseworker ever need that information. **Through established interfaces and SFTP, HMS will provide monthly case files generated from PIER to the State's MMIS vendor for BMS to load eligibility information.**
Step 3: Process Fees & Premium Payments	Through a lockbox provided by the State Treasurer's office and established/BMS-approved A/R and collections methods, we process the fees, premium payments, and associated documentation for the M-WIN program. If there is a discrepancy between the premium amount due and amount submitted, our team notifies the caseworker to request additional payment. **For the new contract, HMS recommends we create an automatic lockbox report ingest process, through robotic process automation (RPA) to automatically assign the payments within PIER to the appropriate participant.** If the additional payment is not received, **PIER will generate** late notices and terminate their benefit should the appropriate amount of time pass.
Step 4: Manage Payment Notices & Late Payments	In addition to sending initial Premium notices, we generate reminder and late notices: ◎ **Follow-up Letter.** This is the first late notice about overdue payment. If the premium is not received, HMS sends an overdue letter to all late participants on the 16th of the month. ◎ **Final Notice.** If no premium is received, HMS sends a delinquent letter on the 26th of the month notifying the participant that they have until the 10th of the month to submit their premium or face removal from the program. After 40 days, if the premium payment is not received, HMS notifies the LWO caseworker regarding the participant's possible termination from the program. For the new contract, **we propose automating notifications within PIER, to generate letters and terming from the program, if payment has not been received, AND immediately notifying the participant and LWO caseworkers.** We will continue to maintain an active M-WIN enrollee list and premiums due, so BMS remains updated on invoicing status.
Step 5: Communicate with Program Stakeholders	As the current M-WIN program administrator, HMS has developed key relationships with all pertinent stakeholders—participants, LWO caseworkers, the State, and eligibility staff. Effective ongoing dialogue with each of these stakeholder groups—using multiple methods and a detailed outreach plan—predicates program growth and financial results. HMS will continue to meet regularly with BMS, so they can provide the LWOs and their caseworkers with contact information regarding premium collection. Our staff is, ready to assist any LWO caseworker, if they have questions regarding the status of enrollment fees or monthly premiums. We will continue to work with the State to identify additional outreach tasks.
Step 6: Generating Monthly Reports	We track program metrics and generate reports that include case totals, enrollment and premium payments received, and total participants enrolled or terminated for a specific month. We provide reports, such as the M-WIN Back-up Report (sample included as **Exhibit 7.2-3** in **Appendix 1**), to BMS and other stakeholders on a regular basis. We understand that BMS requirements regarding report format, content, and submission frequency are subject to change at any time during the term of the contract. These reports serve as a snapshot that provides key metrics about the status and management of the program. Should we utilize the PIER system within the new contract term, we will review current reports with BMS along with **additional reporting our PIER system can generate**, during project implementation to determine if any changes need to be made.

When necessary, we can adapt our operational and communications processes quickly. As an example, we recently assisted BMS with placing premium and fees on hold due to the COVID-19 pandemic. HMS was available to send notification to participants, informing them of the

changes. We also made sure all participant inquiries were resolved in a timely manner, given their concerns with the unprecedented times during the COVID-19 pandemic.

7.2.3 MEDICARE BUY-IN

The Medicare Buy-In program enables state Medicaid programs to secure Medicare coverage for eligible individuals by paying the individual's Part B and (in certain cases) Part A premiums. Individuals who are eligible for both Medicare and Medicaid sponsored Medicare Savings Programs (MSP) are commonly called "dual-eligibles" (42 U.S.C. §§ 1395v & 1395i-2(g); members who are dually entitled by being covered by both the Medicare and Medicaid programs.

For BMS, effective administration of West Virginia's Medicare Buy-in program is critical:

- Buy-in of Medicare coverage allows WV to fully leverage available Medicare coverage and avoid primary liability for medical services provided to dual-eligibles, who often have complex health needs with high costs that are chronic in nature.
- Expenditures for dual-eligibles are generally more than double those of the non-dually entitled.
- Payment of Medicare premiums also has the effect of increasing Social Security income for dual-eligible individuals, who otherwise would see premiums deducted from monthly checks.

The Buy-In process is also complex and requires effective understanding and management of data and inputs from multiple sources, both State and federal. In WV, with more than 80,000 dual-eligibles enrolled in Medicaid and Medicare Savings Programs, hundreds of accretions to and deletions from the Buy-In process can occur weekly. This is based on new Medicaid enrollment, changes in individual SSI/disability status, deaths, residency, and eligibility category changes:

HMS understands the challenges of operating the Buy-In process through our previous work with multiple state government clients, including WV. Under previous contracts with BMS, we helped the State manage the dual-eligible population by ensuring the accurate and optimal payment of Medicare premiums.

- **Improper accretions** result in an ongoing monthly premium charge to WV, and ongoing payment of premiums for ineligible, deceased, or non-resident individuals create unnecessary cost for the State.
- **Improper deletions** can create gaps in Medicare coverage and/or impact individuals who become responsible for ongoing payment of monthly Medicare premiums, a significant burden for low-income individuals.

By optimizing the Buy-In process, BMS can more effectively address this population and generate the highest cost savings possible for the WV Medicaid program. The Medicare Buy-in program must also comply with the State plan, federal Buy-In agreement, and policy and ensure appropriate and timely service to Medicaid members and state/local agencies.

Our Buy-In Solution Capabilities

Our Buy-In solution combines the capabilities of HMS' data management best practices, sophisticated analytics, data matching techniques, premium assistance/Buy-In program-specific applications, and experienced staff who are well-versed in managing Buy-In and premium assistance programs for state government clients. Our solution leverages these capabilities to automate the daily intake, organization, and analysis of the various data inputs that drive/support the Buy-In process.

Our solution is flexible and can be configured to support existing State systems and processes, incorporate multiple types/formats of data, and produce reports tailored to state requirements

7.2.3.1 HMS' Medicare Buy-In Strategy (App 1, OS029)

Understanding this is a TPL Optional Service, we provide HMS' proposed strategy for supporting the Medicare Buy-In program for BMS in the new contract.

Further below, in our responses to requirements **TM030** through **TM035**, we describe our proposed process for accomplishing specific tasks required for the program.

Our Strategy

HMS' proposed strategy for delivering Medicare Buy-In services for BMS is to configure our technologies and apply our expertise and other capabilities appropriately to implement our proposed solution for BMS. The service will integrate with available data, policies, and other procedures to automate the Buy-In process, while also providing the appropriate level of transparency and control for State staff.

HMS' Proposed Medicare Buy-In Solution for BMS

Currently, BMS manages the Medicare Buy-In program in-house. The solution that HMS will deploy for BMS will reduce state resource costs, streamline operational processes, and reduce overall administrative burden.

The core of our solution is the database that houses and organizes all the pertinent data to provide an accurate, ongoing picture of each individual and their eligibility status as well as all transactions and premium payments related to them. This database includes features that automate monitoring of the process and identifying potential issues as well as dynamically generating outgoing transaction files and reports.

Our solution's core database organizes and provides the appropriate level of transparency required for efficient management of Buy-In program members and large transactions volumes.

Our solution will be customized to support the current program and will include the following components:

- Intake and consolidation of existing CMS and State data files pertaining to Medicare and Medicaid eligibility, including data from the BMS MMIS and eligibility systems, from CMS, and from Social Security Administration (SSA).
- Management of data match and transaction processes with appropriate federal and State databases, including CMS, SSA, and State agencies.
- Loading of member eligibility and transaction data into our PIER database and case management system. The ability to obtain and use a variety of Medicare data files is essential to an efficient Medicare identification and premium management process.
- Generation of a Medicare-Medicaid Master file (aka the Buy-In Export File) that arranges Medicaid members into six different Medicare Buy-In categories (SSI, Deemed SSI, Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, Qualified Individuals, Full Medicaid) and identifies accretion and deletion transactions/changes for eligible members
- Buy-In program operation and management, including review of WV Medicaid members whose coverage period has terminated. We will utilize our Premium Identification, Evaluation, and Reimbursement (PIER) system, which is the system used to manage BMS' MWIN and WV HIPP programs today.
- Full Quality Assurance (QA) of the process and all deliverables
- Case management and customer service support to respond to and track client, State, and county welfare office inquiries and requests

With HMS' Buy-In solution, our staff can:

- Fully identify dual-eligibles
- Track that Buy-In of Medicare coverage occurs for all eligible individuals
- Ensure premium payments are not being made for ineligible individuals in accordance with the State Plan and policies

Throughout the remainder of this section, we describe our proposal and solution components for delivering the proposed Medicare Buy-In solution, including how we will:

- Evaluate current BMS Medicare Buy-In processes and make improvement recommendations for the new contract
- Operate the program, including interfacing with the State's MMIS
- Support the program through staffing, technical support, and a customer service center for program members
- Provide reporting

7.2.3.2 Process Evaluation and Recommendations (App 1, OS030)

At the start of the Implementation phase, HMS will perform an in-depth review of BMS' current Medicare Buy-in processes and data, including the following:

- Medicare Parts A and B
- Enrollment
- Operations

HMS staff has supported numerous large and small state Medicaid agency clients with incorporating procedures and migrating data from existing program systems into our PIER solution. We are confident in successfully doing the same for BMS.

The purpose of the review will be to identify configuration requirements as well as opportunities for improvement based on BMS priorities, HMS experience, and national best practices. During the review, we will determine the best way to migrate legacy data over to our PIER system, integrate and customize BMS program processes into our solution, how best to support WV Buy-In staff, and define deliverables and reporting.

We will also review the data flow between State organizations to outline process inputs, determine process outputs, review data, and produce solution recommendations and implementation plans.

7.2.3.3 Program Operational Processes (App 1, OS032)

Because we have experience operating premium assistance programs for states nationwide, including WV, we have established processes we can pull from to develop a custom step-by-step process for BMS that we will use to operate the BMS Medicare Buy-In program. We will work with BMS during implementation and following design conversations, to finalize and document the process. Below are operational components and processes we can leverage when building out the process:

- Eligibility Data Intake and Analysis
- Buy-In Transaction File Load
- Operational Analysis and Review
- Case Review
- HMS' Quality Assurance Process

ELIGIBILITY DATA INTAKE AND ANALYSIS

The HMS process begins with intake and integration of multiple data sources of Medicaid, Medicare, and Social Security eligibility data. This data creates the foundation of our PIER Master File database. Eligibility data sources include (but are not limited to):

- **Medicaid Eligibility Data**. HMS can integrate with the State's MMIS on a batch or API basis to pull daily/weekly/monthly data on WV Medicaid members. Cumulative information regarding each WV Medicaid program member becomes the base layer of the PIER eligibility Master File. In addition to the MMIS eligibility data, HMS can incorporate supplemental data feeds from other State systems such as enrollment or county systems if not already integrated with MMIS. In addition to demographics and identifiers, HMS tracks eligibility category and dates for each member on a cumulative basis. Our database also tracks events such as residency changes and dates of death.
- **CMS Eligibility Data**. HMS manages and integrates multiple sources of Centers for Medicare & Medicaid Services (CMS) and Social Security Administration (SSA) eligibility data to monitor known Medicare eligibility and identify new Medicare and Buy-In eligible individuals. Data files that we can incorporate include:
  - Enrollment Database (EDB) file
  - Territory and States Beneficiary Query (TBQ) file
  - Medicare Modernization Act (MMA) file

Depending on BMS' preference, HMS can obtain these files from the WV systems/operations or manage submission and receipt of the files directly with CMS, which we do for a number of states. HMS currently receives both the EDB and MMA files regularly from BMS.

- **SSA Data.** HMS can also incorporate State Data Exchange (SDX) data from SSA into our Buy-In process. As WV is an auto-accrete state, SSA automatically accretes Supplemental Security Income (SSI) and deemed-SSI individuals to the Buy-In process; however, HMS will monitor accretions and deletions via SDX files as well.
- **Other Data Impacting Medicare and Buy-In Eligibility**. In addition to integrating Medicaid and Medicare eligibility data, HMS offers the option to integrate other data feeds such as vital statistics, SSA Date of Death Master file, and PARIS data match results that identify members also enrolled in other programs. This data can be used to identify individuals potentially eligible for deletion from the Buy-In process, saving costs for the State.

Once the eligibility data is loaded to the HMS environment (PIER), our solution uses sophisticated **data match analytics** to match Medicare and SSI eligibility data to Medicaid data. This process identifies all WV Medicaid program individuals with Medicare eligibility as well as changes in that eligibility (e.g. SSI/disability changes). Our data match analytics ensure accurate and optimal association of Medicare and Medicaid data, even when SSN is not available, and demographics do not match exactly. Data matches are subject to verification by automated and manual QA processes by HMS.

Changes in Medicare eligibility and attributes are flagged within PIER and reflected in automated change/exception reports and screens.

Buy-In Transaction File Load

Once Medicaid and Medicare eligibility information is loaded to PIER (daily), we load Medicare Part B and Part A Buy-In transaction data and post it to each member's database entry. We can accommodate daily, weekly, or monthly transaction data. We will bring in files from the State system or manage transactions directly with CMS. We maintain a cumulative record of all Buy-In transaction data and summarize key attributes/elements at the individual level. As part of the Buy-In transaction intake we analyze the various Buy-In Codes in the data to correctly organize transactions. We set exception flags as appropriate based on Buy-In transaction codes and update each individuals' financial tables based on premium amounts and adjustment transactions.

As Buy-In transactions are loaded, records are monitored to identify various types of exception records, including CMS-rejected transactions. These records are flagged and sent to the **Buy-in Transaction Exception Report**. This report can be configured to report on any type of Buy-In transaction, based on transaction codes.

Operational Analysis and Review

After eligibility data and Buy-In transactions are loaded, our operational analysis processes begin. These are automated queries within PIER that identify specific situations, depending on the State's policies, processes, and requirements. We summarize key queries below.

- **Open Analysis – Potential Accretion Cases.** The Open analysis query selects individuals who are identified as having new Medicare eligibility. These may be individuals who are newly enrolled in a Medicare Savings Program or who have acquired Medicare eligibility through turning age 65, End Stage Renal Disease (ESRD), or disability, and who are not already enrolled in the Buy-In process.
- **Close Analysis – Potential Deletion Cases**. The Close analysis query identifies individuals who are currently accreted to the Buy-In process but who have had a change in eligibility or circumstance that would cause their removal from the Buy-In process. The most common changes resulting in a close recommendation are loss of Medicaid program eligibility or loss of Medicare eligibility (for instance cessation of disability).
- **Change Analysis.** The Change analysis query identifies individuals who have had a change in eligibility attributes that would not necessarily result in an accretion or deletion transaction or change in Medicare eligibility or Buy-In activity. For instance, if an individual is no longer eligible for SSI, but is still eligible for Buy-In under a Medicare Savings Program (for instance QMB), the Change analysis notes that event.
- **Exception Analysis**. PIER also contains a number of exception analysis queries that can be used to identify notable occurrences or potential issues within the Buy-In process. Exception

analysis identifies situations such as Retro Accretions (significant), missing transaction/months, duplicate eligibility records, and premium adjustments that exceed preset threshold limits. Exception analysis are configured to the requirements of the State program.

In addition to built-in exception reports, our data warehouse has an interactive interface for the development of SQL-based queries that allow for ad-hoc queries of the data. PIER was designed to minimize the need for additional programming resources for ad hoc queries or changes to Open Reports and Closed Reports.

CASE REVIEW

As PIER analytics identify potential Open/accretions, Close/deletions, and exceptions, the query results are reviewed by HMS' caseworkers, who analyze each case and double check the underlying data based on operational protocols. All cases meeting defined Open/Close criteria or indicating an exception are manually reviewed. By incorporating both automated and technology-assisted manual review processes, we ensure accuracy while lowering administrative cost. We describe these reviews below.

- **Open Report Review.** New dual-eligible Medicaid members, and members newly eligible for Buy-In are reviewed to ensure that the basis for the Open determination is accurate. For instance, our team may need to confirm Medicaid eligibility directly in the MMIS. This is a crucial step in the process if we currently receive only monthly eligibility data and eligibility information may have changed. Our team will update any information that has changed in PIER and update the status of the individual. For situations such as this, during our Implementation phase, HMS will discuss with BMS the potential for adding automated interfaces to the MMIS to streamline processing and reduce the need for manual review.
- **Close Report Review**. Our team also reviews all cases for members who have been identified as no longer eligible for premium support. Each incorrect deletion transaction reduces a member's Social Security check by approximately 10%. This reduction has a significant impact on the member who already maintains a standard of living below the federal poverty level. During processing, the PIER application reduces false-positives and corresponding member complaints.

  To guard against improper deletions, PIER compares members with terminated coverage with the Open Report to ensure that termination was not a result of a change in program status code that resulted in a corresponding "open". By comparing with the Open Report, we refine the deletion process by ensuring that only truly termed members are identified.

HMS' QUALITY ASSURANCE PROCESS

Quality assurance (QA) is an important part of the Medicare Buy-In process. Our proposed programmatic quality review process begins with automated QA processes in data intake and within the database analytics process. Redundant analytics look for discrepancies and anomalies based on expected volumes and values. All reports are manually reviewed by CSR

analysts, and deliverables are reviewed by HMS technical QA staff and project staff prior to transmission.

Quality Control for Accurate Submissions to CMS

Our review process adheres to federal and state regulations as well as contractual procedures. This structure is incorporated into our proposed methodology. The rules governing the West Virginia Medicare Buy-In program will be used to configure our PIER application and operational protocols. The policies and procedures that govern the program create specific steps for action. PIER incorporates these action steps into a coherent process with minimal human intervention. In addition, we have used a workflow to ensure that all decisions are determined in a uniform and consistent manner.

To better serve our clients, HMS has developed an issue notification module to track each request, whether from Medicaid staff, county offices, or SSA. Whenever another party refers a case, the user enters the information into a tracking system that tracks the member, reason for referral, summary of issue, next steps, and status of the request. This tracking enables the Medicare Buy-In supervisor to continually review the Client Notification Module to ensure that all requested actions are completed.

7.2.3.4 Program Support (App 1, OS031, OS034, OS035)

HMS has a team of individuals ready to support the forthcoming BMS Medicare Buy-In programming, which will range from member customer support, technical support, and staff for program administration and management.

Customer Service Center Support for Members

HMS currently operates a WV HIPP customer service center on behalf of BMS with a toll-free telephone number in place. The center is staffed by our Customer Service Representatives (CSRs) between the business hours of 7:00 a.m. to 5:00 p.m. local time, Monday through Friday, excluding State holidays. All requests received by our customer service center are tracked in PIER; CSRs will also log case notes detailing the nature of the call.

HMS will leverage this infrastructure to support Medicare Buy-In program-related inquiries from Medicaid clients, Buy-In staff, and staff at other State agencies. HMS will dedicate CSRs for the Buy-In related inquires and ensure they are trained and able to differentiate between WV HIPP and WV Medicare Buy-In inquires, so members will always receive the relevant and appropriate level of support.

Technical Support

When there are technical issues specific to the PIER application, our Project team works in tandem with HMS' Programming and Technical staff to quickly and efficiently solve any system

or process problems to return PIER to full functionality with minimal interruption of service. HMS keeps BMS staff informed of the status of active technical issues through to resolution and will continue to openly communicate with BMS in the upcoming contract.

Proposed Medicare Buy-In Staffing Plan

HMS has the people, process, and technology already in place to assume all aspects of BMS' Medicare Buy-In project. We have determined that all proposed roles that support the Medicare Buy-In solution for BMS can be fulfilled by existing HMS staff recruited from our existing employee base with the appropriate qualifications. Our staff members currently operate similar services for other state Medicaid agency clients across the country and can easily transfer solution knowledge and expertise, skillsets, and experience to quickly ramp up and support the Project team for the new BMS contract. We provide our proposed HMS Project team for BMS, including for Medicare Buy-In, in proposal **Section 4.0,** and define the roles and responsibilities of every role on our Organization Charts in proposal **Section 7.3.3 Staffing Management Plan.**

The resources we have initially assigned to support the Medicare Buy-In program include:

- HMS Project team key staff
- Medicare Buy-In Project Lead
- Team of existing CSRs and caseworkers

Our key staff and Medicare Buy-In Lead will collaborate to ensure we have the appropriate level of CSRs and caseworkers assigned and trained to maintain this scope. They will leverage HMS' seasoned healthcare professionals who possess a deep understanding of the federal and state rules governing the Medicare Buy-In process and have specific experience serving the needs of the BMS to train our existing CSRs and caseworkers on BMS' specific Medicare Buy-In program. Our existing WV HIPP staff are already in place and ready to assume all aspects of the Medicare Buy-In project.

7.2.3.5 Reporting (App 1, OS033)

Our WV Medicare Buy-In service capabilities will include detailed, flexible reporting that will provide information on our program activities. Our web-based PIER system offers enhanced, robust reporting functionality. For example, PIER can generate a file listing all denied, terminated, and active Buy-In cases as well as current insurance coverage data, carrier codes, and policy information validated during the application-verification process.

Reports will include accurate, detailed accounting of WV Medicare Buy-In program members and dollars expended. Our project reports will comply with BMS' program requirements regarding content, format, and frequency of delivery, which we will confirm during implementation. PIER provides multiple custom reports, and HMS can generate financial reports that include premium and savings totals as well as statistics relating to accretion and deletion transactions to meet the Bureau's specific requirements. The PIER system separates reporting into four basic categories: System Statistics (SS), Workflow Statistics (WS), Financial Statistics

(FS), and Aid Category (AC). These reports enable the supervisor, project managers, and BMS staff to review monthly outcomes, ensuring that Medicare Buy-In time frames are met.

BUY-IN EXPORT FILE AND OTHER DELIVERABLES

Once all data has been loaded, and queries run and reviewed, PIER generates the required output and deliverables required for the Buy-In program. The specific data files, formats, and frequency can be configured to the State's requirements, although we understand that BMS requirements regarding report format, content, and submission frequency are subject to change at any time during the term of the contract. Examples of the deliverables we can include are provided in **Exhibit 7.2-8**. All deliverables are reviewed by technical QA staff as well as HMS Project team staff to ensure quality.

Exhibit 7.2-8 Deliverables HMS Can Provide to BMS
The specific data files, formats, and frequency can be configured to the State's requirements.

Deliverable	Description
Main Buy-In Export File	A snapshot of each individual member's data within the PIER database (current time frame). Members are organized into one of six eligibility categories (SSI, Deemed-SSI, QMB, SLMB, QWI, and full Medicaid eligible), according to Medicaid eligibility data and criteria. Each member has a status that indicates current Buy-In status, and attributes that describe any recent changes in the individual's status. The information in the Buy-In Export File can be used directly to generate CMS Buy-In file transactions, including accretion, deletion, and ongoing Buy-In transactions.
Open Report	Contains a list of members for whom a Buy-In transaction has been recommended.
Close Report	Contains a list of members (with relevant data) for whom a Buy-In close transaction has been recommended.
Exception Report	Contains a list of transactions and member status exceptions that are of interest to the Buy-In staff or other agencies.
Buy-In Transaction Files	If BMS wishes, HMS can generate and manage daily/weekly Buy-In transaction files for CMS.

Deliverables can be provided to BMS in batch format, or we can develop automated feeds into the State MMIS. PIER automates the import and export of data to help streamline creation of the Buy-In deliverable. This process enables the Buy-In administrator to control timeliness of each delivery.

7.2.4 Recovery Audit Contractor (RAC)

As a long-standing, national Medicaid Recovery Audit Contractor (RAC), we have developed and acquired best practice processes and resources that comply with the CMS Final Rule for the Medicaid Recovery Audit Contractors Program (Title 42 of the Code of Federal Regulations/CFR Part 455 Subpart F). We understand that these regulations require states to contract with a RAC, and establish a RAC program consistent with State law, to review claims paid under the State plan, or associated waiver, to identify overpayments and underpayments, recoup overpayments, and prevent future improper payments.

In the wake of the ongoing COVID-19 pandemic, healthcare is forever changed. More than ever, every tax dollar counts. To maintain or expand access and minimize cuts to programs, services, and benefits, states will need to account for Medicaid dollars like never before. West Virginia will need to have strong payment accuracy initiatives to bring money back into the Medicaid program. Our proposed project is aligned with driving the highest recoveries possible for BMS.

In proposal **Section 7.2.0 TPL Optional Services,** we describe HMS' broad national experience as a program integrity vendor, including our background as a long-standing RAC services provider for CMS and 13 other state Medicaid agencies currently. **We are unique in the Medicare and Medicaid RAC space having the expertise and proven results as a state and federal RAC recovering overpayments in both Fee-for-Service (FFS) and managed care environments.**

HMS Knows West Virginia Medicaid

Across all HMS services provided on behalf of WV Medicaid, we understand BMS' goals, challenges, project needs- the scope to respond to these problems, and the level of effort and expert services required to manage them. Our current CBA work in the State has allowed us to understand BMS' recovery methods, overpayment and payback policies, and the providers' systems and limitations. Our overall audit experience provides us with additional insight on target areas to pursue for new RAC overpayments. We further understand that WV Medicaid was granted a waiver for the RAC program through September 2019, due to a large percent of the Medicaid population being enrolled in managed care.

BMS already knows and trusts us from our work on the TPL services contract. This knowledge of BMS informs our approach and gives us a better understanding of your needs.

PROPOSED RAC AUDIT SOLUTION FOR BMS

We offer BMS the following primary solution components from our full-service RAC capabilities to fulfill the requested scope of work outlined in the RFP:

- Audit concept design and edit development that accounts for the aspects specific to BMS' RAC needs
- Claim selection through data mining to identify providers and claims to review, that avoids duplication of efforts
- End-to-end clinical/coding review process including medical record requests and submission
- Highly trained, certified clinical/coding review staff
- Outreach and education through our Provider Engagement Program
- Improper Payment Prevention Plan
- Reporting handled through our supporting case management system
- Workflow for identifying and referring potential fraud, waste, and abuse to the West Virginia Medicaid Fraud Control Unit (MFCU)
- HMS Portal with functionality for electronic submission of records, mailing address updates, case status verification, and notification updates by email

HMS fully understands that a successful RAC program will be judged primarily on two vital factors – dollars recovered and minimal provider abrasion and complaints. Our RAC services accomplish both.

OUR SOLUTION WILL INCORPORATE BEST PRACTICES AND CONTINUOUS INNOVATION

States that have implemented recommended best practices have experienced vast success from a recovery and cost savings perspective. In the past 12-month period from September 2019 through September 2020, a southern state has realized over $10 million in recoveries. A Midwest state recovered over $64 million in that same 12-month period, and a northeastern state recovered over $93 million.

HMS' BEST-PRACTICE RECOMMENDATIONS FOR A SUCCESSFUL RAC PROGRAM

Below we have provided HMS' recommendations for best practices to follow for a successful RAC program:

- Extend the lookback periods, preferably to five years from the service date, allowing a more thorough and complete analysis of possible over and under payments by providers. Waivers for increased look back periods have been approved by CMS in several states.

- Establish reasonable audit volume standards that account for the Medicaid dollar value of the providers' annual claims. For providers with lower annual claim spend, reduced clinical audit volumes may be appropriate. For providers with higher annual claim spend, audit volumes should increase accordingly. HMS typically recommends a tiered approach:
  - $5 million+ = 250 medical records/month/provider number
  - $100K to $5 million = 150 medical records/month/provider number
  - <$100K = 40 medical records/month/provider number
- Eliminate the full time Medical Director requirement. A CMS waiver can be obtained for a Medical Director panel vs in place of a Medical Director FTE. This provides more flexibility in audit types, review timelines and guarantees the appropriate support through the appeal process.
- Engage your MMIS vendor, policy team and provider community early and often. The MMIS vendor will be critical in the processing of recoveries and their engagement and commitment to the process is critical to success. The most successful RAC contracts have standing stakeholder meetings to discuss challenges, opportunities and continued improvement plans.

Continuous Innovation

The program integrity landscape is constantly changing with new payment issues and risks continually developing. We actively seek innovative ways to deliver the best operational and financial benefits to BMS to identify and recover from these ever-changing issues and risks.

Beyond initial audit concept design and edit development, we must continually look for new audit concepts and develop new edits throughout the life of a contract, to remain accurate and relevant. HMS' extensive experience as a Medicaid and Medicare improper payment review vendor provides us with a wealth of improper payment data from which to draw to identify payment errors, including any new concepts. The new ideas and theories that we develop for WV at the onset and throughout the life of the contract will stem from many places including state-specific policy research and review, manuals, contracts, and payment schedules; collaboration with BMS and other clients; successes in other contracts; and even communication from providers.

Next, HMS continually innovates and invests in new technologies to improve existing system functionalities and processes that benefit our clients, including those that support our proposed RAC solution for BMS. While HMS already maintains high accuracy rates with our solution, below are ways we leverage new technologies and processes to continually fine-tune and improve our data analytics, which we utilize in both our payment analytics for improper payment identification and clinical/coding review for claim selection.

- Artificial Intelligence (AI), Machine Learning (ML), and Natural Language Processing (NLP) to:
  - Enhance and improve claim selection accuracy – more specifically to reduce false positives and pinpoint claims that are most likely to result in an improper payment

- Autonomously review and code medical records by using unstructured data for claim identification and adjudication

- Robotic Process Automation (RPA) to increase operational efficiency and effectiveness. HMS is leveraging new techniques and tools aimed at increasing our approval rates and content volume by creating automation of data capture and usage of pricers and groupers. This enables us to free up additional resources to support our clients and provide detailed analytics during our claim reviews.

7.2.4.1 RAC Services Approach (App 1, OS015)

HMS provides our RAC services in accordance with all relevant DHHS, State, and federal requirements. However, revisions in federal and state legislation or regulations may be enacted or implemented during the period of performance of this contract and directly affect the WV RAC program. As described in **Section 1.0 TPL Services Overview,** our dedicated, in-house Government Relations team not only keeps us abreast of current federal regulations that govern RAC programs but also provides regular updates on proposed legislation that may impact our state clients and affect this project. As a result, we realize the deliverables under this RFP may vary year to year. We are keenly focused on changes and variations occurring within state policies and regulations and have proposed a solution that anticipates changes; we are prepared to be flexible to assess and implement required changes in a timely manner.

In the remainder of this document, we describe our approach and processes for delivering RAC services for BMS.

Audit Concept Design and Edit Development

Edit design and development is a key start-up and ongoing activity we perform at the very beginning and throughout a RAC services contract. As referenced below under HMS' Edit Library and in Step 2 of our RAC audit process, we routinely collaborate with BMS and look for program vulnerabilities and opportunities for new audit concepts to develop into edits to address new potential payment issues.

We begin edit design and development by analyzing BMS' data and identifying potential edits and audit concepts (a process also known as "designing"). We do this through various tools and resources and at multiple levels – by referencing our library of existing RAC edits, applying analytics and analyzing historical BMS claims data in-house, and researching BMS and State-specific policies and other information.

HMS' Edit Library

Through our work as the current RAC for many Medicaid RAC programs, we have identified, tested and obtained client approval on common payment-error issues that can be used to identify fraud, waste, and abuse; we house these existing scenarios in our proprietary HMS edit "library." We have hundreds of edits housed in this library, which we can draw from to configure BMS' data and identify payment errors, as appropriate. While some of the existing algorithms

(e.g. date of death, duplicate billing, etc.) typically span across all state programs, not all are applicable for BMS as claim-billing codes and/or reimbursement methodologies vary from state to state. Billing rules change and CMS, states, and fiscal intermediaries (e.g. MMIS vendors) all make regular updates. Each client can have hundreds of edits they require in a RAC solution. For example, one edit could apply to:

- Each line of policy
- Each ICD-10 code
- Each review audit concept

Before using any existing edits, we will research to determine if they are truly relevant, based on WV's payment rules and data, in confirming the existence of improper payments. Existing edits from the library are leveraged only if the same outcome is found within the scenario in BMS' current data and their claim payment policies support the edit.

Interpreting Policies, Rules, and Regulations

Important to the success of WV's Medicaid RAC program is HMS' WV Medicaid experience and ability to review and fully apply all the State's Medicaid program regulations, policies, provider guidance, and reimbursement methodologies governing coverage, coding, and payments for each service type. We base under and overpayment identifications and determinations on valid regulatory source authority/requirements as well as on local standards of practice. We apply the rule in effect at the time the claim was made (unless regulatory authority explicitly declares that a retroactive rule applies) and cite the applicable regulatory authority in our communication with providers during the recovery process.

Our team understands the importance of both the published and unpublished policies for each program, and we configure the analytics according to the policies and State identified exclusions that may need consideration. We base our improper payment determinations on comprehensive research and understanding of federal and state laws, rules, policies, manuals, contracts, and payment schedules that serve as a basis of enforcement for recovery of overpayment. Our expert team of certified professional coders and registered nurse reviewers thoroughly researches regulations and policies around each service and configure our analytics around those policies. Interpreting this information leads to ideas about where potential overpayments might exist within BMS' program.

In **Exhibit 7.2-9** we list some of the regulatory source authorities and criteria often used in research by HMS in the development of new edits to identify and validate improper payments, and which we can leverage for WV.

Exhibit 7.2-9 Sources HMS Can Utilize to Determine Potential Improper Payment Edits for Medicaid
Our experts analyze various information and criteria in the development of the review protocols.

Regulatory Sources	Medical/Coding Sources		
WV State Code	MCG Guidelines	National Correct Coding Policy & Procedures	Crosswalk Coding Reference
Medicaid Policies	InterQual® Criteria	Medicare Carrier Manuals	Commercial Coding Publications
Medicaid Administrative Rules	UB04 Uniform Billing Editor	First Databank	
WV Medicaid Provider Manuals	Coding Clinic	Medi-Span	
WV Medicaid Provider Bulletins	Encoder Pro	NCPDP NPI Reference Database	
WV Medicaid Official Publications	AMA CPT Guidelines	CMS Medicaid Pharmacy Benefit Use & Reimbursement	
WV Board of Pharmacy (BOP) Rules & Regulations	ICD-9	FDA Reference Data	
CFR 42	ICD-10	DSM-IV-TR	
BMS State Operations Manual	HCPCS Reference and Guidelines	HHS Win Strat	
OIG Exclusion Database	3M DRG Reference and Groupers	APC Grouper	
WV Exclusion Databases	CMS NCCI	3M Coding / Coverage Tools	
Title XIX of the Social Security Act		AIS, Other Coding Bulletins	

HMS will always confirm with BMS that the interpretation of any policy is accurate before initiating a review of BMS claims or recovery of any overpayments.

Performing Initial, Independent Data Analysis

Our team independently analyzes BMS' historical claims data in-house in our search for new edit opportunities to identify potential improper payment issues that may result in overpayment findings and ultimate recoveries. To do this, we use a variety of data mining tools and methods:

- Statistical analysis to identify outliers and high-growth areas that might represent potential overpayment edits. For instance, if we notice use of a certain rate or procedure code rapidly increasing, we might target that code for further drill-down analysis and edit development.
- Using a variety of software-based analytic tools we developed over time to review for specific types of patterns, such as overlapping services or potential upcoding patterns.

We obtain insights into potential improper payment issues to develop into new edits from other sources, including:

- Collaboration with BMS and their providers

- Review of findings from our nationwide scope of program integrity audit and investigation initiatives
- Insights gleaned from our experienced nurses, coders, and other experienced clinical personnel. For example, our "diaper bandit" algorithm was a result of the knowledge of one an employee with a child in a Waiver program. A vendor would deliver large volumes of unneeded diapers to the program before the end of each month and then bill the state.
- Attendance and participation in industry conferences and educational programs, such as NAMPI, National Health Care Anti-Fraud Association, and data analytics conferences across the nation

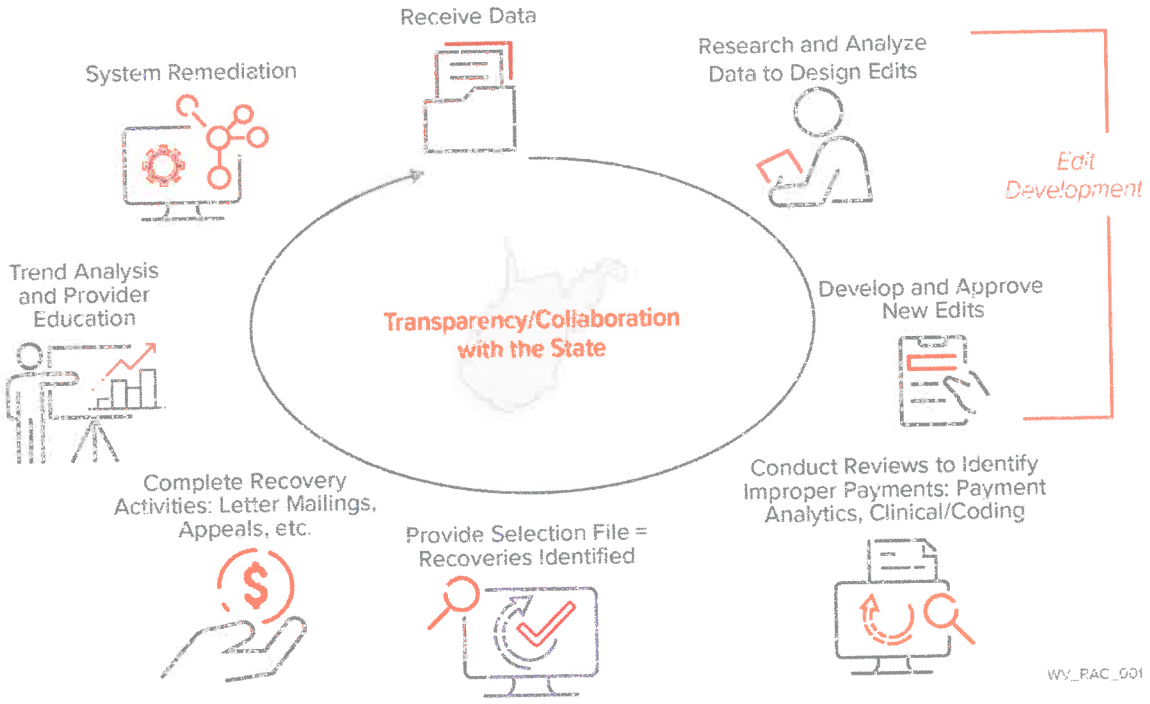
Based on the outcome of both our research and analysis, we develop proposals for specific claim audit clinical/coding review concepts that, upon BMS approval, will be programmed, tested and moved into production to identify and validate improper payments.

Our Iterative RAC Audit Process

In this section we describe our end-to-end, iterative RAC Audit process (depicted in **Exhibit 7.2-10**) from data receipt through to recovery and system remediation that we will follow during the Operations phase of the RAC scope of work. Further below in this document, within each appropriate requirement, we break out some of these steps in our process to provide greater detail about that activity.

The ReSults platform, our dual case management and review tracking system (described in our response to OS026), supports and documents all aspects of this end-to-end process. ReSults allows for full tracking and documentation requirements across both the payment analytics and clinical coding solution components.

Exhibit 7.2-10 HMS' RAC Audit Process to Identify Improper Payments
During the operations phase of our RAC solution, the end-to-end process we follow is iterative, from data receipt through to recovery and system remediation.



In the following exhibit (**Exhibit 7.2-11**), we provide a high-level, narrative overview of each of the steps in our iterative RAC audit process.

Exhibit 7.2-11 Description of our RAC Audit Process Steps
Our iterative process incorporates all the tasks necessary to provide a successful RAC services solution to BMS, covering clinical/coding review.

Step	Description
Step 1: Receive BMS Data	We will receive BMS' data through Secure File Transfer Protocol (SFTP) based on the frequency and method for the new contract with BMS determined during project implementation. The data includes paid claims, encounter data, provider, and recipient source data.
Step 2: Audit Concept Design and Edit Development	Because changes and variations occur within state policies and regulations and new improper payment issues arise, we routinely perform audit concept design and edit development. The audit concepts developed for WV will stem from: • State-specific policy research and review • WV manuals (note: we always refer to the latest manuals available through: https://dhhr.wv.gov/bms/pages/manuals.aspx) • Contracts and payment schedules • Collaboration with BMS and other clients • Successes in other contracts, and provider communications Where appropriate, we will also leverage available and applicable CMS edits. HMS is the leading RAC for CMS (Region 4).HMS and BMS will work together to review supporting

Step	Description
	policy and confirm that the interpretation of that policy is accurate prior to initiating review or recovery.
Step 3: Conduct Reviews to Identify and Validate Improper Payments	Once the new audit concepts are approved, and the resulting edits tested, we move them into production to run against BMS claims data to identify and validate improper payments.
Step 4: Provide Selection File of Recoveries Identified	The results of our reviews (also known as "findings") are provided in a Selection File, which we send to BMS for approval before proceeding with the recovery process (e.g. notification letters).
Step 5: Complete Recovery Activities to Help BMS Collect on Identified Overpayments	After making an adverse determination, and within the BMS-approved timeline based on our Final Selection File created in Step 4, we notify the provider of the potential improper payment finding. ◉ **Notification:** The ReSults platform automatically generates the Preliminary Findings Notification, which we mail to the provider, giving them 30 days to supply further documentation if they disagree with the finding. For clinical/coding review, we notify the provider of "no finding," which will also be reflected in the HMS Portal. ◉ **Provider Response:** If the provider agrees with the preliminary finding, we issue a Final Notice of Recovery, as noted below, and proceed with initiating recoupment based on the BMS' designated process. If the provider does not agree, we offer an opportunity for them to dispute the finding and/or amount by sending in additional documentation for review. If, after additional review, our determination holds, the provider may appeal the decision per WV guidelines. ◉ **Recoupment/Recovery:** To recover identified claims, HMS prepares and forwards a Final Notice of Recovery letter to the provider as well as posting the notification electronically on our HMS Portal. Our flexible system can accommodate offset recoupments or refund collections. During the project start-up phase, HMS will work with BMS to establish, document, and receive approval for the respective recovery process for WV.
Step 6: Trend Analysis and Provider Education	For our RAC services, HMS educates providers on how to bill properly. We leverage the results of our payment analytics and clinical/coding claim reviews to identify trends and discover potential areas for provider education and outreach. We educate providers through our Provider Engagement program, which we describe below. The education can be delivered in many forms, including provider bulletins, on-site conferences/seminars, webinars, and one-on-one telephone meetings. HMS documents all educational efforts as well as the attendees for each educational session. During the life of the contract, and at a pre-set cadence, we will re-run edits already recovered to confirm if providers continue to bill incorrectly. This activity assists to further identify trends and provider education needs.
Step 7: System Remediation – Preventing Future Improper Payments	We will also work with BMS to help the State understand how to avoid paying claims in the future through the identification of system and process enhancements and/or modifications; also known as system remediation. We review each type of overpayment to determine if the overpayment could have been avoided with adjustments to the claims processing system. The results of this review are typically presented during our regular client status meetings. If it is necessary to provide this information in a different way, we will collaborate with BMS on an agreed-upon manner.

7.2.4.2 Case Management System (App 1, OS026)

HMS has invested millions of dollars in our program integrity platform that serves as the backbone of our improper payment identification and overpayment recovery processes. We can ingest and analyze several years of data, across all claim types. This platform is comprised of the appropriate IT systems and data infrastructures to execute multiple projects simultaneously in support of our current client portfolio. We leverage two systems in performing our RAC

programs: our ReSults Platform and the HMS Portal. We leverage this integrated platform to manage and monitor the production of high-quality results in a cost-effective manner. HMS will work with the State's System Integrator (SI), selected as part of the MES implementation, to determine requirements for integrating with the State's system.

HMS' ReSults Platform

The ReSults platform is an internal hybrid case management and tracking system that manages all aspects of the review process. Highly automated, customizable, and scalable, the system tracks activity from the initial notification or record request to the complete resolution of the case file. BMS will have access to ReSults data and reports, through our secure HMS Portal, to review our efforts and results.

The ReSults platform and its algorithms were designed to support review processes, including data and SAS analysis, document management, medical documentation review, downstream production process flows, provider services, quality management (QM), appeal management, reporting, and invoicing. Built-in continual time checks verify that we meet established state and federal time requirements. **Exhibit 7.2-12** illustrates the ReSults platform functionality and interfaces, at a high level.

Exhibit 7.2-12 ReSults Platform Functionality and Interfaces
The ReSults platform is highly automated, customizable, and scalable.

As a claim tracking database, ReSults contains all claims with potential improper payments we identify as well as both current and historical claims and related data that we use to perform historical analysis of our review activities and results.

As we make improper-payment determinations, we will compile rationales and improper payment amounts from ReSults by case and forward them to BMS for use in its recovery process (when applicable). We will generate these on a weekly basis or at a frequency specified by BMS.

Through information in ReSults, we will provide BMS and designated stakeholders with reports, transactional data, and online information (through our HMS Provider Portal) regarding each identified claim/case with a potential improper payment, the status of each case, and the history of activities, determinations, and documentation related to each case.

Exhibit 7.2-13 lists more detail around the ReSults system functionality.

Exhibit 7.2-13 ReSults System Functionality
The ReSults platform is highly automated, customizable, and scalable.

Functionality Category	Specific Results Capabilities
Tracking All Case Activity	◉ Contains all claims identified with potential improper payments ◉ Generates a Claim Record detailing claim status from selection to close out or recovery.
Tracking Anticipated Recoveries, Overpayments Adjusted, and Final Recoveries in an Accounts Receivable Application	◉ Documents and maintains all payments received ◉ Documents mailing dates of outgoing correspondence
Making Entries Associated with Cases	◉ Organizes all incoming correspondence to the appropriate Case File ◉ Houses supporting case-related documentation/notes ◉ Documents written/verbal communication
Tracking Underpayments and Overpayments Identified and Communicated to the Program Integrity Unit	◉ Enables monitoring, approval management, and quality assurance (QA) of each workflow event ◉ Creates an electronic Case File containing all documentation for each case
Documenting Case-Related Communications	◉ Directly issues and saves copies of all letters from the system ◉ Creates Review Notification Letters and attaches them to claims ◉ Provides a repository for the Provider Services team to log all communication through email, telephone, or fax for each claim
Generating Case-Related Review Tools, Letters, and Attachments	◉ Provides customized denial reasoning, including policy, based on each review tool ◉ Facilitates multiple, customized letter formats for each review type ◉ Supports email or fax of letters ◉ Includes QA process prior to mailing
Providing Standard and Ad Hoc Reports	◉ Creates project recovery/activity summary reporting including but not limited to: • Summary by project code, provider, date or a combination • Number of cases opened and/ or closed by month by program • Overpayment balance of open cases • Other reports, as requested by BMS
Obtaining Electronic Records from Providers	◉ Tracks status of record receipt through automated workflow ◉ Follows-up if no record received ◉ Allows receipt of records through fax, mail, or Secure File Transfer Protocol
Assigning Cases to the Appropriate Review Team Member	Assigns cases to the appropriate Review team member based on various criteria
Documenting Clinical-Review Results and Rationale	Tracks reviewer narrative and notes at the claim level
Documenting Overpayment/Underpayment Amount	Updates system with recovered amounts from BMS
Generating Fiscal Agent Listings and MMIS Updates of Claims Ready for Action	Creates configurable data extracts for recovery/collection activity and MMIS updates
Coordinating with Other State Recovery Activity	Provides coordination and non-duplication of efforts related to review/recovery activities

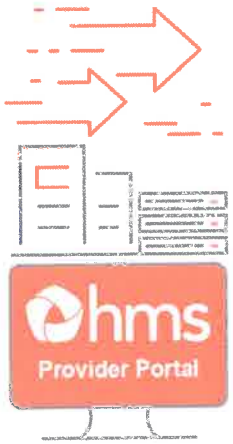
HMS PORTAL

The same single-interface system we use for TPL provider disallowance, the HMS Portal contains additional functionality to also support other HMS solutions. For RAC services, the HMS Portal allows providers to manage the entire claim identification and recovery process, in one place and without interruption. This offers both providers and BMS an innovative online experience for reviewing claims, statuses, outcomes and the ability to update contact and address information using a broad range of self-service options through a secure and paperless cloud-based application. BMS will have access to ReSults data, call logs, and reports through our secure HMS Portal. **Exhibit 7.2-14** visually shows the key features and benefits of the HMS Portal, that specifically support our RAC solution and full, end-to-end review capabilities.

Exhibit 7.2-14 HMS Portal Features that Benefit RAC Services
Our HMS Portal will enable WV provider community to engage in the improper payment review process, with minimal administrative burden.

HMS Portal Features

- Secure data environment
- Real-time access
- On-demand reports
- Direct upload of medical record/documentation
- Area to update provider contact information
- Receipt of notifications and medical record requests
- Screens to monitor review progress and track status
- Ability to communicate, send inquiries, and respond directly within tool



HMS Portal Benefits

- Automates and streamlines provider communication
- Accelerates recoveries
- Expedites provider involvement in review process
- Decreases provider abrasion
- Enables real-time review
- Facilitates transparency into reviews
- Reduces administrative burden
- Supports interaction among providers, HMS, and client
- Enhances security and privacy of PHI received from providers

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Once onboarded, WV providers who access the HMS Portal will be able to update contact information for BMS billing inquiries and requests, download overpaid claims listings, upload pertinent documentation and submit questions to HMS' Provider Services team throughout the review period. If enrolled, providers will receive an email at their registered email address whenever a new claims listing has been posted on the portal. They can download the reports immediately rather than waiting for delivery through postal mail. As an added benefit, HMS will also automatically log which members of a provider's staff accessed a given listing and when it was downloaded. This information has proven valuable for our clients when providers submit an appeal stating that they never received a recovery request. The system is easy and intuitive for providers to use, but we do provide web-based training as well as an online manual to train providers on how to use the portal. Providers can also reach out to our Provider Services team members for

HMS targets completion of the HMS Portal for BMS in Q4 2020. During implementation, we will onboard and educate providers and BMS on how to maximize use of the portal, further increasing transparency and collaboration while minimizing administrative burden and abrasion.

assistance. We have already successfully implemented the HMS Portal for multiple TPL and program integrity clients, which has helped streamline efforts for providers.

HMS will work with BMS to identify and finalize any forms, standards, and file layouts necessary for HMS to interface with BMS systems. These will be defined further during the implementation period.

7.2.4.3 Our Review Methods and Processes (App 1, OS019 – OS020)

As stated previously in Step 3 of our RAC process, the configuration of each edit, established during the edit design and development process, will determine the review type we will conduct – by applying payment analytics against the data or performing a manual clinical/coding review of medical records. Both review methods leverage data mining in some capacity.

Payment Analytics

We apply our payment analytics review method to FFS Medicaid claims and managed care encounter data, confirming payments to providers. With this automated review type, we determine if services were provided based on federal and state laws as well as Medicaid benefits, rules, policies, manuals, contracts, and payments schedules in effect on the adjudication date for the claim date of service.

Our system runs the data received from BMS against the set of rules within each edit to identify an improper payment. A review using payment analytics utilizes data-driven, rules- based adjudication. The identification of improper payments is clear-cut and unambiguous, completed through data analysis, without the need for additional documentation review. The inputs (e.g., policies, rules, agreements) are well-defined, unlike clinical or coding review where the analytics detects possible overpayments that require further review. Applying payment analytics minimizes the risk of provider abrasion as overpayments are identified without the need to request or review any information from the providers.

With a payment analytics review, our system independently analyzes the claims data to detect erroneous payments and system-processing issues. We apply the algorithms against the claims data to extract or funnel down to a narrower data set known as targeting. The system flags claims by logic, using BMS' rules (edit algorithms), BMS exclusions and contracts.

Our analytics go beyond standard MMIS editing logic to identify errors the MMIS or claim adjudication system does not catch. Analytical capabilities include identifying duplicate payments undetected by the claim processing engine due to timing issues, billing, or other errors. Additionally, payment analytics identify overpayments driven by multiple causes, including Administrative Error Correct, Policy Compliance, and Contract Compliance.

After our system identifies a claim as overpaid, 100% of the findings are manually validated by medical claims auditors through their access to BMS' claim payment system. We then proceed with provider notification, provider response, and recovery.

Clinical Claim Review

With our clinical claim review method, we leverage data mining for activities such as targeting, scoring and selection of claims for review, all the way through to mailing selection and appeal review.

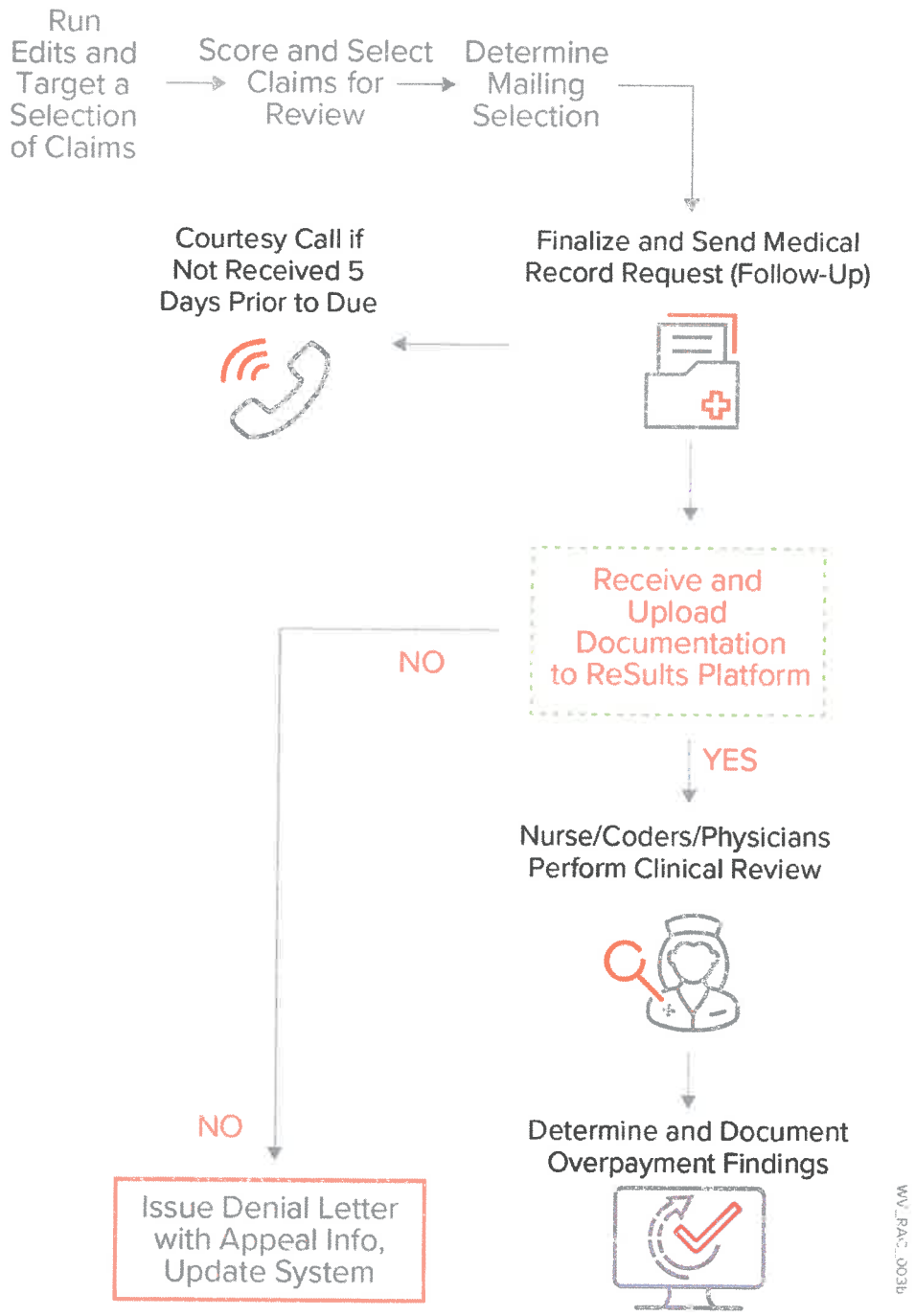
We conduct clinical claim reviews when data analysis identifies a potential improper payment that cannot be automatically validated. For example, the claims data and inputs (e.g. diagnoses, codes, medical necessity criteria, etc.) do not provide enough information to make a determination and are subject to clinical judgment and interpretation. HMS targets these claims that are more appropriate for a medical record review and scores them based on the likelihood of finding an improper payment. Based on an approved selection, we will request medical records and other documentation (e.g., patient's medical record, billing records and other financials, etc.) from the provider for manual review to determine if an improper payment exists.

Our Analytics team is continually retooling and refining our selection methodology, using machine learning algorithms that improve our results and minimize provider abrasion.

HMS assigns clinical/coding review cases to qualified team members with the appropriate credentials and expertise related to the specific type of potential payment issue. This team of registered nurse (RN) reviewers and/or certified coding specialists compare medical record documentation to claims information to detect overpayments (findings) made to providers. They evaluate the documentation for the appropriate Diagnostic Related Groups (DRG), Ambulatory Payment Classification (APC), length of stay, level of care, medical necessity, readmission, and other audit concepts based on industry-best practices and prevailing regulatory requirements. Additionally, they review the documentation for items related to clinical, coding, billing and record, and contextual review of selected claims when necessary.

Exhibit 7.2-15 depicts our clinical/coding documentation review process, while the subsequent narrative details each of the steps.

Exhibit 7.2-15 HMS' Clinical/Coding Documentation Review Process
HMS assigns clinical/coding review cases to qualified team members with the appropriate credentials and expertise related to the specific type of potential payment issue.



In **Exhibit 7.2-16**, we describe the primary tasks our reviewers carry out for each step in our clinical/coding documentation review process.

Exhibit 7.2-16 Description of HMS' Clinical/Coding Documentation Review Process Steps
We conduct clinical/coding reviews when data analysis identifies a potential improper payment that cannot be automatically validated.

Step	Description
Step 1: Run Edits and Identify a Selection of Claims	For maximum precision, our claim selection process for clinical review runs through several levels of analytics. Once BMS' paid claims data is received and loaded into our system, we select edits to run on the claims data based on certain claim data elements. To select edits, we apply various inclusion and exclusion rules based on the different clinical review types we can perform. ◉ Inclusion rules such as bill type, payment method ◉ Exclusions specific to prior audits, concurrent audits by other agencies, and provider-level exclusions as defined by BMS based on current audit activities **Immediately following this Exhibit, we describe how HMS excludes appropriate claims from improper payment review.** During this step, we narrow the pool of claims to claims that have the greatest potential for overpayment. Our goal is to be as targeted with our claim selection as possible to minimize provider abrasion.
Step 2: Score and Select Claims for Review (Generate the Selection File)	After we identify a selection of claims from the edits, we run them through our automated Statistical Analysis System (SAS®)-based analytics engine, scoring claims on the probability of overpayment and to further select the "right" claims for loading into our ReSults system. These analytics incorporate the probability of a finding based on: ◉ Historical experience (known history) ◉ Data-driven proprietary models These are the claims we will tag, and submit in the Selection File, which is submitted to BMS for approval.
Step 3: Determine Mailing Selection	After BMS approves the pool of claims selected and tagged by HMS, the claims go through our mailing process. We optimize the mailing selection, accounting for any applicable State rules on provider mailing limits established during implementation. Our mailing predictive models enable the best possible selection, considering each claim's probability of an overpayment and the savings potential.
Step 4: Finalize and Send Request for Medical Records and Other Documentation	Once the final selection file is returned by WV, HMS will use this file to select the claims to send a letter to the provider-generated from our ReSults platform requesting medical documentation associated with the claim for review. We understand there is potential for this process to cause provider abrasion due to the cost, time, and resource requirements imposed on providers. In addition to working with BMS to set a number and frequency of the medical record requests and reviews requested per provider per audit, we focus on minimizing provider disruption by tailoring letters to request items specific to the claims under review. In our response to requirement **OS026**, we also describe the capabilities of our HMS Portal, which include electronic documentation upload. If a provider has an electronic medical record (EMR) system, HMS' IT department will work directly with them to set up a secure process for the transfer of medical records through a secure online submission, such as SFTP. We have successfully established this process with numerous providers on behalf of our state agency clients. To ensure we obtain the required records and other documentation to support the review in a timely manner, we maintain effective communication with the providers through established follow-up processes. We typically follow up with providers through phone and/or email between 15 and 25 days after the medical record request letter is sent to the provider, if we have not yet received it in-house.
Step 5: Receive and Upload Documentation to the ReSults Platform	As we receive provider responses and documentation, we scan and post the documentation to the associated claim within the ReSults platform. All incoming letters, correspondence, medical records, and documents related to a claim are scanned and indexed using bar code technology. The platform capabilities allow a reviewer to select the claim, retrieve the

Step	Description
	associated electronic documentation, and view the image of the document, all while inputting the review results for the claim in the ReSults platform.
Step 6: Perform Clinical/Coding Review of Medical Records and Other Documentation	Following the request, receipt, and upload of medical records and documentation, our review team—comprised of specialty RN reviewers, certified coders, and a physician review panel as needed—follows defined standard operating procedures for clinical/coding review. During each step in the review process, our reviewers/coders update the ReSults system. Once HMS receives the medical record, we complete the review within the client-approved timeline as agreed on with BMS.
Step 7: Determine and Document Improper Payment Findings	After making an adverse determination, also known as a "finding," the reviewer/coder documents the finding in the ReSults platform, along with the criteria reviewed and details surrounding this determination. Our panel of physician reviewers are available for support on difficult cases and findings sign-off, as required.

HMS will retain all review documentation in electronic format for a minimum of five years following the final payment under this contract, or the date on which all questions related to the services performed under this contract are resolved, whichever happens last.

Excluding Appropriate Claims from Improper Payment Review

As introduced in Step 1 above, HMS can exclude providers or services that should not be reviewed, limiting the impact to BMS. During implementation, we will work with BMS to identify all the services that should be excluded from review. Examples include:

- **Date of Service.** We can use the BMS-approved exclusion criteria to validate that only claims eligible for review are included in the selection file and provider request process. These could include aged claims (e.g. claims that are older than six years from the date of service), claims by date of service, or claims by date of remittance limitations.
- **Settled/Negotiated Claims.** Claims that have been settled or negotiated through a State Fair Hearing process or through BMS
- **Claims Already Under Review.** Claims already pursued, in process of being reviewed by HMS, or being pursued by another entity
- **Claims for Certain Services.** Services that BMS would like to exclude from review. We can also apply additional exclusion logic for each project to set aside claims based on BMS' guidance, such as those claims from specific service types, providers, program categories, dates of services, or low dollar value.

Prior to submitting a Selection File to BMS for approval, HMS will exclude claims noted. As claims load into ReSults, the system checks them against its internal Claim Tracking Table and various Exclusion Tables and criteria to make sure that excluded claims and claims previously reviewed are not part of the review population. Claims identified as excluded will have a status of EXCLUDED and assignment of a status reason indicating the reason for the exclusion. A case's Event Table will track each transaction/event related to the case.

7.2.4.4 Clinical/Coding Review Aspects (App 1, OS022)

In addition to performing audits for compliance with state and federal regulations through payment analytics, HMS will identify and verify any underpayments and overpayments for recovery reimbursement of inappropriate services. Per this requirement, underpayments and overpayments may include, but are not limited to:

- Non-covered services
- Inadequate supporting documentation for services
- Services that were not rendered
- Services not properly authorized
- Non-medically necessary services
- Incorrectly coded services
- Inappropriate level of care
- Excessive utilization of services
- Billing and payment calculation errors
- Underpayment amounts

HMS will expand our offering to include dental claims, pharmacy claims, and PBM reviews.

As described previously, during our audit concept design and edit development process, HMS researches and assesses many different types of improper payment issues or potential risk areas for BMS' consideration. Our approach to identifying and recovering claims for improper payments spans the full range of Medicaid service types – inpatient, outpatient, Durable Medical Equipment (DME), hospice, professional services, pharmacy, dental, and waiver programs.

By expanding efforts beyond traditional types of overpayments, BMS has an opportunity to:

- Increase potential recoveries
- Focus on all areas of potential overpayment
- Fulfill State fiduciary responsibility
- Remind different provider types to be mindful of billing practices

7.2.4.5 Examples (App 1, OS025)

Our response herein already describes our audit methodologies and parameters specific to identifying improper payments for BMS. To further satisfy this requirement, in **Appendix 1** we provide the following generic samples illustrating some of the materials used in our RAC process.

- **Sample Claim List Template** – included with our Preliminary Findings Letter sent to providers. Used to communicate the claims and used to communicate the details about our review findings (**Exhibit 7.2-9** in proposal **Appendix 1**).
- **Sample Medical Record Request Letter** – sent to providers after claims are selected, to request medical records for the review (**Exhibit 7.2-10** in proposal **Appendix 1**).
- **Sample Audit Concept Approval Form** – used to submit audit concepts to BMS for approval prior to undergoing development approval (**Exhibit 7.2-11** in proposal **Appendix 1**).

We tailor our communications with a strong sensitivity to the provider-BMS relationship. This includes developing BMS-specific templates for all provider communications. These are generic

samples, and we will collaborate with BMS on the creation of these materials during implementation.

In **Exhibit 7.2-17**, we recommend our best practice timelines during a RAC audit for driving successful outcomes.

Exhibit 7.2-17 HMS' Recommended Best Practice Timelines for a RAC Project
HMS maintains a strong relationship with BMS by setting and adhering to realistic timelines.

Solution Component	Best Practice Timeline
BMS Review and Approval of an Audit Concept	10 days following receipt of audit concept approval form from HMS
Provider Initial Response to a Medical Record Request	30 days from receipt of Medical Record Request Letter
HMS Time to Complete Medical Record Review	60 days from receipt of medical records
Provider Response (Rebuttal) to an Improper Payment Finding	30 days from receipt of Preliminary Findings Letter to supply further documentation if they disagree with finding
Time for Provider to Initiate Recovery or Notify State of Request for Appeal	30 days following receipt of Final Notice of Recovery Letter

7.2.4.6 STAFFING (APP 1, OS016 – OS017)

We offer a highly qualified HMS Project team for BMS to deliver the RAC services proposed.

We describe our full Staffing Plan across all proposed scopes of work for BMS, including RAC Services, in **Section 4.0 Attachment 4: Project Organization and Staffing Approach.**

REVIEW STAFF QUALIFICATIONS

The review staff members we propose include skilled medical professionals, who are appropriately trained to conduct clinical and/or coding reviews and in good standing with the relevant licensing/certification authorities. These roles include the following:

- Clinical Nurse Reviewers
- Certified Coding Specialists
- Panel of Physician Reviewers

CLINICAL NURSE REVIEWERS

Across the organization, HMS has more than 150 qualified clinical reviewers on staff that we can leverage to assign to our individual project teams. These personnel, who are experienced in clinical review of medical record documentation, include registered nurse reviewers and seven dual-certified nurse-coders. Our clinical RN reviewers have, at minimum, three years of experience in post payment review and working knowledge of audits, medical record review, and application of agency policy to claim review.

Nurse reviewers are Registered Nurses (RNs) with active state licenses and many have Compact licensure. The nurse-coders have active state licenses and coding certifications as outlined per Certified Coding Specialist requirements. Nurse review staff have experience in

utilization review as well as direct care experience. Nurse reviewers are experienced in reviewing records for appropriateness of Level of Care, documentation requirements, utilization of multiple criteria sets such as InterQual, MCG, local coverage determination (LCD), national coverage determination (NCD) and agency policy, validation of diagnosis codes, and overutilization of services. This enables us to streamline and scale operations. Our extensive experience in State RAC, PI, utilization review, and other specialty lines of business makes HMS' reviewers specifically qualified to meet BMS' requirements.

Certified Coding Specialists

HMS has a team of 30 certified coding specialists on staff, and seven dual-certified nurse-coders we can leverage to assign to our individual project teams. Our qualified staff has the appropriate skills to interpret Medicaid regulations and policies—all certified coders have at minimum three years' experience completing medical reviews, hospital billing procedures, and inpatient/outpatient services utilizing clinical and coding knowledge.

Our coders hold certifications through at least one of the nationally recognized credentialing bodies such as the American Health Information Management Association (AHIMA) or the American Academy of Professional Coders (AAPC). While the certifications of our coders span across various designations, the most common among those employed with HMS are the Certified Coding Specialist (CCS) and Certified Professional Coder (CPC). Additionally, a number of our certified coders also hold dual credentials for coding such as Registered Health Information Administrator (RHIA) and CCS. Our talent pool continues to grow with dual-certified registered nurse (RN) and certified coders. This enables us to streamline and scale operations appropriately for a fluctuating inventory and leverage our resources to meet project needs. All our certified coding specialists have the demonstrated ability to apply American Hospital Association (AHA) ICD-9-CM and ICD-10-CM Coding Guidelines and Coding Clinic; and American Medical Association (AMA) CPT Coding Guidelines and Coding Assistant appropriately and accurately.

Panel of Physician Reviewers

HMS has a panel of 440 credentialed physician reviewers nationwide, supporting our medical reviewers. These physician reviewers perform medical record review regarding issues of medical necessity, resource utilization, standard of care, and overall quality. They provide a reasoned opinion and respond to specific questions posed. These are based on the physician's medical knowledge and experience, as well as sound medical judgment and professionally recognized standards of care. Physician reviewers also participate in hearings, pre-hearings, and other meetings when required. We require our physician reviewers to have the following minimum qualifications:

- Current unrestricted medical license (MD or DO) to practice in the United States
- No loss of staff privileges or restrictions
- No conflict of interest

- Current board certification in declared specialty
- Active practice of medicine in declared specialty for at least five years
- No history of sanctions and/or disciplinary actions
- Demonstrated ability to analyze and evaluate medical information
- Demonstrated effective written and oral communication skills

Our HMS Chief Medical Officer, Dr. Gary Call, has ultimate oversight of our review personnel. His primary responsibilities include development and oversight of medical review policies, clinical data analytics and algorithms, direction of the Clinical Quality Improvement Program, and management of the PI product. He provides thought leadership for the healthcare marketplace regarding Payment Integrity and Cost Management solutions for both government (Medicare and Medicaid) and commercial payors. He gives direction and oversight for efforts to develop innovative new solutions and process improvements to our suite of clinical products. Dr. Call is a currently licensed and board-certified family physician in good standing with more than 25 years of experience as a physician and 20 years of experience in healthcare-payor management and oversight. If BMS requires a WV-licensed medical director such as Dr. Call, or is supportive of a request for a Waiver, we are willing to discuss this at further length with the appropriate stakeholders.

Staffing Protocols

Our staffing protocols necessitate that our clinical staff in designated roles (e.g. medical director, certified coder, RN) stay current with their respective licenses and meet certain continuing education requirements as part of that process. For example, the physician license cycle requires medical doctors to complete a certain number of continuing medical education (CME) requirements prior to recertification; these vary by state. RNs and certified medical coders have similar requirements with continuing education units (CEUs), related to their respective disciplines. We have an internal credentialing team that maintains physician licensing requirements. Physicians and other clinical personnel are required to maintain certain continuing education requirements to keep the licenses in good standing. We have that information available and can provide it if requested by BMS.

Assigning review of specialty claims to specialists who have the appropriate, relevant expertise improves the accuracy and timeliness of reviews, increases provider satisfaction, and is likely to decrease reconsideration/appeal requests. As such, HMS:

- Assigns specific claims to reviewers specialized in that area only
- Monitors individual reviewer/coder workloads to maintain quality and maximum efficiency

LICENSURE VERIFICATION

HMS has established processes for reviewing and verifying the licensure of our claim reviewers, certified coders, physicians, and other clinical personnel, as required.

- **Prior to Hire.** If licensing or other credentialing is a requirement, we will confirm the active designation of the license or certification through a primary source (e.g., using the appropriate State licensure website, American Board of Medical Specialties, etc.) prior to hire. We will place a printed copy of the confirmation in the associate's personnel file.
- **Ongoing Annual Verification.** During our annual Performance Review cycle, our Human Resources Department uses the appropriate State licensure website again to confirm all licenses are still active and without restriction. We will place a printed copy of the confirmation in the associate's personnel file.
  - If we discover the suspension of an associate's license due to failure to meet recertification requirements, the associate will have a 90-day grace period in which to meet the requirements and renew the license. Until the license is in good standing, the associate must take vacation and/or an unpaid leave of absence until the final resolution of any outstanding issues. If an associate fails to renew the license within the grace period, or if we discover that the suspension of the license is due to criminal conduct, the associate will be subject to the appropriate disciplinary actions, up to and including termination.
  - An associate without a license, an associate whose licensure is in suspension, or an associate who is otherwise not in good standing will not perform any activities that require licensure as a healthcare professional.
- **Credential Maintenance.** We will maintain and provide documentation, per BMS request, for the credentials of the individuals making the medical review determination.

7.2.4.7 PROVIDER EDUCATION, OUTREACH, AND CUSTOMER SERVICE (APP 1, OS018)

HMS has effective working relationships that we have established and continue to cultivate with provider communities with WV and across the nation. These relationships have been the key to HMS becoming the most experienced and largest RAC Services vendor. Our efforts to connect with your providers help us increase provider satisfaction while successfully implementing and managing a Medicaid RAC program. Thoughtful and direct interaction with providers enhances overall understanding and cooperation for achieving BMS' program goals.

In response to the COVID pandemic, HMS has taken additional steps to minimize provider abrasion during this time, including:

- adhering to client requests for allowing providers additional time to submit medical records.
- delaying offset for overpayments at the client's request.

We engage in many practices to help minimize provider abrasion during audits. Each of our program integrity programs, including RAC, also incorporate provider engagement in some capacity. Through our efforts, HMS supports providers and BMS personnel with high-quality communication and customer service, which includes effective outreach materials, a customized Provider Engagement Program, and ongoing, personalized support from our HMS Provider Services team.

Provider Communication and Outreach Methods

Through our communications protocol, providers gain a better understanding of your RAC program and BMS and WV rules and regulations. We identify common ground for improvement, strengthen our credibility, and cultivate an environment of mutual trust and respect; providers will be motivated to better support BMS policies, regularly communicate with our team, and promote evidence-based interventions.

. Our communication methods, whether for general outreach or provider education, are clear and direct and focus on improving provider satisfaction, even when providers have little or no notice of the reviews.

We use multiple methods to engage and educate providers and other stakeholders as described in **Exhibit 7.2-18.** Additionally, we work with our state partners to customize messaging and methods of outreach to best meet their needs.

Exhibit 7.2-18 HMS' RAC Provider Communication and Outreach Methods
We use multiple methods to communicate with, educate, and engage the BMS provider communities.

Outreach Activity	Information
Meetings of Introduction	Scheduled meetings to introduce our company and discuss the purpose of the audit and its process.
Provider Webinars	Prior to any audit activity, conduct introductory webinars that reach providers who cannot access training or communication sites. These webinars are extremely useful in communicating new procedures, new system interfaces, new rules, and to introduce new facets of a review program.
Toll-Free Telephone Number	A dedicated toll-free telephone number that connects providers directly to our Provider Services staff for program questions and issues. Note that all policy-specific questions are referred to BMS.
Email	HMS provides a specific email address for providers and other stakeholders to submit questions or comments and as an avenue to present additional information to individuals. This email is continuously monitored and answered by HMS Provider Services staff.
Program Website	A "public" website for all project stakeholders that includes educational materials, FAQs, and a link to BMS' website.
Provider Services Team	This team performs a wide range of customer service activities for BMS-related to the RAC program. While ensuring service availability through toll-free telephone number and email address, this team generally: provides live staff during normal business hours in time zones applicable to WV provider locations, facilitates provider communications, maintains an outgoing message, responds to questions and concerns, and directs individuals to proper resources.
Special Sessions	Special meetings or educational forums for all providers/stakeholders, as needed.
Provider Portal	Allows providers to access status/recovery information as well as upload documents directly and correspond. This Provider Portal serves as the primary point of entry for our entire process and is available 24x7.
Notifications/Letters	Letters to providers that contain information specific to review policies and procedures and errors. These letters are an effective tool for educating providers regarding proper practices.
Reports	Provider-specific reporting that shows compliance with medical record submissions and findings. Enables BMS to provide additional outreach to providers struggling with the audit, if necessary.

HMS Provider Education

HMS has developed a Provider Engagement Program to expand customer service and promote engagement, help ensure a positive provider experience, and minimize provider abrasion For

our RAC programs. We will partner with BMS to customize a project-specific provider engagement model based on a series of activities, designed to engage each provider and encourage interaction with our HMS Provider Services team. Once launched, we maintain many of the activities during the Operations phase and throughout the length of the contract.

HMS educates our key client stakeholders (e.g. provider and network services, clinical teams, etc.), so they are familiar with the planned audit program and understand the value of the RAC program to BMS. As subsequently described, our HMS Provider Services team answers calls from providers with issues or concerns and escalates to the appropriate internal teams to provide a response or resolution within 48 hours. As the first touchpoint for providers, this education arms our client-facing personnel with the appropriate information to positively support providers who reach out with questions and concerns about a program. With the Provider Engagement program, we provide ongoing outreach and education to providers, through various methods such as webinars and self-guided learning. We also deliver provider-specific reporting that shows compliance with medical record submissions and findings. With this information, BMS can provide additional outreach to providers struggling with the audit, if necessary.

While we will work with BMS to tailor this program, we provide general information and examples about the Provider Engagement program and how it works. We affirm our understanding that any education and outreach program must be approved by BMS prior to implementation. In **Exhibit 7.2-14** included in proposal **Appendix 1**, we provide an illustration describing the phases in our Provider Engagement program and subsequent activities.

Customer Service

HMS communicates with many stakeholders during the RAC audit process. The most important communication occurs between HMS and the WV provider community. The goal of our HMS Provider Services team is to establish and maintain effective communication with providers throughout the entire improper payment review process, help ensure the process remains effective, and facilitate continued positive working relationships.

Supported by the latest call center technology and proprietary case management tools, the Provider Services team effectively communicates with providers and other stakeholders, making sure information about the RAC program is easily accessible and clear, addressing inquiries and resolving issues that arise during the review period. Some of the tasks they perform include:

- Request medical record inquiries and receipt verification
- Review process requirements and documentation
- Answer questions regarding the time frames during which providers must respond to claim review requests
- Provide status of reviews
- Supply copies of correspondence

Our qualified and experienced representatives will be thoroughly knowledgeable regarding HMS efforts on behalf of BMS, including potential recovery methods and any appeal process. To make sure all providers have access to accurate and comprehensive information associated with our services, HMS' Call Center capabilities include our ability to respond to both English and Spanish-speaking providers.

Provider Services representatives have access to supporting program systems, including HMS' ReSults case management system and the HMS Portal, enabling them to access claim- specific data and documentation that supports their ability to accurately respond to callers' needs. This team also helps providers understand how to improve their billing practices and avoid future audits.

Provider Services' Customer Service Center Capabilities

Our Provider Services team members apply lessons learned and best practices from our commercial health plan and Medicaid/Medicare program integrity work to continually improve our customer service.

Establishing a constant communication flow is essential for fostering collaboration, building strong provider relationships, and ensuring a high level of provider adherence. To that end, we include our toll-free telephone number and mailing address in all provider correspondence for inquiries and customer support. Our experienced team members are logged into the telephone line and available to accept calls between the hours of 7:00 a.m. and 5:00 p.m. Eastern Time, Monday through Friday, excluding State holidays. We will retain sufficient staff and support levels for anticipated call and email volumes during BMS's standard business hours.

Should a situation or issue occur pertaining to BMS' RAC project, HMS has established processes in place to escalate such issues to expedite resolution. If we are unable to resolve the dispute, we notify BMS of the issues raised and provide a summary of the pertinent facts and applicable laws and/or rules, copies of relevant documents, present the courses of action that are available and our recommended course of action. We will work with BMS to resolve the issue and the provide BMS' decision to the stakeholder.

7.2.4.8 Audit Coordination and Deconfliction (App 1, OS021 and OS027)

HMS works closely with our clients to make certain the reviews we undertake do not duplicate or disrupt work being conducted by other entities, including state and federal agencies and their vendors.

Audit Coordination

Oversight of audit coordination will be performed by our delivery team, ensuring that all claims identified for review are coordinated with BMS to prevent duplication. We submit all claims selected for review to BMS for examination and determination as to whether the claim information is included in another review by a separate entity. We meet regularly with our clients

and other entities to apprise them of our activities and to understand the reviews they are undertaking. Our ReSults case management system helps us coordinate review activities to eliminate duplicate reviews and efforts. ReSults will load specific claims from agencies and vendors for match-off, and we can use the system's exclusion tables to exclude specific providers, types of services, and dates. Additionally, HMS has an internal match-off process to validate claims are not reviewed under multiple scenarios; we can also provide extract files to entities for match-off.

As part of our Implementation process, we will work with BMS to identify all services and any providers that BMS wishes to exclude from review.

As a best practice, HMS recommends a review of all excluded claims twice a year. This practice is currently in place with many of our state Medicaid agency clients and has facilitated thousands of claims previously not eligible for review to be pulled back into the process, generating additional overpayment identification and recovery for the state.

DECONFLICTION

Similarly, deconfliction is the process of ensuring HMS is not auditing a claim that is being audited by another agency or division within the WV system. It ensures a match off is completed by BMS when HMS provides them with claims identified and selected for an audit. The selected claims need to be reviewed by BMS and tagged as approved or denied for auditing by HMS, based on what the other agencies are doing. For example, the MFCU or the OIG may flag a provider and all its claims for audit. In this case, BMS can advise HMS that these claims are ineligible, in one of two ways.

- BMS can advise HMS of a provider-level exclusion where we would then build in an exclusion for all claims for that provider.
- Alternately, BMS can indicate each claim with a Denied indicator on the return file to us identifying those claims are denied for audit by HMS.

7.2.4.9 Identifying and Reporting Potential Fraud, Waste, and Abuse (App 1, OS028)

For more than 35 years, HMS has worked in the Medicaid claim environment to identify, audit, and recover improper Medicaid payments for both fee-for-service and, for the past 16 years, managed care populations. As a result, our team members are highly skilled in detecting outlier behaviors and fraud, waste, and abuse (FWA) patterns.

HMS trains our analysts and reviewers to look for these potential or suspected FWA patterns and, if identified, to immediately refer the case appropriately. If, during any part of our review process, we have reasonable grounds to believe that fraud or criminal activity has occurred, we will report such information to BMS and the West Virginia Medicaid Fraud Control Unit (MFCU). We will do this within the designated timeframe, so that BMS can evaluate and review the circumstances for each case and make a referral to the appropriate law enforcement agency, which may include the Medicaid Fraud Control Unit or the HHS Office of Inspector General.

While delivering program integrity services for one client, HMS identified a case of suspected FWA. After discovering that one of the client's providers was issuing, on average, six prescriptions per patient seen in their office, and 99% of those prescriptions were filled by the pharmacy located within the provider's office, HMS referred the provider to the client's Medicaid Fraud Control Unit. The subsequent investigation resulted in a multi-million-dollar fraud settlement.

7.2.4.10 Reporting (App 1, OS023)

After contract award, we will work with BMS to review and customize our standard reporting to meet the reporting needs in the forthcoming contract term. Along with generating summary reports based on contract year or fiscal year time horizons, we can generate reports on a regular cadence (e.g. weekly) or on demand as requested. HMS will deliver detailed transaction-level reports on all recoveries and outstanding overpayments and on underpayments at the frequency and through the methods required by BMS. We will report on all RAC activities required for CMS reporting as well as any additional items requested by the State. Our Implementation Plan will cover the development of report formats, reporting tools, and a schedule of report deliverables, understanding that requirements regarding report format, content, and submission frequency are subject to change at any time during the term of the contract. Development will occur in cooperation with BMS, and we will obtain report approval prior to use.

With HMS' approach to reporting, we extract data and documentation from secure systems within our technology platform. These systems maintain every available claim data field, creating an extensive audit trail capturing claim status at every stage of analysis and activity, and supporting rationale for an improper-payment determination.

We can provide BMS and designated stakeholders with the following types of information:

- Reports
- Transactional data
- Online information regarding each identified claim/case with a potential improper payment (underpayments and overpayments)
  - Case status
  - Total recovery amount

HMS status and results reporting are supported by our ReSults claims tracking and case management platform. This system contains all claims identified by the project. For each claim, we maintain extensive data elements that enable tracking and reporting on status, results, event status and dates, and virtually all activity/information related to the identification, verification, and recovery process.

Along with reporting through our portal, HMS can transmit electronic versions of each report to BMS through secure email or other transmission protocol. Our customizable reports capture all the data elements needed to update claims in the MMIS and provide documentation for State and federal auditors and reporting requirements.

7.2.4.11 Improper Payment Prevention Plan (App 1, OS024)

As introduced in Step 7 of our iterative RAC process, we will support WV Medicaid in avoiding future overpayments through our system remediation and provider education processes, both already described in this section, which involve outreach and education to the provider community and the identification of system and process enhancements and/or modifications.

We will work with BMS during implementation to determine any specific or unique needs as well as develop a WV-specific Improper Payment Prevention Plan for any RAC-identified vulnerability. For most RAC clients, we typically review each type of overpayment to determine if the overpayment could have been avoided with adjustments to the claims processing system. The results of this review are typically presented during our regular client status meetings. If it is necessary to provide this information in a different way, we will collaborate with BMS in a manner that we agree on.

7.2.5 Additional Value-Add Services

HMS continues our tradition of presenting additional service options for BMS to consider as West Virginia moves into the next phase of its TPL program and embarks on a formal Recovery Audit Contractor (RAC) initiative. After careful evaluation, we assert that these proposed ideas, which are beyond the services requested in this procurement, provide an opportunity for BMS to expand cost savings and recoveries for the Medicaid program.

- **MCO Come-Behind Billing** for a near-immediate cash boost in recoveries and informal MCO TPL program audit
- **PARIS Match Enhancement** to enhance the current PARIS interstate match process for additional cost savings
- ***Eliza®*** to bolster the effectiveness of outreach and follow-up activity for our proposed premium assistance program solutions as well as for emergency preparedness

Described below, these services may incur additional cost and require further discussion between HMS and BMS, which we welcome at any time.

MCO Come-Behind Encounter Billing

Managed care has grown exponentially in recent years, with more than 40 states today contracting with managed care organizations (MCOs) on a capitated managed care model. As states continue to shift their Medicaid populations to managed care, they must protect the value received by implementing effective TPL oversight activities.

We know that BMS currently operates Mountain Health Trust (MHT), the Medicaid managed care program that has operated in West Virginia since 1996. As of early 2020, approximately 80% of all WV Medicaid members are enrolled in managed care – in one of the State's three managed care organizations (MCOs). West Virginia's managed care program also includes Mountain Health Promise (MHP), a newly formed specialized managed care program for children and youth.

There are multiple reasons for BMS to implement a Come-Behind Encounter TPL billing program – benefits that are not only financially significant but timely as well. They can serve as:

- **A Near-Immediate Boost in Recoveries.** During these unprecedented times created by COVID-19, states are witnessing losses in tax revenue while simultaneously facing historic expense increases in Medicaid and other social services. Come-Behind insurance billings on encounter claims will provide a much-needed and nearly immediate boost in cash recoveries for BMS. The collections from this program will come from insurance carriers that have the legal obligation to reimburse Medicaid for these claims, and not the

HMS conservatively estimates BMS' recovery potential to be in the millions within the first six months following implementation of an MCO Come-Behind Encounter billing solution.

providers in WV's network. Additionally, the federal minimum look-back period of three years from date of service provides BMS with the opportunity to quickly recover millions of dollars from three years of previously paid, but never recovered, historical claims.

- **An Informal MCO TPL Program Audit.** Come-Behind encounter billings also serve as an informal audit of each MCO's TPL program. As part of the monthly financial reporting, HMS will provide BMS with the Come-Behind billing recoveries for each MCO. Where HMS recovers less than the MCO has reported in TPL recoveries, it can be assumed that the MCO has an adequate TPL program. However, where HMS recovers significantly more behind an MCO, BMS can utilize the information to investigate further into the MCO's contractually required TPL efforts.

Reasons MCOs Struggle with Effective TPL Programs

There are several reasons why MCOs struggle with effective TPL programs:

- **MCO data and recovery restrictions.** Plans do not typically have full rights when compared to a state that has explicit authority under their Deficit Reduction Act of 2005 (DRA)-compliant legislation. Without a statute expressly granting plans these same rights, carriers often refuse to provide eligibility files for Medicaid coordination of benefit purposes.
- **Process restrictions.** Many plans exclusively used disallowance methodologies to seek TPL reimbursement, resulting in significant gaps in recovery timelines. MCOs are restricted to the timely filing window between the provider and commercial carrier, which is often 12 months. Thus, the MCO cannot bill the carrier for claims back the full 36 months allowed by the DRA. Consequently, up to two years of TPL claims may go uncollected.
- **Plan conflict of interest.** MCOs may elect not to bill health plans owned by the same parent company. Therefore, the plan has a conflict of interest in maximizing the full TPL recovery opportunity available.
- **Reverse incentives.** As managed care plans recover TPL overpayments, the state readjusts plans' capitated rates accordingly. As a result, plans' revenues are negatively impacted by maximum TPL results. Therefore, even if plans keep the recovery, some plans may treat TPL as a compliance issue that raises their costs and lowers their fees.

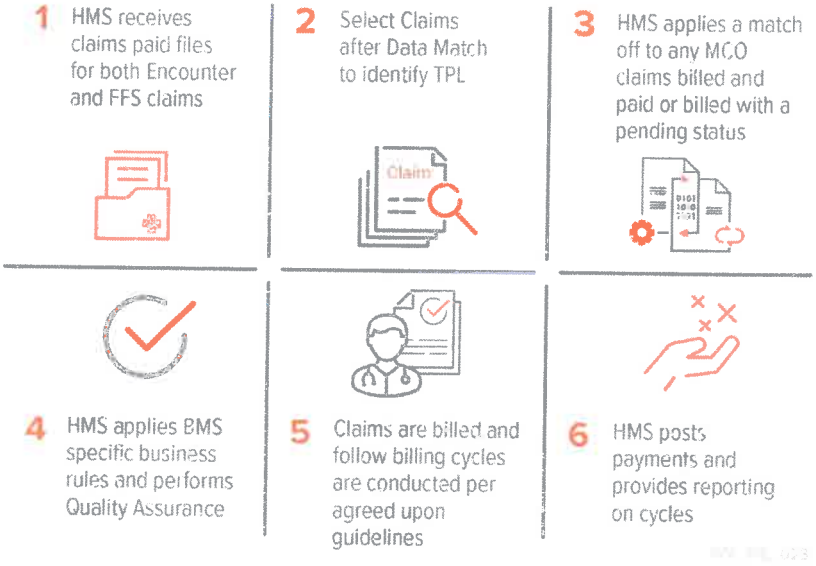
HMS has developed viable solutions for including MCO Come-Behind encounter billing in our recovery processes for BMS. We have more than 16 years of experience working with encounter claim data in multiple states and have been successful in pursuing these recoveries, delivering millions of dollars to numerous clients currently using the encounter claims initially paid by the MCOs. We currently conduct MCO Come-Behind encounter billings for Medicaid agencies in the following states:

- Arizona
- Indiana
- Louisiana
- Minnesota
- Mississippi
- New Jersey (state is primary)
- New Mexico
- New York
- Ohio
- Oregon
- Pennsylvania
- Tennessee
- California (in implementation)
- Florida (in implementation)

- We have hands-on experience working with WV's encounter data and fully understand from our work in the 14 states identified above how to come behind the MCOs and recover outstanding claims in BMS' managed care environment.

Exhibit 7.2-19 illustrates a high-level look at our general MCO Come-Behind billing process that we will customize for BMS.

Exhibit 7.2-19 HMS' General MCO Come-Behind Billing Process
HMS has developed successful solutions for including MCO Come-Behind encounter billing in our recovery processes for BMS



In the following narrative, we describe the steps in our process that we will adapt for BMS.

Step 1: Receive Encounter Claims Paid Files

Upon approval, HMS will begin receiving an Encounter Claims Paid File from BMS and our recommendation will be to receive from BMS weekly.

Step 2: Select Claims

HMS leverages the same process for selecting claims for Come-Behind billing of Managed Care as we do for the FFS population.

We perform the data match to the cumulative BMS Encounter Paid Claims File, which allows us to identify the entire populating of potential claims for billing. Using this data, we identify all encounters paid for an enrollee where there is identified third party coverage.

Step 3: Apply Match Off to MCO Claims Billed

After selecting claims for inclusion in our billing process, we leverage a match off process to remove claims previously billed by the MCOs. During project initiation and kickoff, HMS will establish this process. We understand the importance of an accurate match off process and that

the failure to do so creates unnecessary burden on the commercial carriers by slowing down their ability to adjudicate claims and slowing recoveries to BMS.

Step 4: Apply BMS Business Rules and Perform Quality Assurance

We program all claim level edits according to client and carrier specific requirements and policies. These edits include data elements such as procedure codes, modifiers and facility types.

For delivery of a high-quality solution to our clients, HMS refines our claim-selection process frequently to guarantee we can accurately identify and bill claims. After completing the final claims selection process, we produce summary quality assurance (QA) reports for internal review and approval. Our QA team compares the billing to the established internal checklist that contains all BMS-specific and carrier-specific requirements.

Step 5: Submit Claims To Liable Third Party

Following our internal QA review, we prepare and submit billings to carriers using a variety of methods based on agreements with each carrier. Our Come-Behind billing process aligns with our FFS billing process creating a seamless process for the commercial carriers and eliminating the need for separate files.

The process for recovery of Managed Care claims follows the same extensive and complex process for the BMS FFS population of claims. HMS will add steps to the process to ensure thorough identification and follow-up on every claim for BMS. Additional actions taken to pursue Come-Behind recoveries include:

- **Follow-up on Open Claims.** To the extent possible, HMS will identify claims that have been billed to a commercial carrier by a contractor but have not been either paid or denied. We will load these claims into our A/R for appropriate action including re-billing or carrier follow-up by a carrier account representative.
- **Follow-up on Denied Claims.** HMS Yield Management staff can follow up on claims denied by a carrier for reasons that do not comply with state or Federal law (e.g. timely filing). The staff will work with the carrier to resolve compliance issues. HMS also resolves issues such as missing information that would prevent a carrier from repaying a claim to the State.

Step 6: Post Payment and Provide Cycle Reporting

The Come-Behind Recovery process will leverage the lockbox process currently in place. All payments received from commercial carriers into the lockbox will be posted into our A/R, which then allows for Come-Behind-specific recovery reporting, posting file generation, and invoicing. Our A/R delineates between the FFS and Come Behind claims that are billed, eliminating the need for carriers and BMS to do so and allowing HMS to produce separate, accurate reporting to reflect the associated recoveries from this project for tracking and reporting at BMS.

PARIS MATCH ASSISTANCE

In accordance with Section 1903(r) of the Social Security Act, all states are required to have eligibility determination systems that provide for data matching through PARIS. Beginning October 1, 2009, participation in PARIS is also a condition of receiving Medicaid funding for automated data systems (including the Medicaid Management Information System). Performing the PARIS match, and acting on the results of the match, are not only required but also provide significant fiscal value.

West Virginia currently participates in the PARIS cross-state match, which helps identify Medicaid members who may no longer meet the residency requirements of the WV Medicaid program. A PARIS match helps find and prevent future improper payments and minimizes fraud and abuse yet presents several challenges, including the fact that the return file contains both valid matches and low-quality (partial) matches. In addition, depending on the begin date of the eligibility in the new state and the last known claims date of service, the BMS can terminate eligibility up to 12 months prior to the match.

To support BMS with their PARIS match efforts, HMS can offer our PARIS match assistance services, which are available at the following service levels:

- Match Results Review and Residency Verification
- Match File Augmentation
- Expansion of Interstate Residency Match and Verification to Other Programs

MATCH RESULTS REVIEW AND RESIDENCY VERIFICATION

We can assume responsibility for various components of BMS' existing PARIS process, such as helping to process the files that come back from the PARIS match to verify residency. Through our Medicaid Residency Verification solution, we quickly leverage the information from the PARIS process to identify members that are potentially no longer residing in the State and verify whether they are eligible. Our easy three-step process, outlined below, is supported by a mobile-friendly website that Medicaid members can easily navigate and provide documentation to support their residency. Our trained staff answer any questions a member may have. Additionally, we can verify 100% of matched members ensuring that a full review is completed.

1. **Obtain the match file and perform outreach** – We review the file for completeness and duplicates, then identify the members for mailing. The members are required to respond with supporting documentation to prove residency to keep their Medicaid coverage.
2. **Review and verify residency documentation** – We receive telephone calls, mail, and online uploads from members that reside in the State. We review and verify whether they meet the residency requirements.
    a) Our system, available on computer and mobile devices, can manage and accept pictures of documentation.

b) Follow-up letters can be sent and/or telephone calls can be made to ensure compliance and answer questions.

3. **Provide reporting for terminations** – We provide reporting of members who failed to respond or provide sufficient documentation to prove residency. The State can use this listing to potentially disenroll the identified members from the program.
   a) This file can be delivered weekly, bi-weekly, or monthly.
   b) Verification and collection of proof of residency solution, as described in the following text, will help ensure only ineligible members are identified for disenrollment.

Using this proven solution, the time from identification of other residency to verification is dramatically shortened. By performing these activities, we can alleviate administrative burden and help WV free up resources.

Match File Augmentation

While effective, the existing PARIS cross-state match has limitations that restrict results. These limitations, may hinder an efficient process for optimized cost savings, including:

- Time lapse between submission of data for matching and receipt of the results
- Limited scope of states participating each month
- Lack of eligible categories submitted by all states
- Quality/format of data out of the match

As a vendor to more than 40 state Medicaid programs, HMS has a near-real-time national view of program eligibility. We have begun to implement cross-state Data Usage Agreements that will enable us to compare eligibility from each state to identify individuals enrolled in multiple states and help states determine primacy.

This supplemental match can help save WV millions of dollars in annual costs by avoiding payment of claims and MCO premium payments for non-eligible individuals.

Expansion of Interstate Residency Match and Verification to Other Programs

HMS understands that BMS is focused on the interstate match and residency/eligibility verification process to identify Medicaid members who are no longer eligible for Medicaid programs. However, there may be other State assistance programs that would benefit from identification and verification of non-eligible members. As part of our scope of work under this project, HMS will work with BMS to explore benefits from expansion of this project to other assistance programs.

Eliza®

In **Section 7.2.1 Premium Reimbursement Program**, we introduced our *Eliza* health engagement management solution that can offer BMS to bolster the effectiveness of our

outreach activity and offer additional benefits to WV HIPP members. Part of our Population Health Management (PHM) suite of integrated solutions, *Eliza* is a scalable, multi-channel technology platform that integrates exclusive data sources, industry-leading analytics, and experience-drive program design. *Eliza* leverages billions of member data points and interactions to tailor messaging for individuals to address medical conditions, social determinants, and other factors.

Eliza does not just talk at consumers – it moves them to take meaningful action by engaging members through real conversations. We identify barriers, develop highly tailored outreach strategies to overcome them, and drive engagement through multiple, two-way channels (any combination of email, text, digital web, mobile, live agent, mail, or IVR/telephone), and intelligent interventions that are flexible, configurable, tailored, and timed, using branching logic and dynamic variables. *Eliza* clients achieve outcomes that make a difference, including:

- 2-5% increase in quality measure (closing gaps in care)
- $4.5 million in savings by moving healthcare consumers to act
- 97% reduction in member complaints and an increase in home monitoring compliance

Below we present a few scenarios where *Eliza* may be valuable for BMS.

Eliza for Emergency Preparedness (for COVID-19)

HMS prides itself on being flexible and having the capability to react to unforeseen events that may occur. One instance that demonstrates this flexibility surrounds the COVID-19 outbreak.

Eliza creates personalized engagements that address the management of Coronavirus (COVID-19) health conditions, and access to care and services. It captures patient-reported health outcomes and social barriers. For COVID-19, we strive to help our clients proactively respond by giving them a way to measure, monitor, track, and predict the effects of COVID-19. All but one of the COVID-19 vaccines currently in Phase 3 clinical trials in the United States need two shots to be effective. As these vaccines become available, *Eliza* can be utilized to aid in the distribution of the vaccine and help in reminding and engaging members to ensure they receive the second shot. During the pandemic, *Eliza* effectively outreached to more than 10 million consumers providing information, education, and support, reaching 7 million with messaging to support needed care, services and access, health information, and benefits.

Using our deep knowledge of the healthcare and population heath management landscape, we created COVID-19 dashboards embedded with machine learning-based predictive models. These dashboards provide:

- An interactive retrospective lookback at COVID-19
- A way to identify trends and findings in need of deep dive analysis
- A tool to inform clients about COVID-19 in their populations and highlight opportunities
- A way to explore population trends and predictive model results

These predictive models identify patients with severe complications when diagnosed with COVID-19. We use a Severity Index Model (SIM) to predict individuals that will have severe clinical complications because of COVID-19. We also use a Vulnerability Index Model (VIM), which predicts a member's vulnerability for a COVID-19 infection.

Eliza's patented technology was first-to-market and recognized as a leading IVR solution. Our digital engagement tools are TCPA- and HIPAA-compliant, minimizing member abrasion while maximizing health engagement impact. *Eliza* easily integrates with other systems and solutions while providing continuous innovation that drives leading-edge consumer engagement.

Eliza programs leverage comprehensive consumer data sets, accessing billions of data points that address medical conditions, social determinants, and other factors. Our flexible approach is member-centric, maximizing reach through multimodal communications and targeted member touchpoints.

Eliza for WV HIPP

Introducing *Eliza* into the WV HIPP program can be beneficial to both members and BMS. *Eliza* allows individuals to receive important program information when and how it is most convenient for them. It also helps drive engagement and persuade individuals to take meaningful action that will benefit their health. *Eliza* will also allow our eligibility advisors more time to interact with prospective members who may have specific questions on how the program will impact them directly.

In addition to WV HIPP, Eliza may be used in a similar capacity to enhance outreach activity for WV's other premium assistance programs –M-WIN and Medicare Buy-In.

To support WV HIPP outreach campaigns, *Eliza* facilitates automated outreach attempts to reach members, which can be made through telephone call, SMS text message or email, based on BMS' direction. *Eliza* can then perform a multi-point verification to ensure that the correct person receives the information included on the message. For example, in one state where we are currently using *Eliza*'s services, we have implemented a two-step verification process to validate the member's name and the year of birth. Both criteria conditions need to be valid before the message continues.

Other benefits of implementing *Eliza* to enhance WV HIPP program include:

1. **The ability to accept inbound calls 24/7** – Any member that receives a message from *Eliza* can call back and receive the same information they would have received if they had answered the phone when *Eliza* initially called. Given that WV HIPP members are likely at work during our normal call center hours of 7am to 5 pm, this feature allows WV HIPP members to receive valuable program information at a time that is most convenient.
2. **The ability to be transferred into the call center if the member has additional questions** – *Eliza* will automatically transfer members to a call center representative should they have additional questions not answered in the message by *Eliza*.
3. ***Eliza* offers the possibility of opting into other modes of communication** – *Eliza* has the capability to send SMS text messages and email communications. During the initial

telephone call, *Eliza* will ask the member if they would like to receive these other types of communication and logs the member 's response. This information can be shared with BMS to be used with other outreach programs.

Should a member decide that they would rather not receive automated outreach attempts from *Eliza*, this information can be stored in PIER and the member will be flagged for a manual outreach from one of our eligibility advisors.

7.3 PROJECT MANAGEMENT

7.3.0 PROJECT MANAGEMENT OVERVIEW

At HMS we govern every engagement by applying proven project management methodologies for a sound and technically accurate solution. Our tools and processes incorporate quality as part of every deliverable generated. Key elements of our project management approach to delivering successful projects includes:

- Structured supervision and management in accordance with our project management methodology
- Deployment of the optimal organizational structure to meet BMS' unique requirements
- Application and adherence to industry-best practices and protocols tailored to BMS' needs and customized to achieve the project's goals
- Top-down, early review of our current engagement to assess the tools, resources, integration, and data needed to support the engagement and provide accurate results
- Regular quality assurance (QA) reviews of all processes for operations
- Provision of information through both formal and informal meetings and standardized project management tools to provide clear, timely information to all stakeholders
- Ongoing measurement of progress to confirm we meet and exceed compliance with all statement of work (SOW) contractual requirements.

Combined, these elements form the foundation for consistently achieving superior project results for our clients. We are committed to maintaining a tight project-control structure with stringent compliant operations for every project, and for this engagement with BMS.

As a long-time, strategic partner in West Virginia, HMS has performed the full scope of work successfully for BMS, in accordance with the requirements and timelines. We employ a time-tested and performance-proven project management methodology, based on industry standard project management techniques, as described in this section. We leverage this methodology in partnership with BMS to effectively coordinate, manage, and monitor HMS Project team efforts to make sure all tasks, activities, and functions are completed in an effective and timely manner in accordance with the overall project schedule.

PROJECT MANAGEMENT METHODOLOGY

HMS follows industry-standard, professional project management standards, methodologies, and processes consistent with State and BMS guidelines. We use the Project Management Institute (PMI[SM]) Project Management Body of Knowledge (PMBOK®) guidelines, and the Software Development Lifecycle (SDLC) to manage projects, which we tailor to fulfill the specific client needs. Our approach helps to ensure projects are delivered on time, within scope, within budget, and in accordance with clients' quality expectations. Our typical management approach aligns organizational resources to fulfill start-up and execution requirements. Using these PMI-based practices in combination with the comprehensive reporting capabilities available through the ServiceNow™ Project Portfolio Management application, we deliver a full suite of management tools to execute, monitor, and control client projects, from start-up to operations and maintenance.

The PMBOK guidelines to manage projects are the internationally recognized, industry standard for project management, providing BMS with a universally accepted approach to project management.

In addition, we incorporate the subject matter experience gained from managing small, medium, and large TPL engagements since 1985. These engagements span more than 40 state Medicaid agencies, including Florida, New Mexico, New York, and North Carolina. The scopes range from new implementations and/or re-procurements to MMIS conversions and MECT Certifications. Our System Development Life Cycle (SDLC) methodology, based on a hybrid approach of Waterfall and Agile techniques, allows for effective requirement discovery and streamlined development and testing, without increasing project risk.

Our experience and success managing the current contract under BMS gives us a unique advantage. We understand BMS' goals, data, environment, and preferences and have adjusted our approach to accommodate BMS' needs. We have effectively completed all tasks, activities, and functions in a timely manner.

PROJECT CONTROL METHODOLOGY

HMS controls all aspects of our TPL project services by applying proven project management methodologies that incorporate ongoing BMS feedback. We will continue to work closely with BMS to solicit and address feedback, including the review and acceptance of all project deliverables and milestones. HMS and BMS will work together to establish acceptance criteria and associated review/sign-off procedures. Our project management resources and our assigned Account Manager, Michelle Hayes, will manage this effort during the initial stages of the project following contract award. Their identification of any service-related issues will result in immediate mitigation according to the Corrective Action Plan (CAP) for quick, efficient resolution. By consistently referring to contractual requirements and benchmarks, HMS will review the status of every process, whether to confirm contract compliance (in the case of a contract deliverable) or confirm it meets established quality standards.

Regardless of the size or complexity of the deliverable or project, HMS utilizes project management life cycle groups recognized by PMBOK as our approach that provides management consistency and minimizes project risk and potential miscommunication between our team and BMS.

The basic project life cycle groups recognized by PMBOK include:

- **Initiating Phase.** Includes a baseline review of current project documentation, establishment of the project infrastructure, and the project kickoff.
- **Planning and Design Phase.** Includes identification of tasks, timelines, work activities, deliverables, risks, and goals and milestones, with subsequent development of the Project Management Plan. Also involves organizing the resources necessary to begin the project, then creating and maintaining a framework to accomplish the objectives the project must achieve.
- **Executing Phase.** This phase involves the bulk of the project oversight work including integrating people and other resources to carry out the project schedule. The project management team engages in day-to-day operational activities and conduct reviews of current and future deliverables and work products, monitor project progress, and supports management of the project through issue and risk management, and contract compliance assessments.
- **Monitoring and Controlling Phase.** Occurs in parallel to all other phases and includes regularly measuring and monitoring project progress to ensure that the project is progressing as planned as well as to identify variances from the plan, so that corrective plans and actions can be taken to meet project objectives
- **Closing Phase.** The final phase of the Implementation Plan and provides formal acceptance of the product, service, or result that brings the project to an orderly completion.

We describe how we use these life cycle principles more within **Section 7.3.5 Implementation Plan**, as appropriate.

7.3.0.1 PROPOSAL FORMAT (APP 1, PM053–PM055)

HMS affirms that we have formatted our proposal in alignment with the requirements herein.

7.3.1 Communication Management Plan

7.3.1.1 Communication Management Plan (App 1, Item PM001)

Stakeholder communication is central to the success of any project. As we do today, HMS will keep lines of communication open with all stakeholders involved in the TPL Services project and will ensure that we continue to employ reliable project communications throughout the new contract term.

HMS subscribes to the Project Management Institute's[SM] best practices for communication management. As part of our forthcoming Project Management Plan (PMP), we will submit a Communication Plan specific to the BMS project, that will be agreed upon by HMS and BMS during implementation.

In our Communication Plan, we will define how and when communication takes place during the project for proper collaboration and coordination with stakeholders. It will address our approach for handling project communications with stakeholders and the associated timing and method. The Communication Plan will be tailored to BMS stakeholder groups and their information needs regarding the project, status, and accomplishments. We will engage in formal communications planning activities to identify the appropriate level of communication for each project stakeholder as well as determine what information should be distributed and at what frequency.

7.3.1.2 Defining Target Stakeholder Groups (App 1, PM003)

HMS communicates with many different stakeholders throughout our TPL solution processes, including BMS and other State personnel, internal HMS departments, and various stakeholders related to the individual solution scopes of work.

Therefore, one of the first communication planning activities we will complete to develop our Communication Plan is a stakeholder analysis. A stakeholder analysis is the process of identifying target stakeholders, grouping them according to their levels of involvement in the project, determining objectives for communicating with each group and their information needs, gathering and maintaining their contact information including messaging preferences, and ideal communication frequency. As indicated in **Section 7.3.5 Implementation Plan**, HMS uses a RACI (Responsible, Accountable, Consulted, and Informed) chart. The RACI chart will include information for all stakeholders with a role in implementing the proposed solution. This chart will act as a guide in the development of our final Communication Plan.

7.3.1.3 Communication Vehicles, Participants, and Schedules (App 1, PM002)

For the Communication Plan, we will identify the communication method(s) we will use to communicate with each stakeholder group, the intended participants, and the schedule for each.

HMS has numerous communication methods we use to perform outreach and engagement, relay project results, discuss potential challenges and solutions, and present other topics of importance to stakeholders. We will meet with BMS at project initiation to determine the agreed-upon methods for the new contract. These communication vehicles can include, but are not limited to, the following:

- **Formal and informal meetings.** HMS currently conducts monthly status meetings held at BMS offices or through teleconference that will help meet project timelines. During implementation and while involved in a change request projects, we recommend more frequent meetings to obtain needed information, obtain necessary approvals, and communicate project status. We will also schedule and be available for additional ad hoc meetings as needed. Agendas will be provided in advance of meetings and we will provide BMS with minutes from those meetings.
- **Project Life Cycle Phase Review**. As described in **Section 7.3.0 Project Management Overview**, we utilize a project management lifecycle approach and will conduct regular Project Phase reviews, which will indicate the project's position in the project lifecycle and address any identified issues or risks.
- **Reports**. In collaboration with BMS, we will continue to provide and enhance our existing reports along with developing additional reporting and dashboards, designed to communicate project status during implementation and operations. These reports will equip the project team, executives, and other project stakeholders with the visibility and control needed to secure timely, successful project implementation and operations. See **Section 7.3.1.3** below.
- **Formal presentations to BMS and project stakeholders.** A formal presentation to BMS and their project stakeholders effectively increases project awareness and support. It also demonstrates the value of a program's activities. We will conduct such presentations to provide BMS and project stakeholders with a detailed overview of our team's activities and accomplishments. The presentations will include discussion of goals and status reports on contract deliverables for each contract year. They will engage participants in a discussion of the project activities, enhancements, and refinements that are of the greatest interest to them.

One of the tools we use to present information in our Communication Plan is a Communications Matrix, which we will further customize for the new BMS contract. We will use the Communications Matrix to document the various aspects of the communications as well as to help organize outreach and engagement activities to achieve intended communication objectives. Some of the details captured in this matrix include, but are not limited to the

following: communication, target audience (stakeholder), description/purpose of the communication, frequency, format, owner, internal/external, communication distribution vehicle, etc. In **Exhibit 7.3-1,** we provide a sample Communications Matrix.

Exhibit 7.3-1 Sample HMS Communications Matrix
One of the tools we use to present information in our Communication Plan is a Communications Matrix.

Communication	Stakeholders	Purpose	Frequency	Format	Delivery Media
Kickoff Meeting	PMO, BMS, Module Vendors, IV&V	Introduce project Roles and Responsibilities Timelines Scope	One time; 10-days within start of contract execution	Power Point	WebEx or Zoom
Risk/Issue Meeting	BMS Module Vendors, IV&V	Prioritize Risks Discussion Risks Assign Risk actions and status	As scheduled by BMS	Excel and BMS Repository	◉ WebEx or Zoom ◉ E-mail
Special Presentation or Meetings	Module Vendors, Executive Team	Dependent on topics	As needed	To be determined, based on request	◉ WebEx or Zoom ◉ E-mail
HMS Status Report Meeting	Module Vendors, BMS, PMO, IV&V	Relay HMS progress, roadblocks, and future work	Weekly	Status Report Form	◉ WebEx or Zoom ◉ E-mail
HMS Outreach - Providers	BMS, Providers	Education Outreach	During Operations	Audit Policies and Protocols	◉ Email ◉ Postcards ◉ Letters ◉ HMS Portal
HMS Outreach - Community	BMS, Provider Communities	Recruitment Education	During Operations	Premium Reimbursement Program	◉ Email ◉ Postcards ◉ Letters ◉ Web Portal

7.3.1.4 Reporting, Project Communications, Resolution Approaches, Techniques (App 1, PM004)

Our approach to project management and control includes establishing clear lines of authority that facilitate the communication and distribution of relevant information and management of quality issues.

In **Section 7.1.0 TPL Services Overview** as well as throughout multiple scope of work proposal sections, we have addressed project reporting, required project communications for each scope of work, issue/complaint escalation and notification approaches, outreach and education activities, and other general stakeholder engagement communications and techniques. For the Communication Plan, this information will be aggregated and input into the Communication Matrix for distribution with our Communication Management Plan.

Our team's assigned Account Manager, Michelle Hayes, will serve as the single point of contact for this engagement and will facilitate the Communication Plan for our Project team as well as to identify any action required by BMS for the contract.

7.3.1.5 Acceptance Criteria (App 1, PM005)

HMS affirms that the Communication Plan deliverable will meet the acceptance criteria established between BMS and HMS. During project initiation, we will work with BMS to identify and document all acceptance criteria and be prepared to adjust our communication plan accordingly.

7.3.2 Documentation Management Plan

7.3.2.1 Documentation Management Plan (App 1, PM006–PM009)

The Documentation Management Plan, which HMS will provide as part of the overall Project Management Plan (PMP), will describe how we will manage the various documentation elements that are integral to all aspects of the project from implementation to operations to future CMS Certification for BMS. The plan identifies not only the documentation required for the project, but also the process and procedures used to manage the documentation throughout the project lifecycle. It will cover the storage, transmission, management, and disposal of project information.

Managing project-related documentation is an important component of our project and operations management approach. Centrally storing project management documentation and other materials and making it available to all authorized stakeholders helps ensure we fulfill the project requirements successfully. This approach also establishes traceability associated with the activities completed, who did them, and when they occurred. Because documentation lays the foundation for quality, traceability, and history, it is important that documents are well arranged, easy to read, and easily accessible. HMS utilizes our internal service management suite, powered by the ServiceNow™ Project Portfolio Management application, to store and manage project-related documentation. This tool provides the tracking necessary to ensure we are properly managing and storing the correct information for the project.

Documentation Types

Throughout the course of providing the TPL Services, HMS develops, uses, and distributes a wide variety of documents. These are used both internally and externally, as appropriate. For example:

- **Internal HMS Project team and other staff** may leverage user guides, job aids and other training documents, standard operating procedures, operations manuals, project management documents, etc.

- **BMS and other project stakeholders** may use user guides, job aids and other training documents, knowledge transfer documents, status and other project reports, meeting notes, acceptance criteria, project deliverables, project management documents, etc.
- **MES Certification team/System Integrator(SI) -** Artifacts and system documentation are critical components of the MES Certification process. As explained below, HMS is prepared and will remain flexible to support BMS as they undergo MES Certification. At the appropriate time, we will present artifacts and other documentation we have already prepared and have stored as part of the CMS Certification process that we are currently undergoing with NM, VA and WY.

CERTIFICATION DOCUMENTATION

We have produced extensive documentation and deliverables to serve as artifacts for CMS' review. This documentation will be an excellent starting point for BMS in the effort to achieve CMS Certification.

In addition to the MITA 3.0 architecture framework, CMS has introduced a Medicaid Enterprise Certification Life Cycle (MECL) methodology for the certification process. The MECL includes four lifecycle phases and three types of certification milestone reviews, each with specific documentation requirements. The review cycles and required documentation may be iterative until full compliance is achieved.

- CMS publishes and maintains the MECL along with the certification checklists, which contain the business-centric requirements that Medicaid systems must have to ensure alignment with MITA 3.0 and the associated standards and conditions. The newest version of the toolkit is v2.3.
- Our team will provide all required artifacts and substantiating documentation for the TPL Services Project to support the CMS Certification process. A few examples of artifacts include the:
  - Project Management Plan,
  - Security Plan (and related policy documentation)
  - Test Plan
  - Training Plan

We will help the State obtain optimal federal funding and enhanced matching funds through achieving CMS certification by providing timely and accurate documentation needed for the MES Certification process. We will support BMS in providing information and documentation for other oversight agencies, as required.

DOCUMENTATION ACCESS AND STORAGE (REPOSITORY)

Access to documentation, both internally and externally, will be by authorized users only, on a need-to-know basis, and through role-based access. Having a central repository that can be accessed by our Project team will allow us to efficiently provide documentation to authorized BMS stakeholders, upon request. In **Exhibit 7.3-2**, we provide an example matrix showing some of the deliverables HMS will make available to BMS during the project and where we plan to store them internally.

Exhibit 7.3-2 Sample - Project Monitor and Control Deliverables
We will store deliverables during the project and make them available to BMS.

Document	Output Media	Delivery Frequency	Storage Location
DD01 HMS BMS Project Kick-off	Microsoft® PowerPoint®	One time	ServiceNow

Document	Output Media	Delivery Frequency	Storage Location
DD01 HMS BMS Project Kickoff Meeting Notes	Microsoft® Word	One time	ServiceNow
D067 Project Schedule	Microsoft® Project PDF	Biweekly – During Implementation	ServiceNow
Changes made to the Project Schedule (submitted with the Project Schedule)	TBD	Biweekly – During Implementation	ServiceNow
D068 Project Status Agenda	PDF	Monthly	ServiceNow
D069 Risk Register/Exception Plan	CMS Risk Template	CMS Certification Milestone Reviews	ServiceNow
ID071 Initial Requirements Traceability Matrix (RTM)	Excel®	TBD	ServiceNow
D070 Interim Requirements Traceability Matrix (RTM)	Excel	TBD	ServiceNow
D070 Final Requirements Traceability Matrix (RTM)	Excel	TBD	ServiceNow
D072 Updated Training Management Plan	Template	With any revisions to materials or approach	ServiceNow
D073 Contract Monitoring Overview (Risks, SLA's, Invoicing)	PDF	By 10th of each month	ServiceNow
D024 Project Procedures Report	IRS Template		ServiceNow

DOCUMENT MANAGEMENT AND VERSION CONTROL

Document management is a framework that facilitates an easy, yet secure, flow of essential information across an organization. Two hallmarks of a solid documentation management plan are organization and version control. An organized system, along with version control protocols, helps securely maintain and keep track of important documents, speed up workflows, improve communication, and ensure accuracy.

VERSION CONTROL TABLE

In some cases, it may also be appropriate for us to use a version control table. A version control table provides further details of what changes were made to an item, when, and by whom. This table must be updated each time a change is made to the document. As shown in **Exhibit 7.3-3**, is a typical version control table details the following:

- New version number
- Purpose of the change or the change itself
- Person making the change
- Date of the change

Exhibit 7.3-3 Sample Version Control Table
A version control table provides further details of what changes were made to an item, when, and by whom.

Version Control No	Purpose/Change	Author	Date
1.0	Update File Layouts	Jane Doe	12/5/2020
2.0	Change deliverable requirements	Jane Doe	12/15/2020

7.3.3 Staffing Management Plan

7.3.3.1 Staffing Management Plan (App 1, PM010)

In **Section 4.0 Project Organization and Staffing Approach**, we provide our Initial Staffing Plan for BMS that summarizes our approach for how we will supply knowledgeable, skilled, and experienced staff for the TPL Services project as well as introduce our proposed key staff.

The Staffing Management Plan supplements the Project Management Plan (PMP) and formalizes HMS' approach and strategy for providing and managing the qualified resources we will assign to the BMS TPL Services project. We also describe the Project team roles, responsibilities, and reporting structure that will support the project and operations. We affirm the HMS Project team staff will be adequately trained and have a working knowledge of system operations prior to starting on the project.

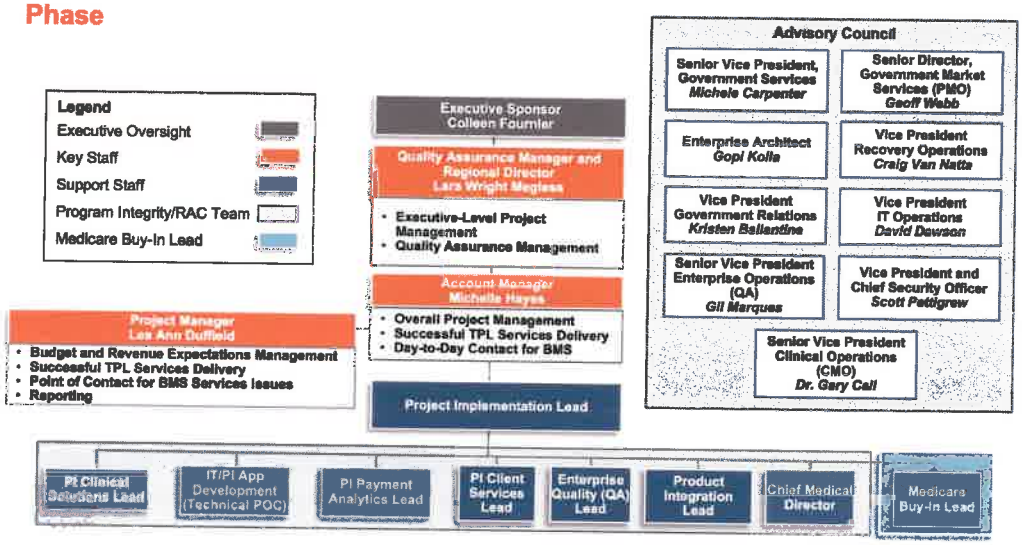
In this section, based on the requirements in RFP Appendix 1: Detailed Specifications, we describe our Staffing Management Plan. This Plan will be a living document reviewed at least annually and updated, as needed, to account for additional resources required or replacement of key staff.

7.3.3.2 Organizational Charts (App 1, PM011 and PM014)

Our final Staffing Management Plan will include organizational charts for each phase of the project. In **Exhibit 7.3-4**, we have provided again our initial organizational chart for each phase of the project – Implementation phase and Operations phase— for immediate reference. These organizational charts show the key staff required to support the project, along with a summary of their individual high-level Project team responsibilities.

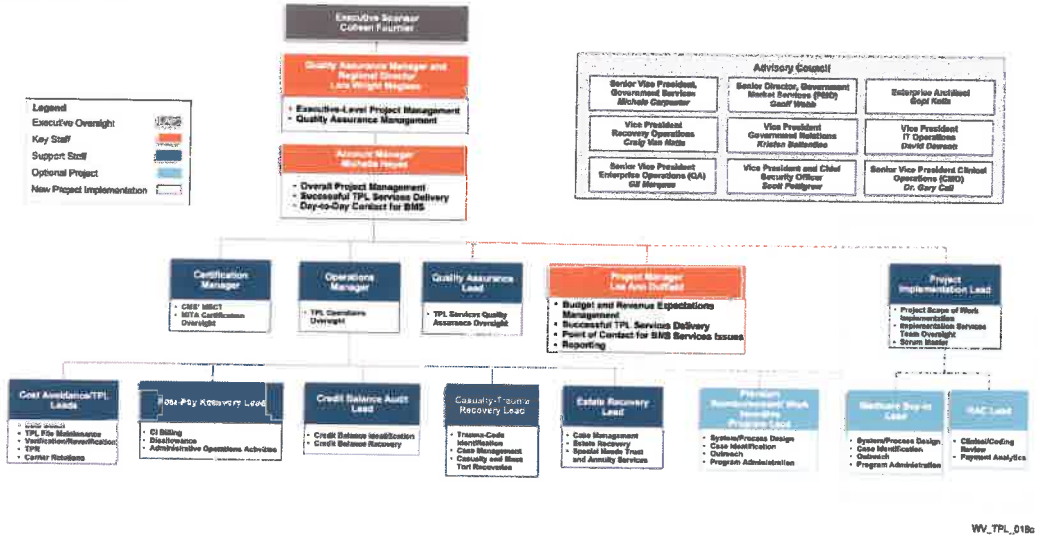
Exhibit 7.3-4 HMS Project Team Organizational Charts
Our organization is shown by Implementation and Operations project phases.

Implementation Phase



WV_TPL_017c

Operations Phase



WV_TPL_018c

HMS does not rely on subcontractors or vendors to complete our core processes, and all proposed Project team staff, across both organizational charts, are located offsite. As per Addendum 4 of the RFP, we affirm that key staff, and other necessary resources, are available to be onsite for monthly meetings and ad hoc onsite assistance, with advanced notice, at no additional cost to BMS. Our assigned Project Manager, Lea Ann Duffield, is local to Charleston, WV. Our proposed key staff, as well as our entire Project team, will continue to fulfill their project management and quality assurance management responsibilities with maximum effectiveness, standing ready to meet with BMS personnel onsite in Charleston, as needed.

HMS' approach to project management includes establishing clear lines of authority that facilitate the communication and distribution of relevant information and management of daily operations. The proposed HMS Project team for BMS, shown in our organizational charts, represents distinct lines of authority between and among the divisions that will perform the work, together with the primary reporting relationships within the HMS organization.

Beyond our Project team organizational structure and regardless of staff location, HMS consistently assures the quality and timeliness of our work. Quality Assurance (QA) serves as the foundation of HMS, producing a "culture of excellence" where affirmations of high-quality services and results define our success. We have an established QA program for continuous monitoring and improvement of all HMS operations. We have assigned a quality assurance lead role to our BMS Project team. As described further below, this role will be responsible for overseeing end-to-end QA and providing a defect-free environment for the proposed solution and key deliverables. In addition to our QA program, we verify quality and timeliness of our work through numerous other measures. As detailed in **Section 4.0 Project Organization and Staffing Approach**, these include:

- **Project Governance.** Our Project team for the BMS engagement ultimately reports to the HMS Executive Leadership team, which governs HMS and our business activities and assumes overall responsibility and accountability for our organization. This approach allows for quick communication and/or escalation of any issues or operational concerns to the highest levels of the company for resolution. Our project governance structure includes Michele Carpenter, Senior Vice President, Government Services, who will meet regularly with the Project team to monitor status and aid in strategic planning to improve our efficiency.
- **Executive Sponsor.** Reporting to Michele Carpenter, our assigned Executive Sponsor for the BMS project, Colleen Fournier, Vice President, Government Services, is the designated individual responsible and accountable for the completion of each component and deliverable of the RFP. She will work closely with the HMS Project team and BMS to supervise operations and achieve project goals.
- **Key Staff.** The success of BMS' TPL Services project relies on the oversight, direction, and support from our highly qualified and stable Project team of key staff who are accountable for the performance of designated areas for the duration of the contract. These individuals include Michelle Hayes, Account Manager; Lea Ann Duffield, Project Manager; and Lara Wright Megless, Quality Assurance Manager and Regional Director. These individuals will

lead our efforts to help ensure all TPL, and other services, implemented and administered for the State, meet exacting standards for quality as defined by BMS, HMS, and the industry overall.

7.3.3.3 STAFFING FOR OPTIONAL SERVICES (APP 1, PM024)

In the organizational charts referenced previously and provided in **Section 4.0 Project Organization and Staffing Approach**, the HMS Project team will support the optional services requested as well.

All key staff and many of the support staff performing work for BMS today will continue in their roles as part of the proposed HMS Project team under the new contract. This includes the staff that will continue to administer and support the existing optional services for BMS—the Premium Reimbursement program and Work Incentive program.

For the new optional services, the RAC program and Medicare Buy-In program, we have determined all proposed roles that will support these scopes of work can be fulfilled by existing HMS staff from our existing employee base having the appropriate qualifications. Our staff members currently operate similar services for other state Medicaid agency clients across the country and can easily transfer solution knowledge and expertise, skillsets, and experience to quickly ramp up and support the Project team for the new BMS contract.

7.3.3.4 PROJECT TEAM ROLES, RESPONSIBILITIES, AND SKILLSETS (APP 1, PM012 , PM013, PM015)

In this section, we provide an overview of the staff required for each phase of the project, including a description of the roles, responsibilities, and general skillsets associated with each position noted on the organizational charts—for both key staff and support staff. For key staff, we have also included a brief summary of the experience that qualifies them for their role on this project. **Exhibit 7.3-5** presents this information, by function and project scope area. It is assumed that each position on our Project team organizational charts is filled by just one individual. The time allocation percentages for each role below are assumptions, based on projects of similar size and scope as BMS' project.

In our final Staff Management Plan, we will include a detailed resource calendar that includes this information as well as the estimated start date for each role and length of time required of each person for the project.

Exhibit 7.3-5 HMS Project Team Resources for BMS

Our proposed Project team includes the right roles with the right skillsets that can successfully fulfill the tasks required for the project.

Scope Area: Project Management		
Role	**Contract Phase**	**Percentage of Time Allocated to Project**
Executive Sponsor	Implementation; Operations	5%

Primary Job Duties

- Provides executive oversight for the BMS TPL Services contract, with ultimate accountability and responsibility for completion of each component and deliverable of the RFP
- Monitors contract requirements and detailed Project Work Plan to confirm ongoing compliance with the contract and project objectives
- Addresses and resolves service challenges to fulfill service goals
- Applies industry knowledge to help Medicaid clients and CMS establish effective payment accuracy practices
- Authorized to commit resources for the ongoing success of contract operations

Skill Sets

- Excellent management, decision-making, analytical, and problem-solving skills
- Prior experience providing oversight of government agency contracts, including TPL
- Background in and working knowledge of Medicare and Medicaid healthcare programs

Scope Area: Project Management (Key Staff)		
Role	**Contract Phase**	**Percentage of Time Allocated to Project**
Quality Assurance Manager and Regional Director	Implementation; Operations	25%

Primary Job Duties

- Applies in-depth understanding of the WV Medicaid and WVCHIP programs as well as regional knowledge and expertise to provide senior-level project management of HMS' services to the State
- Uses lessons learned and best practices in other states to improve overall services and results for BMS
- Provides quality assurance management and general project guidance

Skill Sets

- Prior experience managing large-scale cost containment and program integrity services for HMS on behalf of our Medicaid client
- In-depth understanding of Medicaid operations and the application of best practice TPL services to maximize recovery and cost avoidance value
- Extensive TPL and program integrity expertise across all scopes of work
- Proven ability to apply robust payment accuracy solutions, develop and implement new and enhanced services, and resolve issues to the satisfaction of the State

Qualifying Experience

- Current Quality Assurance Manager for the BMS TPL Services contract, providing regional oversight for HMS' delivery of comprehensive TPL services for WV Medicaid
- 8+ years of experience providing Quality Assurance management and oversight of large-scale cost containment, program integrity services, and TPL services for multiple states
- Expert knowledge in all proposed scopes of work
- In-depth understanding of Medicaid operations and the application of best practice TPL services to maximize recovery and cost avoidance value

Scope Area: Project Management (Key Staff)		
Role	**Contract Phase**	**Percentage of Time Allocated to Project**
Account Manager	Implementation; Operations	50%

Primary Job Duties

- Serves as primary liaison and point-of-contact for BMS account
- Overall project management
- Directly oversees the entire HMS Project team and delivery of all TPL services work performed under the new contract

- Successful TPL Services delivery
- Day-to-Day Contact for BMS

Skill Sets

- Account management of large-scale cost containment and program integrity services
- In-depth understanding of Medicaid operations and the application of best practice TPL services to maximize recovery and cost avoidance value
- Excellent communication, analytical, customer service, decision-making, and problem-solving skills

Qualifying Experience

- Current Account Manager on the BMS TPL Services contract with direct responsibility for successful delivery of HMS' comprehensive TPL services for WV Medicaid; accountable for $8+ million in annual recoveries and $160 in annual savings for the BMS TPL project
- 7+ years of experience providing TPL services for other state contracts for HMS on behalf of Medicaid members
- Demonstrated ability to manage complex projects and daily project operations, with a high level of skill, to monitor and ensure all services and deliverable fulfill client requirements

Scope Area: Project Management

Role	Contract Phase	Percentage of Time Allocated to Project
Project Manager	Implementation; Operations	50%

Primary Job Duties

- Budget and revenue expectations management
- Successful TPL Services delivery
- Point of contact for BMS service issues
- Reporting

Skill Sets

- 4+ years of related work experience required, managing people and processes preferred
- Prior large-scale client project management experience, in a similar capacity required
- Healthcare and/or technical background preferred
- Bachelor's degree required; Master's degree preferred
- Background in managing data and reporting preferred
- Excellent communication, analytical, customer service, decision-making, and problem-solving skills

Qualifying Experience

- Current Project Manager on the BMS TPL Services contract, working with internal HMS operations teams and supporting HMS' delivery of comprehensive TPL services for WV Medicaid
- 6+ years combined experience in the healthcare and Medicaid industry, including project management activities
- In-depth understanding of Medicaid operations and the application of best practice TPL services to maximize recovery and cost avoidance value

Scope Area: Certification

Role	Contract Phase	Percentage of Time Allocated to Project
Certification Manager	Operations	5%

Primary Job Duties

- Serves as primary interface between HMS, BMS, and other stakeholders, as required
- Ensures HMS' proposed solution meets the CMS Certification level and MECT requirements specified by BMS
- Coordinates the efforts of team members across multiple departments
- Provides oversight and management of the CMS Certification process on the HMS side, from discovery through development and artifact collection and maintenance
- Coordinates communication and other CMS Certification-related efforts with all appropriate stakeholders
- Ensures all artifacts are gathered to support RFP requirements, test cases, and six months of production data

Skill Sets

- Prior experience leading CMS Certification efforts for large, complex state agency projects; for HMS preferred
- 10+ years of related project management experience; excellent communication, team-building, and relationship skills
- Healthcare-related and/or technical certification preferred

- Extensive MMIS knowledge; expertise in state agency MMIS conversions
- Bachelor's degree required; Master's degree preferred

Scope Area: Operations

Role	Contract Phase	Percentage of Time Allocated to Project
Operations Manager	Operations	5%

Primary Job Duties

- TPL operations oversight
- Operations owner for all HMS' TPL service lines
- Oversee the teams responsible for successful delivery of the TPL scopes of work activities

Skill Sets

- Operational management experience supporting project teams
- 10+ years of related work experience with 8+ years managing people and processes
- Operational management experience supporting project teams preferred
- Healthcare background and technical experience preferred
- Bachelor's degree required; Master's degree preferred

Scope Area: Quality Assurance

Role	Contract Phase	Percentage of Time Allocated to Project
Quality Assurance Lead	Implementation/Operations	5%

Primary Job Duties

- Oversees end-to-end quality assurance (QA)
- Provides a defect-free environment for the proposed solution and key work deliverables on behalf of clients
- Manages the services and the activities and teams responsible for QA across all HMS product lines
- Leads development of quality metrics and establishes standards of service
- Manages the services and results of HMS' QA analysts, business optimization project managers, and QA supervisors

Skill Sets

- Background and direct work experience performing QA services
- Experience in business process and performance improvement
- Project Management Professional (PMP), Lean or Six Sigma certifications preferred
- Bachelor's degree required; MBA degree preferred

Scope Area: Cost Avoidance/TPL Adds

Role	Contract Phase	Percentage of Time Allocated to Project
Cost Avoidance/TPL Adds Lead	Operations	5%

Primary Job Duties

- Holds responsibility for the cost avoidance product lines
- Directs delivery and operations of the automated activities related to TPL cost avoidance, including data match, insurance policy identification, verification, third party referral, carrier relations, and maintenance
- Responsible for managing the cost avoidance operations team, which
- Supervises the day-to-day efforts of the verification team specialists
- Identifies and drives enterprise end-to-end process improvements to close the gap on metric actual performance to goal

Skill Sets

- Healthcare background and technical experience, both preferred
- Healthcare-related and/or technical certifications preferred
- 7+ years of related work experience; 4+ years in a supervising role
- Bachelor's degree or equivalent work experience required

Scope Area: Post-Pay Recovery		
Role	**Contract Phase**	**Percentage of Time Allocated to Project**
Post-Pay Recovery Lead	Operations	5%

Primary Job Duties

- Manages the healthcare claims accounts receivable and recovery operations teams, and their respective day-to-day duties under the contract
- Oversees commercial insurance direct billing, provider disallowance, accounts receivables and collections

Skill Sets

- Overall Account Receivable (A/R) and operational management experience, including overseeing the activities of healthcare claims A/R teams
- Finance and supervisory experience required
- Healthcare background and technical experience preferred
- Healthcare-related and/or technical certifications preferred
- Bachelor's degree or equivalent work experience required

Scope Area: Credit Balance Audits		
Role	**Contract Phase**	**Percentage of Time Allocated to Project**
Credit Balance Audit Lead	Operations	5%

Primary Job Duties

- Oversees the specified scope-of-work Credit Balance Audit (CBA) function for HMS, including the activities surrounding credit balance identification and credit balance recovery
- Reports audit findings to the regional program director, project manager, and LDH, as required
- Manages a national CBA team of directors, managers, supervisors, and auditors, including the team of auditors who perform the work

Skill Sets

- 4+ years of healthcare billing, audit or collection and accounts receivable experience required
- 1+ years of supervisory experience required
- Medicaid experience
- Bachelor's degree or equivalent experience preferred

Scope Area: Casualty-Trauma Recovery		
Role	**Contract Phase**	**Percentage of Time Allocated to Project**
Trauma-Casualty Recovery Lead	Operations	10%

Primary Job Duties

- Oversees the Casualty Trauma Recovery team, including caseworkers, providing leadership support
- Areas of responsibility include trauma code identification, case management, Casualty and Mass Tort recoveries
- Assists in ensuring the timely management of project operations
- Focused 100% on ensuring operational effectiveness

Skill Sets

- Bachelor's degree or equivalent work experience required
- Healthcare-related and/or technical certifications preferred
- 7+ years of related work experience; 4+ years in a supervising role
- Healthcare background and technical experience both preferred
- Excellent verbal and written communication skills

Scope Area: Estate Recovery		
Role	**Contract Phase**	**Percentage of Time Allocated to Project**
Estate Recovery Lead	Operations	10%

Primary Job Duties

- Oversees the Estate Recovery team, including caseworkers for estates, Mass Tort, and Special Needs Trust (SNT); provides leadership support
- Areas of responsibility include case management, Estate Recovery, SNT, and annuity services
- Assists in ensuring the timely management of project operations
- Focused 100% on ensuring operational effectiveness

Skill Sets

- Bachelor's degree or equivalent work experience required
- Healthcare-related and/or technical certifications preferred
- 7+ years of related work experience; 4+ years in a supervising role
- Healthcare background and technical experience both preferred
- Excellent verbal and written communication skills

Scope Area: Premium Reimbursement Program Administration		
Role	**Contract Phase**	**Percentage of Time Allocated to Project**
Premium Reimbursement Program/Work Incentive Program Lead	Operations	10%

Primary Job Duties

- Directly manages the teams of specialists who perform the work for our active HIPP clients, including for WV HIPP
- Primary responsibilities encompass system/process design, case identification, outreach, program administration

Skill Sets

- Bachelor's degree or equivalent work experience required
- Healthcare-related and/or technical certifications preferred
- 7+ years of related work experience; 4+ years in a supervising role
- Healthcare background and technical experience both preferred
- Excellent verbal and written communication skills

Scope Area: Project Implementation		
Role	**Contract Phase**	**Percentage of Time Allocated to Project**
Project Implementation Lead	Implementation; Operations	20% during implementation and transition; 2% during operations

Primary Job Duties

- Handles the day-to-day tasks to adhere to the project schedule for overall success of the implemented new contract solution
- Leverages the appropriate project management approaches and methodologies agreed upon for the engagement
- Serves as the primary interface between internal/external clients and the HMS data/systems business analysis Implementation team for deployment of new products and services
- Coordinates the efforts of team members across multiple departments, including the business analyst, data mapper, and the RAC Operations team members who will participate in the implementation activities
- Manages the project deployment timeline and budget
- Develops custom project plans to ensure that requests and deliverables are met in an aggressive time frame
- Understands contract requirements vs. current capabilities gap analysis; works closely with BMS on defining project scope requirements
- Plans and monitors all project activities; manages all processes needed for successful project completion
- Oversees quality control throughout the implementation life cycle; reports all issues and milestones to management

Skill Sets

- Bachelor's degree in related field required; PMP certification preferred
- 5+ years of professional-level and related business experience with strong project management skills

- Proven ability to track and manage multiple complex projects, both internally and with client
- Prior experience with enterprise-wide deployment of system or implementation solutions
- Prior experience in client implementations in healthcare claim processing domain
- Demonstrated competence in writing detailed functional specifications

Scope Area: Recovery Audit Contractor (RAC) Services

Role	Contract Phase	Percentage of Time Allocated to Project
PI Clinical Solutions Lead	Implementation; Operations	15%; then 5% during operations

Primary Job Duties

- Participates in implementation activities with Implementation Services team to stand up RAC solution
- Leads the clinical solutions product team
- Develops clinical review concepts, optimizes the chart selection and medical record review business processes to improve P&L and scale the business for future growth
- Defines and manages the clinical solutions product strategy and roadmap
- Improves client satisfaction by partnering with HMS Account Management to provide successful delivery and ongoing support of our Clinical Solutions products

Skill Sets

- 10+ years of healthcare experience, including clinical operations
- 10+ years of leadership and supervisory experience
- Bachelor's degree required; Master's degree preferred

Role	Contract Phase	Percentage of Time Allocated to Project
IT/PI App Development (Technical POC) Lead	Implementation	15%

Primary Job Duties

- Participates in implementation activities with Implementation Services team to stand up RAC solution
- Serves as the HMS Project team technical point of contact for all IT and system-related activities
- Initiates, focuses on, and facilitates ongoing communications and information exchanges regarding telecommunications and data exchange

Skill Sets

- 10+ years in IT leadership roles specific to healthcare entities, program integrity, payor, and provider organizations
- Prior experience supporting our stated Medicaid PI and/or RAC projects
- Experience working and integrating with MMISs utilized by HMS' state Medicaid agency clients and their respective vendors
- Current, active IT/technical certifications required
- Bachelor's degree required; Master's degree preferred

Role	Contract Phase	Percentage of Time Allocated to Project
PI Payment Analytics Lead	Operations	10% then 5% during operations

Primary Job Duties

- Participates in implementation activities with Implementation Services team to stand up RAC solution
- Leads the Payment Analytics (aka "data mining") Product team
- Key areas of focus include creating new content to improve payment accuracy results for our clients
- Responsible for defining the data analytics product strategy and roadmap

Skill Sets

- 10+ years of healthcare experience, including clinical operations
- 10+ years of leadership and supervisory experience
- Bachelor's degree required; Master's degree preferred

Scope Area: Recovery Audit Contractor (RAC) Services		
Role	**Contract Phase**	**Percentage of Time Allocated to Project**
PI Client Services Lead/RAC Lead	Implementation; Operations	10%

Primary Job Duties

- Participates in implementation activities with Implementation Services team to stand up RAC solution
- Serves in the role of RAC Lead during the Operations phase of the project, assuming overall responsibility of the liaison between the RAC team and Account Manager who oversees the overall TPL Services team; ensures appropriate communication and synchronization across solutions
- Directs full, end-to-end delivery of our RAC improper payment review and recovery service through our client services team
- Focused on improving the quality of our delivery and creating an excellent client experience
- Will lead all RAC services team operations for the BMS engagement, which also includes oversight for the Research and Resolution team, the Reporting Services team, and the Provider Services team

Skill Sets

- 10+ years of experience of operations management and implementation experience
- 5+ years healthcare experience preferred; technical certifications preferred
- Bachelor's degree required; Master's degree preferred

Role	Contract Phase	Percentage of Time Allocated to Project
Product Integration Lead	Implementation; Operations	15% then 5% during operations

Primary Job Duties

- Participates in implementation activities with Implementation Services team to stand up RAC solution
- Leads and manages the overall Delivery team, ensuring successful delivery of requested RAC services for Medicaid
- Directs the PI Implementation Delivery team
- Works in conjunction with the Project Implementation Lead and Implementation Services team during Requirements Gathering phase

Skill Sets

- 10+ years of experience managing overpayment identification and recovery operations
- 10+ years of experience in applying industry-best practices to serve client solution needs
- Prior project management and solution delivery experience for large-scale, complex PI projects required
- Bachelor's degree required; Master's degree preferred
- Excellent communication, decision-making, analytical, and client relationship building skills required

Role	Contract Phase	Percentage of Time Allocated to Project
Chief Medical Director	Implementation; Operations	5%

Primary Job Duties

- Participates in implementation activities with Implementation Services team to stand up RAC solution
- Provides clinical leadership and direction for the project
- Effectively applies knowledge of the Medicaid program, and particularly the coverage and payment rules, to make review decisions regarding medical necessity, experimental/investigational status, diagnosis-related group assignment/reassignment, and quality of care
- Manages the physician recruitment process, serves as a liaison between our team and the medical community
- Participates in hearings and meetings as required
- Coordinates the services required from our Physician Panel for review activities related to the project

Skill Sets

- Relevant prior work experience in the health insurance industry, a utilization review firm, or another healthcare claims processing organization
- Experience serving as a national medical director for state-level Medicaid RAC projects (HMS preferred)
- Board-certified Doctor of Medicine or Doctor of Osteopathy
- Current, active, and unrestricted license to practice medicine in one or more United States licensing jurisdictions

- Education resulting in receipt of a Doctor of Medicine or Doctor of Osteopathy degree from an accredited university medical program
- General knowledge of the Medicaid program, particularly the coverage and payment rules

Scope Area: Medicare Buy-In

Role	Contract Phase	Percentage of Time Allocated to Project
Medicare Buy-In Lead	Implementation; Operations	15%

Primary Job Duties

- Participates in implementation activities with Implementation Services team to stand up Medicare Buy-In solution
- Oversees the specified scope-of-work Medicare Buy-In function for HMS
- Leads the day-to-day activities of the Medicare Buy-in team and serves as the primary point of contact for all program-related questions.
- Provides reports on program performance, including individual project metrics, performance by population, and testing results

Skill Sets

- Bachelor's degree or equivalent work experience required
- Healthcare-related and/or technical certifications preferred
- 7+ years of related work experience; 4+ years in a supervising role
- Healthcare background and technical experience both preferred
- Excellent verbal and written communication skills

7.3.3.5 HMS BUSINESS ANALYST (APP 1, PM018)

The business analyst role is responsible for working with designated BMS resources during implementation to capture accurate and actionable project requirements, transfer the requirements into a requirements specification document, and prepare a gap analysis for evaluation and discussion among the Implementation team. For this project, the business analyst role will be handled at two levels by our HMS organization. The business analyst provided by our Implementation Services team, led by our project implementation lead, will work with BMS on requirements gathering and analysis for the existing TPL Services solution. Meanwhile, our proposed RAC product integration and Medicare Buy-In leads will handle requirements gathering and analysis for their respective new scope-of-work areas. Altogether, these individuals will collaborate and synchronize efforts to present a single, client-facing Implementation team for BMS.

7.3.3.6 BMS BUSINESS AND TECHNICAL RESOURCES (APP 1, PM016)

As referenced in our response to **Section 7.3.5 Implementation Plan**, our HMS Project team will collaborate both internally and with BMS resources throughout both project phases, the Implementations phase and Operations phase, to support the creation of all deliverables. From our current experience and best practice knowledge, HMS recommends BMS allocate a strong mix of operations, clinical, and IT staff to help ensure successful implementation and operations of our proposed solution. We will work with BMS during project initiation to further refine the roles and exact business and technical resources required from BMS to support the creation of

all deliverables. Below, we provide a sample list of some of the client resources we have worked with on other similar projects, by phase.

- **Implementation**
  - Business
    - Project Owner (contract manager)
    - Business Decision-Maker(s)/Department Lead
    - Business SME to assist with requirement discovery and documentation of requirements
    - Project Manager
  - Technical
    - Technical SME to assist with mapping and integration
    - Certification Manager (if applicable)
    - System Administrator (from each department/division that will be involved in using the solution and supporting systems)
    - Tester
- **Post Go-Live**
  - Business
    - Project Owner (contract manager)
    - Business Decision-Maker(s)/Department Lead
    - Business Analyst
    - Project Manager
  - Technical SME
  - System Administrator

7.3.3.7 Training and Knowledge Transfer (App 1, PM017, PM019, and PM021)

As part of our overall PMP, we will develop and provide a BMS-specific Training Management Plan during the Implementation phase that will address the training needs for all users of the TPL solution. It will describe how and when the training will be developed, delivered, and tracked as well as who will deliver the training and any supporting materials. The purpose of this document is to provide a single, integrated plan that documents and tracks all training needs, timelines, and training outcomes. The plan will also allow for ongoing training during the Operations phase of the TPL Services project, supporting additional staff and stakeholder training requirements.

In this section, we provide an overview of HMS' approach to training BMS business and technical staff as well as other authorized stakeholders (e.g. providers), as appropriate, so they can utilize and interact appropriately with our proposed solution.

Our approach to training involves two concurrent paths:

- Knowledge transfer / technical training for BMS technical resources
- Business stakeholder training for users of our TPL solution

The goals of our training programs are to make sure that:

- BMS technical staff have the appropriate knowledge to support the solution and perform the functions required for their respective roles during the implementation and/or post go-live
- Other BMS stakeholder users are properly trained, can correctly access the solution-supporting systems/tools, and can accomplish the functionality needed to achieve the objectives for their role

To meet these goals, HMS provides both initial and ongoing training, as needed, throughout the life of the contract. We deliver training:

- During implementation:
  - For transfer of system and business knowledge, project management methods, and processes to relevant BMS staff
- For other project stakeholders on new scopes of work, system access and functionality, specific deliverables, updated processes, and solution enhancements
- Post Go-Live:
  - For new project stakeholders and those transitioning between project roles and phases
  - For users of new systems and/or tools as they are made available to support our solution.

Our Process for Transitioning Essential Knowledge

Not all clients have the same set-up, resources, and availability for training. Therefore, it is important to develop a training program based on each BMS' specific objectives. During a new contract term, we will collaborate with BMS to determine the project area(s) that require training and expectations regarding effectiveness assessments and results; this will be done during the Requirements-gathering phase of implementation. The HMS Project team key staff will work with BMS to determine the appropriate level of education, background review, and practical application necessary for transitioning essential knowledge to BMS technical staff and project stakeholder users. During this time, we will also identify and confirm appropriate training content, specific stakeholders, methods, and location(s). Our training programs cover four aspects:

- **Education.** The solution, how it works, and how the supporting tools/systems are integrated with client operation
- **Portal Functionality.** Portal capabilities, how to navigate the portals, and how to use portal functions

- **Material Support.** Supporting materials and reference guides that illustrate how to use the system
- **Analytical Application.** Using the portals, systems, and tools to perform role-based functions

Our training program and technical resources ensure that all BMS stakeholders, and other authorized personnel, have the knowledge and skills needed to support our delivery of successful TPL services. This includes accomplishing certain tasks such as how to:

- Access the needed systems portals and tools
- Enable and maintain secure data exchange and interfaces
- Run reports and queries
- Track/search TPL functions
- Upload documentation
- View cases or findings

Where technical knowledge transfer will typically take place throughout the Implementation phase, immediately prior to go-live, HMS will schedule web-based training (through WebEx or a similar collaboration tool) with the additional BMS technical and business resources to walk them through demos of the systems/tools that support our proposed solution. We then schedule additional training through WebEx sessions for screen share purposes. We can provide training during our onsite monthly status meetings with BMS as well.

Training Personnel

For the BMS project, our Account Manager, Michelle Hayes, supported by the other key staff, will own and oversee the entire training process from beginning to end. They will also be a major contributor to the forthcoming Training Management Plan. Michelle will gather the training requirements from BMS, as described above, and work with the designated, internal HMS subject matter experts to build the corresponding presentations and tutorials and amend any training manuals, as needed. She will deliver the training and incorporate subject-matter experts, or other HMS corporate trainers, as needed. Our key staff will make sure that each BMS project stakeholder is properly trained, can correctly access the system, and can utilize the functionality needed to achieve that stakeholder's objective.

7.3.3.8 Personnel Management (App 1, PM020)

HMS maintains a robust Human Resources (HR) Department, the mission of which is to attract, retain, motivate, and maximize the performance of all employees. As a recognized leader in career development, HMS actively cultivates the talents of employees throughout their careers at HMS. HMS' HR Department administers company hiring and termination processes as well as processes that support employee relocation.

HIRING AND TERMINATIONS

The HMS HR Department maintains a team of specialists committed to talent acquisition. These qualified and experienced staffing specialists are dedicated to targeting and attracting quality talent in a timely, progressive, and cost-effective manner that provides value to our internal clients. As described in **Section 4.0 Project Organization and Staffing Approach**, this team applies formal screening processes to ensure that we hire the right person for the right position.

HMS' HR Department also applies formal employee separation procedures, for both voluntary and involuntary terminations. Involuntary terminations require HR approval before termination to ensure consistency with HMS practices. At the time of termination, company property is collected from the employee if applicable (i.e., keys and/or access badges, computer equipment, etc.). All terminated employees are required to sign a Corporate Compliance Statement that declares their compliance with separation policies including the ongoing maintenance of data security.

STAFF RETENTION AND CONTINUITY

HMS' approach to staffing and work force management includes providing the right resources necessary to fulfill all project requirements, maintaining adequate staffing levels throughout the life of the contract, and managing attrition. Across our organization, HMS commits to using best efforts to maintain staff continuity throughout the life of the project.

We recognize the importance of maintaining staff continuity, especially for staff who serve on client project teams. Across the HMS organization, our current staff retention rate is 90.6%, whereas our proposed Project team for BMS promotes a 100% key staff continuity rate for the project going into the new contract term.

EMPLOYEE RELOCATION

When an HMS employee relocates to another state, we review state-specific laws and provide appropriate training as needed. If the relocating employee seeks financial support for the relocation, we can offer financial assistance, the amount of which is dependent on the employee's level (e.g., director, supervisor, manager, etc.).

7.3.3.9 STAFF PERFORMANCE MONITORING (APP 1, PM022)

Excellent staff performance begins with a clear definition of the roles and responsibilities for each individual staff member along with goals and regular progress assessment. We continuously monitor and evaluate performance of staff, including those who serve on the HMS Project team for the BMS project. We collect inputs for each employee's formal performance evaluation, which we provide annually along with quarterly check-ins through our established Betterworks™ performance management system described below. These evaluations look at

several key qualities, including performance of core functions, communication, time management, professionalism, contributions toward achievement of client goals, and compliance with government requirements and regulations.

We have a structured performance improvement process in place to identify and promptly address any deficiencies or issues with employee performance (including any issues raised by the State) with regard to work quality, behavior, accessibility, compliance, or other performance area. When an issue is found, we will take immediate steps to resolve any performance problems, including coaching, training, reassignment, or removal from the project.

Our assigned key staff members will regularly monitor the effectiveness of the HMS Project team members to ensure ongoing successful delivery of the TPL services. They will make sure the other support staff and their respective teams comply with all established control processes including deliverable submission procedures, internal team and BMS signoff procedures, and other established procedures. We will utilize our project plan and other project management tools to monitor the performance of our HMS Project team, and the effective delivery of our TPL Services. During all project phases, our Project team members work together closely, communicating frequently to share resources including lessons learned. During these communications, any issues identified regarding team member performance are immediately shared with one or more of the key staff or leads to address. Also, as part of ongoing quality assurance processes, the effectiveness of project team member efforts and results are assessed, and any issues identified are quickly resolved.

As mentioned earlier, HMS uses a cloud-based performance management system called Betterworks that is deployed across our entire organization. Betterworks is a quarterly-based system designed to encourage transparency and frequent check-ins between the employee and their manager. The system supports staff performance tracking, monitoring, and performance assessment.

Betterworks helps drive individual accountability by keeping staff actively involved in their development and performance assessments. Employees and supervisors use the tool to establish goals, monitor progress, and facilitate multiple check-in conversations per year to discuss performance. Through objectives and key results that roll up into quarterly and annual reviews with formal supervisor check-ins, Betterworks helps to determine if staff members are meeting or exceeding expectations. Ongoing monitoring and more frequent check-ins help keep staff performance on track.

The key staff for BMS will leverage Betterworks and other established performance assessment methods to ensure that each Project team member is best **fulfilling** his or her respective TPL service responsibilities on behalf of the State.

7.3.3.10 Succession Planning, Staff Replacement, Staff Backup (App 1, PM023)

We will make sure the HMS Project team key staff named in this proposal will be available at contract award. We recognize that attrition over time can occur. If an HMS Project team member should need to exit the contract due to attrition issues such as staff promotions, retirement, or in an unforeseen circumstance in which a team member is unable to fulfill his or her responsibilities, we will quickly realign our staffing resources to fulfill contract needs. This plan ensures we continue to meet our estimated project timeline and deliverables for BMS, with little-to-no impact. As part of our Staffing Management Plan, we will provide contingency plans for the replacement of staff in the event of loss of named Project team key staff or any support staff.

Given that TPL-related activities are the foundation of our service delivery to public healthcare agencies, we have ample functional overlap within our existing organization to identify an interim or permanent replacement. If any project team member leaves, the impact on the overall engagement will be minimal, until we are able to permanently backfill the position. We can also engage time-tested recruitment practices to replace staff rapidly as to support existing project staff during the contract term. This functionality will reduce overall risk and contribute to successful contract performance. In **Section 4.0 Project Organization and Staffing Approach**, we described several proven methods HMS uses generally to handle Project team turnover and staff replacement.

Additionally, our proposed key staff is engaged at all levels of service delivery throughout all phases of contract operations, which aids in HMS succession planning. The value HMS provides to BMS with all three proposed key staff working so closely together is that several individuals will have deep knowledge and fully understand BMS' needs end-to-end. Having several key resources multi-trained in the same environment will mitigate the risk of a single-thread staff resource. We commit to ensuring that all of our Project team key staff for BMS are prepared to perform necessary tasks, and they will apply their expertise and skills to fulfill BMS' service requirements.

7.3.3.11 Staffing Management Plan Compliance (App 1, PM025)

HMS' Staffing Management Plan will support the project and operations as well as enable us to use the HMS Project team in a manner that complies with requirements described in RFP Appendix 1: Detailed Specifications and any RFP narrative.

7.3.4 Change Management Plan

7.3.4.1 Change Management Plan (App 1, PM026–PM031)

HMS uses a structured approach to change control which helps ensure successful implementations and changes, while mitigating any disruption to service and operations. HMS' Change Management process establishes an orderly and effective procedure for tracking the submission, coordination, review, evaluation, categorization, and approval for release of all changes to the project's baselines.

In this section, we provide a summary of our approach and forthcoming Change Management Plan, including a description of our methodologies, tools, enhancements and modifications, and processes used to manage and document changes to the system.

The HMS Project team has a standard practice for managing and implementing change, which we tailor to individual client projects as appropriate. With change management, our goal is to ensure any negative effects of change will be minimized. To support our practice, we maintain a Change Management Plan, which helps provide direction for managing our change control process and documents the roles and responsibilities of the various resources involved in the process. The Change Management Plan is a document that defines the activities, roles, and tools used to manage and control change during each stage of the BMS TPL Services project. It also helps minimize the impact a change may have on the project and stakeholders involved.

Our Change Management Plan, which will be provided to BMS along with the overall Project Management Plan (PMP), will align with the change management requirements that are provided in RFP Appendix 1: Detailed Specifications and include the elements noted in RFP Appendix 2: Deliverables and Milestones Dictionary.

We provide a high-level overview of our forthcoming Change Management Plan below.

Methodologies

HMS' methodology for handling change requests is structured and based on industry standards and internationally recognized guidelines, such as the Project Management Institute® (PMI) principles, and the Centers for Medicare & Medicaid Services (CMS) guidelines for change management. HMS also adheres to industry standards and frameworks to ensure that a detailed change management and release process is followed, such as:

- **Information Technology Infrastructure Library (ITIL)** which is a framework of best practices for delivering IT services that focuses on aligning IT services with business needs.
- **HITRUST CSF,** a certifiable framework that provides organizations with a comprehensive, flexible, and efficient approach to healthcare regulatory compliance and risk management. It brings together other compliance frameworks such as HIPAA, NIST, PSI, and ISO.

We follow the high-level change management protocols, introduced below in **Exhibit 7.3-6**, to ensure we have fully analyzed and documented each change request, and then verify that we have identified all potential impacts and obtained approval before we begin work.

Exhibit 7.3-6 HMS' High-Level Change Management Protocols
We ensure we fully analyze and document each change request and identify/verify all potential impacts before beginning work.

Step	Description of Protocol
Step 1: Define Scope of Change	Effective planning, documenting, and agreement on requirements is a vital component to a successful change control process and ensures that we are meeting the goals of the stakeholders while avoiding scope creep and mitigating risks. During project Implementation and Operations phases of this project, we will ensure that all changes are thoroughly defined, vetted, including impacts and risks, and documented before we begin development.
Step 2: Develop Expected Outcome and Acceptance Criteria	Understanding BMS' goals and outcomes for any change request will help ensure HMS meets all expectations. Developing an agreement on the acceptance criteria for each change requests helps to ensure we meet the required business objectives.
Step 3: Document and Validate the Full Scope of Work (Create the Work Breakdown Structure)	HMS develops the Work Breakdown Structure (WBS) from the documented change request. We start with the desired end-state goals or business objectives in order to identify the work that will be required to be successful. Coordination with all stakeholders involved in prioritizing and queuing projects is an essential component of the WBS.
Step 4: Manage Change	After defining the scope of change, obtaining agreement and acceptance criteria and developing the Work Breakdown Structure, our foundation is laid for a successful change. The final step is to manage the project according to the Change Request Plan and ensure all final outcomes are timely and meet the business objectives, while mitigating any risks along the way.

TOOLS

With our change management process, we leverage several commercial off-the-shelf tools.

- Our documented change approval workflow includes proof of successful testing by using the ServiceNow IT service-management tool.
- Changes in the applications used to support our projects adhere to a rigorous release-management process that uses the CA Technologies® Harvest Software Change Manager tool to manage code deployments. This is a software tool used for configuration management (revision control, SCM, etc.) of source code and other software development assets.
- Our Project team uses Smartsheet, a software package designed for collaboration and work management. Our team uses it to assign tasks, track project progress, manage calendars, share documents, and manage other work, using a tabular user interface.

Additionally, HMS leverages several internal project management tools to also help track and manage change, such as the Change Management Log, which is a document used by our Project team to log and track change requests throughout the life of the project.

ENHANCEMENTS AND MODIFICATIONS

Regardless of whether changes are an enhancement, modification, or new change, our Change Management Plan will incorporate the documents and methods by which we will coordinate changes and incorporate them into the Project Management Plan and schedule. The Change Management Plan will also include details on Configuration Management, as related to changes or updates (e.g. new features, enhancements, modifications) to the technical systems, software and hardware, that support our solutions.

Our Software Development team maintains all changes to systems and software through a revision-control system that allows us to track all changes to system files and source codes. Once the HMS Project team approves a change, our Software Quality team fully tests all modifications to the system. This team ensures that we only release stable software to production environments for our clients' data. Through this process, we continually make sure that the system meets the evolving needs of our clients.

PROCESSES TO MANAGE AND DOCUMENT CHANGES

HMS uses a structured and repeatable process to identify, log, and assess scope changes. This includes an impact analysis, plus an evaluation and priority status assigned that is based on the type of change and any associated risk. Our Change Management process incorporates:

- A process that evaluates and prioritize changes based on the type of change and its associated risk level
- In-place processes to handle urgent changes with appropriate oversight and documentation
- A Change Advisory Board (CAB), comprising approvers from the Infrastructure, Security, and Application Development teams, oversees and approves changes based on the type of change and its associated risk level.
- Documented change approval workflows and a rigorous release-management process.

HMS uses an internal Change Control Board (CCB) and will work with BMS to create a joint, project-specific CCB by identifying a group of stakeholders responsible for approving or rejecting changes to the project baselines. The CCB will consist of a cross-functional group, coordinated by HMS and responsible for evaluating change requests, priority, cost/benefit, potential impacts to other systems or processes, and implementation schedule.

HMS understands that there may be changes based on State or federal regulations and agrees to follow the change request (CR) process for all changes. There will be occasions where an emergency CR is brought before the CCB. On those occasions, the CR process will be expedited.

Each change request is tracked and monitored through completion and the HMS Project Manager will discuss the status during the weekly project status meetings. When HMS receives a system change request, we document and review the request to identify gaps between what is requested and the current operations. We will tailor the change management process flow to

complement BMS'. A typical process we may use to document a CR is described in **Exhibit 7.3-7**.

Exhibit 7.3-7 Typical Change Management Process Flow
During implementation, HMS will tailor the Change Management process flow to complement BMS'.

Step	Description
HMS creates CR request	HMS completes a Change Request Form and sends the completed form to the HMS Change Manager.
Enter CR into BMS project tool (Enter Status)	The HMS Change Manager logs the CR in the project tool, as determined through collaboration with BMS. The CR's status is updated throughout the CR process as needed.
Evaluate CR - CCB	The CR is evaluated through the Change Control Board, where it is prioritized, and a determination is made whether it is a needed change. If the change is needed, HMS takes the CR and provides an impact analysis with the estimated level of effort to process and develop a proposed solution.
Evaluate Change Effort – CCB	The Change Control Board evaluates the benefits vs. cost for the change and approves or denies the request.
Authorize	If approved, the change is authorized by Project Management from HMS and BMS.
Implement	Once approved, the change is developed and moves through the project processes, as follows: ◉ Classify the change with regards to priority, impact and risk ◉ Conduct a security impact analysis ◉ Create, review, and approve a functional design ◉ Create a technical specification, including the ability to "roll back" to the existing configuration should it become necessary ◉ Code and test the change ◉ Approve test results (once the change passes the user acceptance criteria) and assign the change to a release ◉ Modify all artifacts impacted by the change ◉ Coordinate and schedule planned changes with the client ◉ Verify security functionality after the changes are implemented Regardless of the type of change request, source code for completed changes undergoes unit, regression, and system testing. We assign a version number to each change for tracking purposes. After unit testing, we move the code into a test environment and follow a promote-to-production process that has built-in controls for proper release management.

We require approval from the business owner or user, and the production control staff to confirm we have properly implemented the change. We then notify the business owner that the change has been moved to production, and the change is closed. Our Change Management team publishes all release documentation, making it accessible to our business owners and users. Once approved, HMS makes changes to our production system during non-business hours to minimize interruption to operations. Once we promote a change to production, users may conduct post-implementation testing to ensure we applied the change correctly in the production environment.

7.3.5 Implementation Plan

7.3.5.1 Implementation Plan (App 1, PM032)

The purpose of the Implementation Plan for BMS is to ensure a smooth transition to the new solutions requested in this RFP. Our Implementation Plan will provide the comprehensive approach HMS plans to take to roll out our proposed solution for BMS at Go-Live and will define and document the steps required to conduct the cutover from the existing solution to the new solution. We understand the importance of creating a comprehensive and effective Implementation Plan that identifies existing and new scope of work elements as well as provides key project tasks, task owner, milestones, and estimated durations.

Implementation Plan development and ultimately implementation success, is heavily dependent on requirements gathering and design conversations requiring collaboration and commitment among both HMS and BMS project stakeholders. Upon contract award, we will meet with BMS team members and hold design sessions internally to finalize and submit the Implementation Plan, within an agreed-on timeline.

In this section we provide our general approach to implementation and describe some of the components that will be included in our forthcoming Implementation Plan. For an immediate reference to anticipated implementation activities, please refer to our Initial Work Plan/Project Schedule in **Section 5.0 Initial Work Plan**.

For the implemented services, our approach focuses on identifying changes and gaps in our current processes, data files, business requirements, service-level agreements, security and privacy, system configuration, management of interfaces, reporting, staff training, and performance monitoring. In a new contract term, we are ready to continue to provide the current scope of work services as well as fully implement in-progress solution enhancements.

HMS has deployed all TPL Mandatory Services and two of the TPL Optional Services requested in the RFP. As a result, we have the appropriate IT infrastructure, connectivity, systems, and customized operational processes in place that are generating valuable results for WV.

Our Implementation Plan also provides for standing up the two TPL Optional Services that are not currently in production for BMS—Recovery Audit Contractor (RAC) Services and Medicare Buy-In Services. As the prior vendor delivering the Medicare Buy-In service for BMS, we have existing infrastructure, knowledge, and other resources available for this scope of work that will drive a more efficient and shorter implementation.

We Leverage Multiple Project Management Models

Within our project management methodology, we follow two project management models that are used to best meet the needs of our client projects.

- **Waterfall model.** Overall, our implementations typically follow the traditional Waterfall model, with activities occurring in sequential order for a detailed sequence of operations or steps that should be carried out to deliver the new solution. We leverage Lean project management tactics, which involves focusing on the steps that add essential value to the project while eliminating redundant and inefficient activities. This methodology allows us to reduce our implementation time and improve quality. Our HMS Enterprise Operations team provides guidance to our business-process engineers to improve our focus on Lean initiatives across our processes continually.
- **Agile model.** During the Implementation cycle, our IT personnel/developers assigned to BMS' project will follow the Agile model, working in scrum teams and using "sprints" to perform work in tandem and more rapidly complete tasks using:
  - **Agile release planning**, where the focus will be on the new functionality (not yet in production), which could be for a feature or an entire solution. By engaging the State in the up-front and periodic release plan, we help ensure release plans account for multiple iterations to determine when each release will be delivered.
  - **Sprint/iteration planning**, where the new functionality is developed in sprints. The goal of sprint planning is to determine the features and functionality that will be included in the next iteration. Before each sprint begins, HMS will hold sprint planning meetings with product owners and development team members. We welcome the participation of BMS stakeholders in these sessions. The user stories and backlog are reviewed to determine the tasks that can be completed during the sprint. These plans deliver a finer level of detail (compared to the high-level release plan), including which tasks are to be performed by which team members and how long each task will take.

Our Implementation team employs both models, as appropriate, based on client or project needs.

SMARTSHEET – FOR BOTH WATERFALL AND AGILE PROJECTS

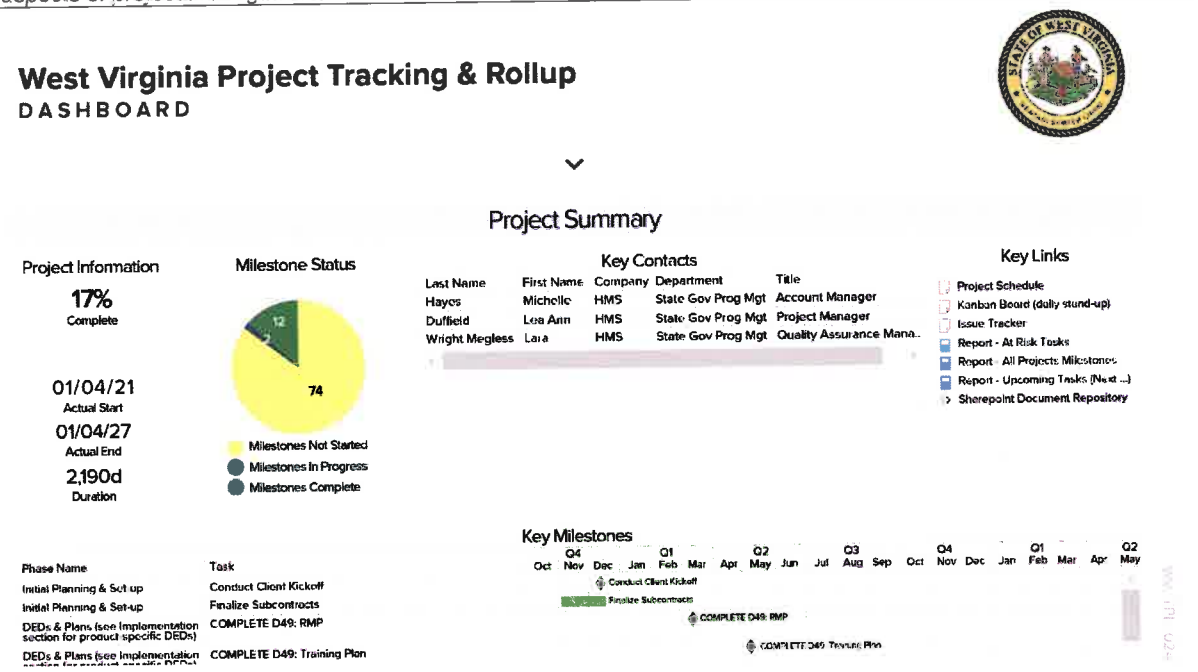
To manage the implementation, the HMS team will leverage Smartsheet, a leading work execution platform that has real-time work management features, collaboration, and automation tools. Organized within a WV workspace, HMS would leverage Smartsheet to assist with the management of key aspects of project management including:

- Project scheduling
- Requirements management
- Issue and risk tracking
- Action items and decisions tracking

Users are presented with a familiar and easy-to-use spreadsheet-like interface. Our clients have found Smartsheet to be very intuitive and efficient in managing implementation activities. HMS uses it to manage both Waterfall and Agile projects, product launches, sprint planning, and more. Being able to attach files, share sheets, receive automated update requests, export sheets into Excel, email, and print, makes Smartsheet an easy-to-use and collaborative tool that

enhances HMS' ability to implement on time. We provide a sample Smartsheet dashboard we will use with the BMS project in **Exhibit 7.3-8**.

Exhibit 7.3-8 Sample Smartsheet Dashboard
Organized within a WV workspace, HMS would leverage Smartsheet to assist with the management of key aspects of project management.



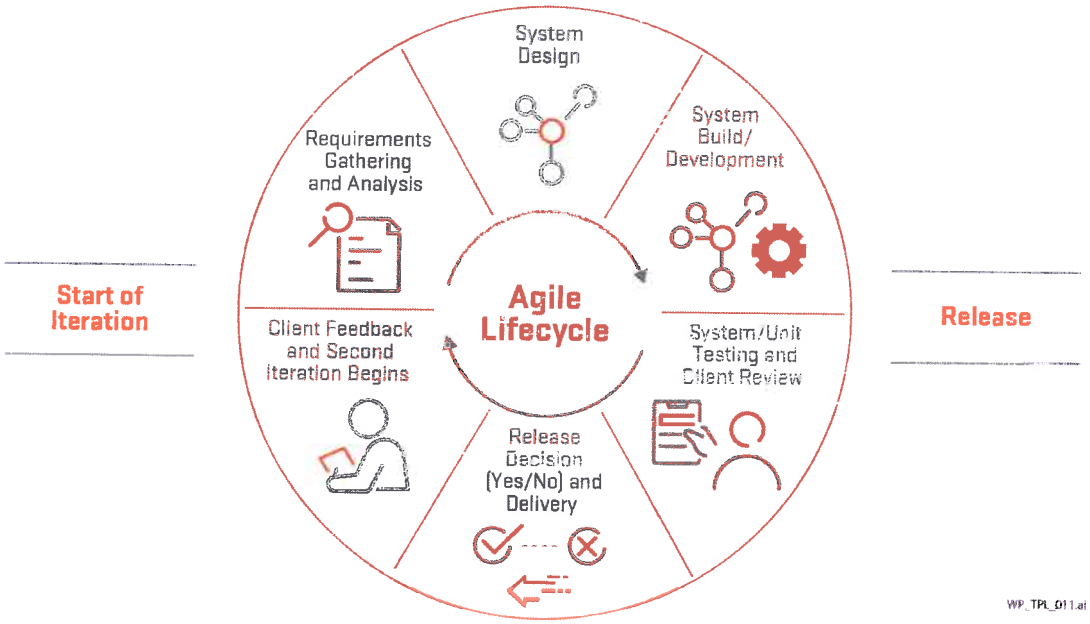
USING THE AGILE MODEL DURING IMPLEMENTATION

By leveraging Agile project model and best practices, our approach is adaptive to changing requirements, while adhering to client timelines, contract deliverables, and a fixed scope. We leverage Agile to:

- Create designs that are flexible to support changing requirements
- Build incrementally with faster, integrated learning cycles
- Base milestones on objective evaluation of working applications
- Increase visibility, cadence, and synchronization with cross-functional planning
- Empower project managers to remove obstacles and work more efficiently through close collaboration and constant communication
- An Agile approach breaks down the development of our large systems/applications into smaller sections – with design, development, and testing done in repeated cycles.

The Agile process flow is more of a loop than a linear process as shown **in Exhibit 7.3-9.**

Exhibit 7.3-9 HMS' Agile System Development Lifecycle (SDLC)
An Agile model is iterative and more of a loop than a linear process.



The Agile System Development Lifecycle (SDLC) phases include the following:

- **Start of Iteration (Sprint)** – Determine the work to be done within a defined time frame based on the project schedule
- **Requirements Gathering and Analysis** – Define the requirements for the iteration based on the product backlog, sprint backlog, client, and stakeholder feedback in an iterative manner
- **System Design** – Design software based on defined requirements
- **System Build/Development** – Develop software based on defined requirements
- **System/Unit Testing and Client Review** – Perform Quality Assurance (QA) testing, internal and external training, documentation development
- **Release Decision** (Yes/No) **and Delivery** – Determine readiness and integrate and deliver the working iteration into production
- **Client Feedback and Second Iteration Begins** – Accept client and stakeholder feedback and include it into the requirements of the next iteration process

With Agile, the scrum teams use "sprints" to tailor systems/applications to meet unique project specifications, test the customizations, and integrate them into the evolving system specifically designed for BMS. Other key elements of the Agile workflow process include:

- **Internal Scrum Meetings**. Constant communication is vital to success when short timelines and tight integrations are at stake. Daily standup and cross-functional sync-up meetings are an essential tool in maintaining visibility and making quick adjustments.
- **Continuous Integration.** When we can set up our systems for continuous and repetitive data integration testing, we do. This allows BMS and HMS teams to develop and integrate quickly and routinely to improve quality, reduce risk, and establish a fast, reliable, and sustainable development pace.
- **Early Visibility and Testing.** Getting business stakeholders involved during the development and integration process helps ensure that we do not design and develop applications that do not meet BMS' needs.
- **Iteration and Collaboration.** We will look for opportunities for BMS to interact routinely to quickly identify problems, measure progress objectively, and expect and support change to business needs. Through more iterative planning cycles, we can more easily plan for the upcoming work and the resources that will be needed from BMS, which we fully understand can be limited.

7.3.5.2 Major Tasks and Implementation Steps (App 1, PM033)

Our Implementation Plan for BMS, which is a subset of our Initial Work Plan/Project Schedule, documents the steps we will carry out sequentially to deliver the solution for the new contract. The general order of activities that occurs for a solution rollout of this nature include:

- Project Initiation
  - Project Kickoff with BMS
- Current State Review and Update
  - Data Analysis/Design
  - Development
  - Deployment
- Implementation of Solution Enhancements and New Scopes of Work
  - Data Analysis/Design
  - Development
  - Deployment/System Rollout and transition to full operations for new scope requirements

An Implementation Plan is far more detailed, and tasks are broken down into identifiable steps. Tasks and responsibilities are assigned to accountable roles, and a definitive timeline for go-live of the various solution scopes of work is created.

The steps in our Implementation Plan are detailed and contain the following information:

- What the task will accomplish
- Resources required to accomplish the task
- Assumptions and constraints associated with the task
- Identified risks and planned mitigations associated with the task
- Reference documents applicable to the task
- Criteria for successful completion of the task
- Miscellaneous notes and comments

Below are examples of some major tasks we will consider for the Implementation Plan:

- Providing for overall planning and coordination for the implementation
- Obtaining personnel for the Implementation team
- Providing appropriate training for personnel
- Ensuring all documentation applicable to the implementation is available when needed
- Acquiring special hardware, software, or network facilities
- Preparing site and support facilities for implementation
- Installing and configuring the various components of the operational environment
- Providing all needed technical assistance
- Scheduling any special computer processing required for the implementation
- Performing site surveys before implementation
- Performing system or situation transition activities
- Performing data conversion before loading data into the system
- Ensuring that all prerequisites have been fulfilled before the implementation date

For reference we have included our Initial Work Plan/Project Schedule in **Section 5.0**. We have prepared the Initial Work Plan/Project Schedule for BMS so that the project phases and deliverables align with both the PMBOK lifecycles introduced in **Section 7.3.0 Project Management Overview** as well as the Task Groups provided in RFP Appendix 2: Deliverables and Milestones Dictionary. The Implementation Plan is covered in Task Groups 1 through 4, which take place in the first 90 days after contract award. Additionally, we have included similar tasks and steps for the optional program scopes of work.

At the conclusion of the design discussions, and based on BMS input and feedback, we will provide a more refined draft Project Work Plan and Schedule to BMS for review.

7.3.5.3 Solution Configuration (App 1, PM034)

The majority of HMS' proposed TPL solution is implemented, configured, and operational today for WV. We list the solution components and supporting systems along with **current enhancements of systems** already underway in **Exhibit 7.3-10.**

Exhibit 7.3-10 The Components of HMS' Current Implemented Solution in WV
For the new contract, we will further configure our solution to meet the needs of BMS.

Solution Offering	Component	Supporting Systems/Portals
TPL Adds/Cost Avoidance	◉ Data Match ◉ Verification ◉ COB on Demand ◉ Third Party Referral	◉ COBConnect ◉ eValidate ◉ eReferral ◉ HMS 360
TPL Recoveries	◉ Direct Bill ◉ Provider Disallowance	◉ A/R Claim Tracker
Estate Recoveries	◉ WV Referral Network ◉ SNT & Annuity Services	◉ Maestro ◉ **Notice of Intent Portal**
Casualty-Trauma Recoveries	◉ Data Match ◉ Trauma Code Questionnaires	Maestro ***Solaris Plus***/HMS Submissions Portal
Credit Balance Audits	◉ Credit Balance audit team (reviewers)	◉ InVision ◉ **CBA Provider Portal**
Premium Reimbursement Programs	◉ WV HIPP ◉ M-WIN	◉ PIER

For the new contract, we will further configure our solution to meet the needs of BMS, as identified during the implementation requirements gathering and design sessions. From these sessions, we will also provide BMS with our recommended solution configuration that specifies how the components for the new scopes of work will be built and deployed. This includes the system structure and major system components that are essential to its implementation. Our forthcoming Implementation Plan for the new contract will include the technical system structure and major system components as well as any hardware and/or software essential to the implementation.

7.3.5.4 Solution Component Installation and Upgrades (App 1, PM035)

During our Implementation phase, we will gather requirements from BMS and discuss our plans for installation of the solution as well as any upgrades planned, including both the existing solutions we provide as well as the new scopes of work – Recovery Audit Contractor (RAC) Services and Medicare Buy-In. In **Exhibit 7.3-11**, we display the proposed components of these solutions for the new contract.

Exhibit 7.3-11 HMS' Proposed TPL Optional Services for BMS
Our proposed solution includes a rollout of the new scopes of work components - RAC Services and Medicare Buy-In.

Solution Offering	Proposed Service Component	Supporting Systems/Portals
RAC Services	◉ Payment Analytics ◉ Clinical/Coding Review	◉ ReSults Platform ◉ HMS Portal
Premium Reimbursement Program	◉ Medicare Buy-In Administration	◉ PIER

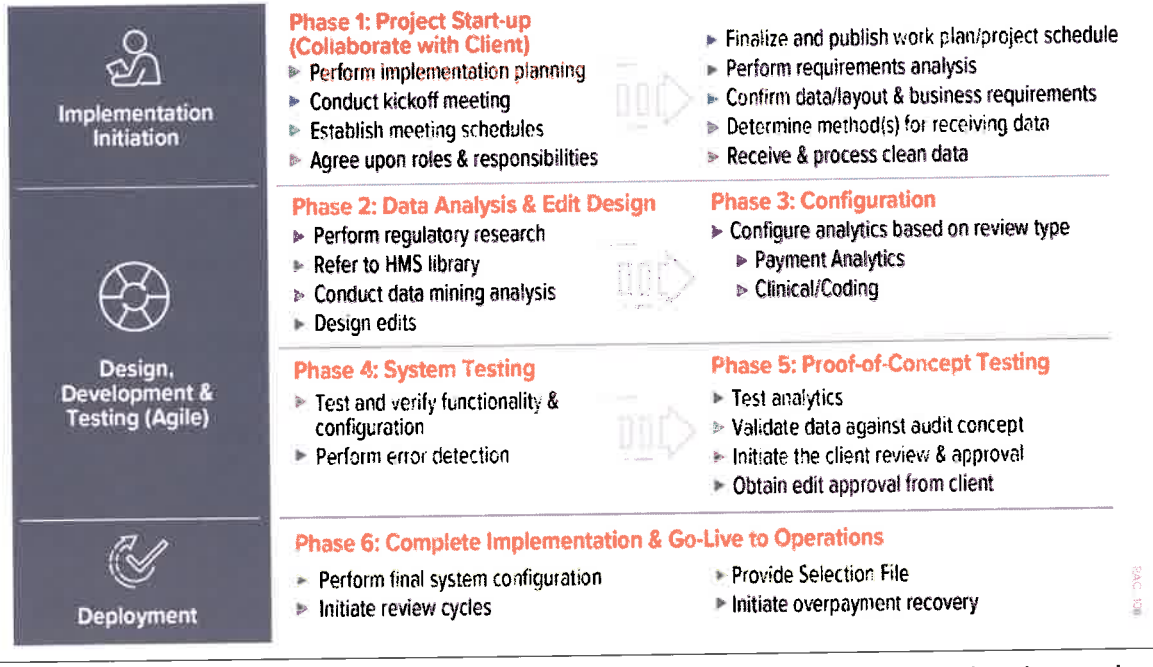
While these proposed solutions will be specifically configured and installed for BMS' unique business and technical needs, for reference below we provide an explanation of how we would typically install and stand up our RAC and Medicare Buy-In solutions for other clients, of similar size and scope.

Finally, to ensure timely upgrades and feature releases of all our proposed solutions, we leverage the same Agile SDLC approach described above.

STANDING UP OF NEW RAC SERVICES

In **Exhibit 7.3-12**, we summarize the steps and activities we typically follow to stand up a new RAC solution (payment analytics and clinical/coding review). While the project phases, and activities are presented linearly, HMS engages in Agile project management methodologies and best practices as needed. This process will be fully communicated to BMS once we provide our comprehensive draft Work Plan and Project Schedule.

Exhibit 7.3-12 A Defined Process for Implementing a New RAC Services Project
Our approach has been successfully utilized in many recent RAC service implementations.



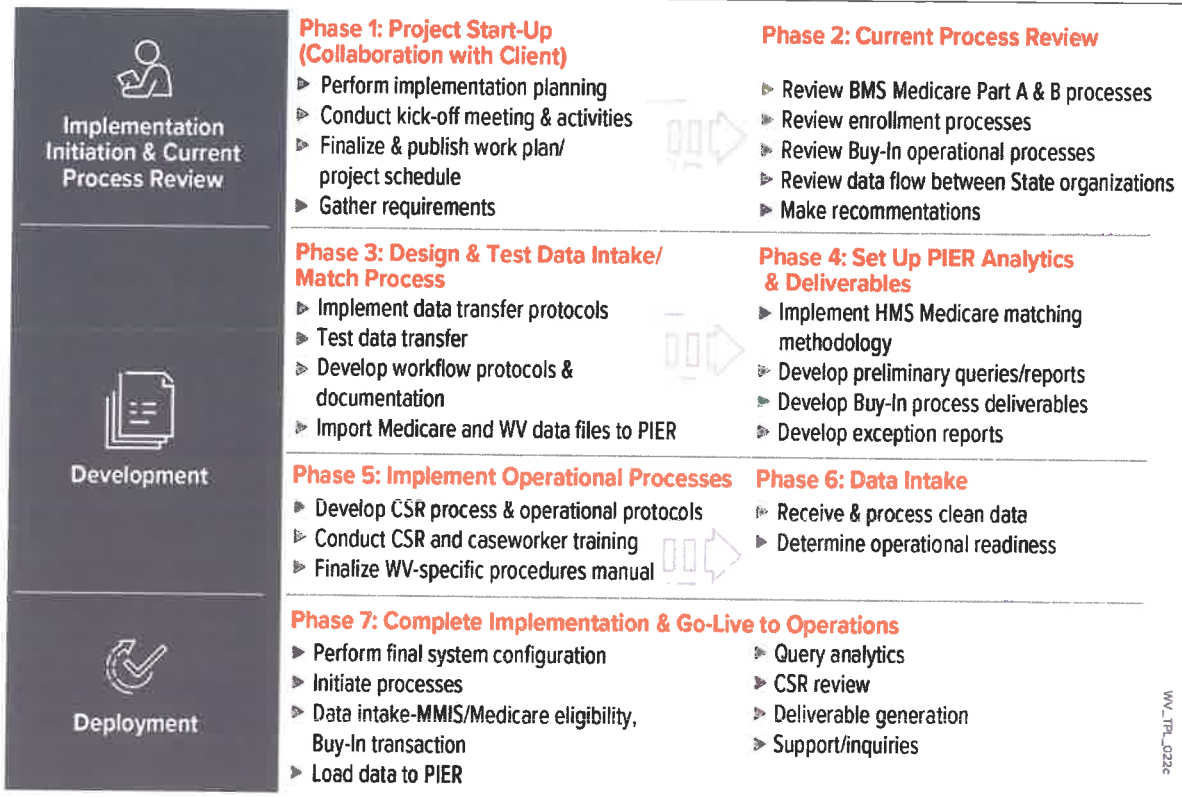
Because the specific audit types, available claim population, concepts and overlapping work performed by other program integrity vendors is unknown, the implementation for an effective RAC project may exceed the 90-day implementation requirement identified in this RFP. We will work with BMS during contract negotiation to clarify the specific scope of work being requested.

For details on our proposed RAC solution for BMS, please refer to **Section 7.2.4 RAC.**

STANDING UP OF THE MEDICARE BUY-IN SERVICES

In **Exhibit 7.3-13**, we provide an outline of the steps HMS plans to take to review BMS' current solution and evaluate processes, make subsequent recommendations, and stand up the new Medicare Buy-In solution during the Implementation phase.

Exhibit 7.3-13 Planned HMS' Steps for Implementing the Medicare Buy-In Service
HMS will kick off implementation by performing an in-depth study of current processes associated with the BMS Medicare Buy-In program.



For more details on our proposed Medicare Buy-In solution for BMS, please refer to **Section 7.2.3 Medicare Buy-In.**

7.3.5.5 Implementation Points of Contact (App 1, PM036)

Our assigned Account Manager, Michelle Hayes, and the project implementation lead will both serve as the primary points of contact for the Implementation phase of the project.

The project implementation lead will oversee the Implementation Services team and handle the daily tasks related to implementation. They will report into Michelle, for this implementation and will oversee the larger project milestones to verify the project remains on schedule.

The final Communication Management Plan, described in **Section 7.3.1 Communication Management Plan,** will detail the communication matrix as well as the roles and responsibilities, along with the phone numbers and email addresses.

7.3.5.6 Implementation Schedule (App 1, PM037)

The Initial Work Plan that we have introduced in **Section 5.0 Initial Work Plan** includes our initial task-by-task Implementation Schedule of the activities to be completed during the Implementation phase (understood to be the first 90 calendar days post contract award) of this project, tying them to the work breakdown structure.

HMS designed this plan based on our understanding of delivering to BMS' specific TPL requirements in our current contract. Our plan will be an active document that is flexible enough to accommodate required scheduling changes resulting from changes in project constraints or needs. The Implementation Schedule includes the major tasks in chronological order, with beginning and ending dates of each tasks, the resources responsible for the task, dependencies, and milestones. During project kickoff and initiation, we will work with BMS to refine our plan for installation and implementation.

As we describe earlier in this section, HMS' Initial Work Plan employs an iteration-based construct that supports an Agile implementation methodology and will include all deliverables described in the RFP and will be delivered to BMS within the time frame specified and required by BMS. We will work collaboratively with BMS to ensure our readiness to complete the activities required in the RFP and resulting contract and stand ready to make any amendments or changes required.

Exhibit 7.3-14 displays a snapshot of our Initial Work Plan that shows the Implementation Plan (Rollout Plan) task. Where opportunities exist for HMS to separate the implementation activities, we will collaborate with BMS to determine the best path forward.

Exhibit 7.3-14 Implementation Plan (Rollout Plan) Task from our Initial Work Plan
There are implementation tasks listed throughout the HMS initial Work Plan.

1.8.1.4	4.4.	D055 Implementation Plan (Rollout Plan)
1.8.1.4.1	4.4.	Review D055 Implementation Plan (Rollout Plan) Requirements
1.8.1.4.2	4.4.	Create Draft D055 Implementation Plan (Rollout Plan)
1.8.1.4.3	4.4.	Conduct Internal Work Product Review of D055 Implementation Plan (Rollout Plan)
1.8.1.4.4	4.4.	Revise Draft D055 Implementation Plan (Rollout Plan) based on Internal Review
1.8.1.4.5	4.4.	DELIVERABLE - D055 Implementation Plan (Rollout Plan) - Draft (Send Email to Client)
1.8.1.4.6	4.4.	Conduct Work Product Review with Client of Draft D055 Implementation Plan (Rollout Plan)
1.8.1.4.7	4.4.	DHHR and Stakeholders Conducts Review of Draft D055 Implementation Plan (Rollout Plan)
1.8.1.4.8	4.4.	Walkthrough Client Deliverable Review Comments
1.8.1.4.9	4.4.	Revise D055 Implementation Plan (Rollout Plan) based on Client Review
1.8.1.4.10	4.4.	Distribute Updated D055 Implementation Plan (Rollout Plan) to Client for Approval
1.8.1.4.11	4.4.	DHHR and Stakeholders Conducts Review of Revisions to D055 Implementation Plan (Rollout Plan)
1.8.1.4.12	4.4.	Milestone - Client Approves D055 Implementation Plan (Rollout Plan)

7.3.5.7 Security and Privacy Safeguards (App 1, PM038)

HMS' robust and customized data security resources work to protect the privacy and confidentiality of all personal information and other sensitive content in the data that we use to fulfill comprehensive service requirements for BMS.

Our Information Security Policy consists of detailed descriptions of administrative, technical, and physical safeguards to protect information assets. As part of this Information Security Policy, HMS has protocols in place for how we actively address privacy and protected health information (PHI) and other confidential information for clients. This includes controlling user access through authentication, user permissions, and other measures.

For example, HMS uses encryption software to secure the encryption of email messages including those that contain PHI. This works to protect the privacy and confidentiality of data, including data used to fulfill service requirements.

We use industry-leading Proofpoint Enterprise Protection™ (Proofpoint), to help accomplish these tasks:

- Keep malicious content out of our email environment
- Prevent the theft or inadvertent loss of sensitive data included in email messages
- Confirm email message-archiving compliance with data-security mandates
- Govern sensitive data for compliance purposes and litigation support
- Provide the ability to communicate and collaborate on sensitive data securely with clients and partners

Further information about logical security controls and privacy safeguards can be found in **Section 7.5.2 Security Plan**.

7.3.5.8 Implementation Support Procedures (App 1, PM039)

During the Implementation phase, our team will ensure appropriate implementation support procedures. Our team will use the following types of procedures and documents to support the implementation activities:

- Production environment setup and testing
- Operational readiness testing
- Execution of training
- Operational readiness checklist
- Project monitoring and escalation procedures.

7.3.5.9 Implementation Impacts (App 1, PM040)

Along with details on proposed solution configuration, our Implementation Plan will describe how the system's implementation is expected to impact the network infrastructure, support staff, user community, and other areas. We will include any references to Service Level Agreements (SLAs) that describe the performance requirements, availability, security requirements,

expected response times, system backups, expected transaction rates, initial storage requirements with expected growth rate, and technical help desk support requirements.

For existing scopes of work, our Implementation and Operations teams will make sure there is minimal impact to currently deployed services during the Implementation phase, during integration of any solution enhancements or upgraded software or systems into the existing workflows.

7.3.5.10 Risks and Contingencies (App 1, PM047)

Risk management is not a stand-alone process but a fundamental part of our integrated project management methodology. A risk that is not properly mitigated may become an important issue, and issues not properly addressed may pose a risk to project success. As introduced in **Section 7.3.0 Project Management Overview**, our Implementation team follows proven PMBOK for risk identification and management to ensure we meet all project objectives and account for any potential risks that could impact implementation. The Monitoring and Controlling phase of the project lifecycle occurs in parallel with all other phases and includes regular measuring and monitoring of project progress to ensure that the project is progressing as planned and to identify variances from the plan, so that corrective plans and actions can be taken to meet project objectives.

This is a weekly process with internal status updates with the Implementation team and reported through the weekly status meetings. It is flexible to adjust quickly to mitigate schedule impacts that could be due to:

- Hardware or software environment
- End-user environment
- Availability of resources
- Interoperability requirements
- Interface/protocol requirements
- Data repository and distribution requirements

Our implementation approach secures the highest standards of service quality and applies risk management measures. We will work closely with BMS to complete all activities on time with the lowest risk possible. With decades of experience implementing large-scale, complex TPL and program integrity solutions, we have experience with the more common risks that may arise to potentially impact implementation. We have established operational processes and systems that produce value for BMS, as evidenced from our results. The cost and planning for the new contract will be minimal, and require no down time, if BMS selects HMS as its vendor as all mandatory scopes of service are currently operational. Below are many of the requirements that we will not need to address during implementation with our in-place services:

> By selecting HMS, BMS will avoid the risk, significant rework, and provider impact that a new, unproven vendor would bring.

- Analysis of system requirements, file layouts, and data exchange and testing protocols
- Implementation and testing of file exchanges
- Development of project Work Plan and procedures
- Development of billing edits and exclusions
- Development of reporting and deliverable requirements
- Development of authorization letters
- Development of invoice procedures and processing.

As part of our Project Management Plan, we will develop and submit a Risk and Issue Management Plan, which outlines the approach and process we will use for the identification, tracking, management, mitigation, and resolution of risks and issues that could have an impact on the success of the project. Our approach includes an assessment of the potential impact with clear actionable mitigation strategies to reduce their probability and impact to control project risk. We will continually monitor and reevaluate conditions until the risk is resolved through prevention, avoidance, and/or contingency actions. We will work with BMS during implementation to define appropriate contacts based on risk and escalation levels.

7.3.5.11 Configuration Management Interfaces (App 1, PM041)

HMS understands that our proposed solutions will need to interface with various internal and external components for optimal operation. As such, configuration management of the interfaces involves documenting the interfaces and their attributes as part of a Configuration Management Plan. In addition to the Implementation Plan and PMP, we will provide BMS with a Configuration Management Plan as part of Task Group 3 deliverables during implementation. This plan will document our approach to managing configuration of the solution to meet and manage business needs. It will describe the configuration management procedures that will be followed, and the interactions that will occur for configuration control, change control, and configuration status account reporting. As BMS furthers their roadmap to modularity, HMS is prepared to work with the State's Systems Integrator to support full interoperability.

7.3.5.12 Applicable User Documentation (App 1, PM042)

User documentation, such as user guides and training support materials, helps the project stakeholders learn more about our solution and properly use the applicable components. We primarily reference user documentation for knowledge transfer during implementation and for training, HMS affirms that we will have user documentation available to support our solution and will make this documentation available to BMS.

As part of our training program, the account manager and other designated subject-matter experts, review and update the training materials to ensure they continue to reflect the most current development releases. We will provide hardcopy, and digital copies of the training materials to BMS staff following training.

We notify clients when we release system updates and distribute a training tutorial either as an addendum or update to the training materials. We schedule online webinars or phone calls as appropriate for major releases of new features.

7.3.5.13 Staffing Requirements and Implementation Roles and Responsibilities (App 1, PM043 and PM049)

Our experience with multiple large-scale and complex implementations for state government clients gives our team the experience and ability to identify the necessary implementation roles and responsibilities for the forthcoming BMS engagement. This includes roles and responsibilities for HMS' PMO staff, BMS, and other vendors (as needed), which we will discuss and confirm during project initiation and kickoff. During the development of the final Implementation Plan, HMS will include a RACI (Responsible, Accountable, Consulted, and Informed) chart. The RACI chart will include information for all stakeholders with a role in implementing the proposed solution. Here we provide an overview.

BMS Implementation Roles

During implementation, our HMS Project team will collaborate both internally and with assigned BMS resources to maximize outcomes and achieve the implementation goals of both organizations.

In **Section 7.3.3 Staffing Management Plan**, we explained that HMS recommends clients allocate a strong mix of operations, clinical, and IT staff to ensure a successful implementation. We also provided a sample list of some of the client resources we have worked with on other similar projects during the Implementation phase. We will work with BMS during project initiation to define the roles and exact business and technical resources required from BMS to support the creation of all deliverables.

HMS' Project Management Office

Our Implementation Services PMO is a team of project managers responsible for overseeing each project implementation from start to finish. These managers take on our complex and large-scale implementations, maintain project templates, and work with our company leadership team to deploy project management best practices. They have proven success managing project teams, so that initiatives meet or exceed requirements outlined in client statements of work.

Project Implementation Lead

Our Implementation Organization Chart for BMS includes a role devoted to leading project implementation. The project implementation lead will handle the day-to-day tasks related to implementation, while our assigned Account Manager, Michelle Hayes, will oversee the larger project milestones to verify the project remains on schedule as well as be accountable for producing high-quality deliverables. The project implementation lead oversees management of the following areas:

- General project management governance
- Overall risk assessment and mitigation
- Development and application of best implementation practices
- Adherence to project management standards
- Collaboration with our Enterprise Operations (Quality) team to develop process-improvement initiatives, establish metrics, and manage project phase gates

Implementation Services Team

Led by our project implementation lead, our Implementation Services team manages the overall implementation process. This team is staffed with highly qualified and experienced project management resources who collaborate with the appropriate operations teams to manage all client implementations, scope expansions, re-implementations, and platform migrations for all HMS service areas. In addition to personnel management, the team provides project evaluation/initiation from implementation through execution and, ultimately, handoff to the Operations team.

As requested in the RFP, **Section 4.0 Project Organization and Staffing Approach** includes an Organization Chart specific to the Implementation phase of the project. This chart identifies the HMS Project team roles that will work with our PMO and be involved in implementation of our proposed solution for the new contract. Each Project team member on our Implementation Organization Chart, will be available to assist our project manager to ensure that we meet deadlines and produce high-quality deliverables. In addition, the entire HMS organization supports our HMS Project team, and team members will have full access to all necessary internal resources, including operational roles related to the proposed scopes of work, for accomplishing the work.

In addition to our project implementation lead, our HMS PMO provides business analysts and data mappers for the project. Operational specialists for each scope of work area round out the Implementation Services team.

OTHER VENDORS

HMS currently does not use any other vendors to implement our solution. When BMS is ready to initiate MES Certification, we will work with the State's other vendors, as required, to support the interoperability plan.

PERSONNEL AND STAFFING REQUIREMENTS

Implementations require specific personnel and staffing requirements, separate from those required to operate and maintain solutions. See **Section 4.0 Project Organization and Staffing Approach**, for our organizational chart specific to the Implementation phase of the BMS project.

At a high level, the team members will perform account management functions as well as design and solution architecting, clinical policy, query development, EDI, build-out, data mapping, client services, and expertise from other subject-matter areas. During project initiation and development of the final Implementation Plan, we will further detail and clarify these roles and responsibilities as well as include the RACI chart.

7.3.5.14 IMPLEMENTATION STAFF TRAINING (APP 1, PM044)

BMS expects our staff to have a working knowledge of the system operations prior to starting on the project. As the current contractor, our implementation training needs for the HMS Project team members who will support the existing TPL Services will be minimal for the new contract. For the new scopes of work, we will fulfill all necessary Project team roles with HMS staff with current employees who have the appropriate qualifications.

These staff members currently operate similar services for other state Medicaid agency clients today. They are well versed in the solution implementation, systems, and operations and can easily transfer solution knowledge and expertise, skillsets, and experience to the BMS contract. In support of their assignment to the WV contract, we will conduct preliminary training on the WV Medicaid environment, specific contract, and service level requirements.

If there is a need for HMS new hires to support the BMS project, for any reason, we will ensure they are appropriately trained prior to starting on the project. HMS provides comprehensive training to support the needs of our internal Project team and as needed.

We have years of experience in creating effective training programs, supported by policy and procedure manuals and operational documents that are comprehensive and accurate. Our training curriculum emphasizes best practices and knowledge acquisition to ensure that our staff remain up to date on any changes to our client's programs, processes, or policies. The training encompasses tasks associated with all the services requested by the State so that every member of the Project team:

- Understands privacy and confidentiality, including HIPAA regulations as they relate to the post-payment review process
- Schedules and receives training from BMS as an integral part of project training for services directly related to the State's programs and systems
- Understands and adheres to the requirements of the contractual relationship with BMS
- Follows applicable WV and federal laws without exception
- Understands the responsibilities of their position related to the integrated suite of payment accuracy services that we propose to deliver to BMS
- Is knowledgeable regarding the operation of WV's Medicaid program
- Is knowledgeable regarding the WV Medicaid State Plan and Provider Reimbursement Policy and Policy Updates

7.3.5.15 Outstanding Issues (App 1, PM045)

The HMS team follows a standard process, with a supporting toolset, to address issues, risks, and action Items. This includes launching a structured, repeatable issue management process to continuously identify and resolve issues in a timely manner and avoid damaging impacts to the project.

The HMS team will take a collaborative approach to managing issues from identification through to closure. The objective of this plan is to aggressively address and swiftly resolve issues as they are identified throughout the project delivery.

Issue management activities will be assessed, performed, recorded, and monitored throughout the project lifecycle to:

- Identify and record issues clearly
- Use Issue Log to document issues properly
- Determine the impact of each issue
- Prioritize issues and report on their status
- Review all issues and decide on a course of action
- Take the steps needed to resolve the issues quickly
- Perform Root Cause and Corrective Action if the issues remain unresolved

7.3.5.16 Approach to Triaging Issues and Defects (App 1, PM050)

HMS staff responds rapidly to triage issues and defects prior to, during, and subsequent to solution go-live. HMS proposed Account Manager, Michelle Hayes, will serve as the single point of contact for this engagement and will facilitate the need for any action required by BMS for the contract. Our Project team will work with all appropriate internal teams, including operations, IT, human resources (HR), and training teams, to allocate the resources necessary to resolve challenges and respond to BMS' inquiries and requests

Triaging Issues and Defects – During Implementation

Prior to Go-Live during implementation, the HMS team will triage issues and defects as part of its in-place testing program, which is built on the following key components and proven effective to resolve defects and issues throughout the implementation lifecycle. HMS will customize the components based on the specific needs of the implementation:

- **Requirement Analysis:** Requirements are key inputs to the testing process and the analysis of requirements is the first step towards designing a testing strategy.
- **Test Planning:** During test planning, the Testing team will create test plan documentation and perform test tool selection, effort estimation, resource allocation, and training for testing activities.
- **Test Case Documentation:** In this phase, the Testing team will document the detailed test cases and prepare the test data needed for testing. Test cases and test data go through peer review by the appropriate Testing team to make sure that the test cases requirements are met.
- **Test Case Execution:** In this phase, the Testing team executes test cases according to the test plan. Failed test cases are logged in Jira for tracking and reported to development for remediation. Re-running of selective test cases are performed, as applicable.
- **Test Results Analysis:** In this step, the results of the test case execution are analyzed for continuous process improvement.
- **Test Cycle Closure:** In this step, the Testing team will evaluate the test completion criteria based on the test coverage. Once the test cycle is completed, a test closure report and test metrics are prepared. This also includes development of lessons learned for quality improvement of any further, or the next, testing cycles. The entry criteria for test closure are the thoroughly analyzed test results of all testing phases with no outstanding critical or major defects, or without sufficiently viable workarounds for the defects that would allow them to be downgraded to a medium.

TRIAGING ISSUES AND DEFECTS – DURING GO-LIVE

Once the new solution features and new scopes of work are in production, the Implementation team will remain intact until this project meets operational readiness guidelines and is approved by both BMS and HMS. Once approved, the Operations team will take over by utilizing our technical, administrative, and management resources as needed to meet and exceed BMS' requirements for the duration of the contract. The Implementation team will continue to address any post-go-live configuration, customization, or data integration issues.

TRIAGING ISSUES AND DEFECTS – POST GO-LIVE

For immediate technical issues reported with our solution by BMS stakeholders that require triage and resolution, HMS has a Technical Support Help Desk available between the hours of 7:00 a.m. to 7:00 p.m. Eastern Time, excluding national holidays, and on an emergency basis as requested. We provide this technical support to BMS-authorized solution users who report a technical problem. Our team will work with BMS business and technical staff to either resolve the issue, or to escalate the issue for important events that are over the SLA response and mitigation time frames.

On an ongoing basis, our quality assurance for our proposed TPL solution is led by our assigned QA Lead on our proposed HMS Project team. This role reports to the HMS Enterprise Operations team, which oversees HMS' QA program.

Our QA program has an established and rigorous problem/issue identification, management, correction, and reporting process to address issues that identified and reported through our quality assurance process and other means, including root cause analysis and follow-up on corrective/preventive action items. We track the resolution, investigation, and remediation actions to closure. HMS uses a defect reporting tool that houses the artifacts of these investigations and tracks all remediation actions to closure. Root cause analysis is a structured approach used to conduct an in-depth analysis and uncover process issues. This systematic approach identifies whether the error is skill-based or whether the error is embedded deeper in the process. We not only investigate to identify the cause but also establish comprehensive steps to correct the acute problem and establish ongoing corrective measures.

As problems or issues arise, we assemble a team of QBO, project and other experts to analyze the issue, identify contributing factors, and determine the root cause. Next, we develop a comprehensive corrective action plan (CAP) with clearly defined steps to mitigate the problem and prevent reoccurrence. HMS reports the results of our analysis and the final corrective action plan to BMS. In addition to identifying steps to prevent future occurrences of the issue, we also look for improvement opportunities to further explore.

Our corrective action process includes a written description of the issue(s) and actions to be taken to resolve the issue, along with a time for completing the corrective action. Our Account Manager and QA Lead oversee the process to ensure completion of any modifications or corrective actions required. The QA Lead schedules follow-up to verify their effectiveness in achieving expected outcomes. When correction of the issue is verified, the corrective action is

considered complete. If the issue is not corrected, the corrective action is assessed for revision and continues to be monitored until the issue is resolved.

7.3.5.17 Performance Monitoring (App 1, PM046 and PM048)

Through the various activities in the Monitoring and Controlling phase of the project, we will monitor performance and perform implementation verification and validation processes, such as gate reviews to ensure the project stays on track and continues to be ready by the Go-Live date.

Project Monitoring and Reporting Tools

We have a full suite of management tools we use to execute, monitor, and control client projects, using the PMI-based practices combined with the comprehensive reporting capabilities available through the ServiceNow™ Project Portfolio Management application. Our use of the project deliverables allow us to track project activities to verity that we meet project objectives and activities within identified timelines. These include, but are not limited to:

- Project Management Plan
- Project schedule with defined milestones and deliverables
- Time and resource management
- Standardized meeting agendas
- Weekly phase gate reviews
- Project status reporting

We structure our process to allow BMS the ability to review and approve deliverables with minimal effort. HMS has an excellent track record of meeting our project schedules.

HMS follows industry-standard, professional project management standards, methodologies, and processes consistent with State and BMS guidelines. We use the Project Management Institute (PMISM) Project Management Body of Knowledge (PMBOK®) guidelines, and the Software Development Lifecycle (SDLC) to manage projects, which we tailor to fulfill the specific client needs. Our approach helps to ensure projects are delivered on time, within scope, within budget, and in accordance with clients' quality expectations.

Monitoring and Control Key Performance Indicators

During the Monitoring and Control phase, we will measure project progression and performance to ensure that all activities remain aligned with the project schedule. In conjunction with our assigned account manager, the HMS project implementation lead will use the following key performance indicators (KPIs) to determine if the project is on track:

- **Project Objectives** to measure if the project is on schedule and budget
- **Quality Deliverables** to determine if specific task deliverables are being met

- **Project Performance** to monitor any changes in the project, including the amount and types of issues and or scope changes and how they are addressed
- **Service Level Agreements** to adhere to all contract SLAs

Our project implementation lead and assigned account manager will ensure that our Project team complies with all established control processes including deliverable submission procedures, BMS signoff procedures, and other established protocols and procedures. We will use our project plan and other project management tools to monitor the performance of our HMS Project team and the effective delivery of our TPL and Optional services.

SOLUTION IMPLEMENTATION VERIFICATION AND VALIDATION

Verification and validation are independent procedures used together for checking that our solution and supporting systems meet requirements and specifications throughout the SDLC, and that they fulfill their intended purpose.

Through verification and validation, HMS' SDLC seeks to determine that the TPL and optional solutions have met the functional, technical, and operational requirements of BMS, prior to going live.

- **Verification** takes place while the solution is still under development.
- **Validation** is performed upon completion of a given component.

These techniques shared between HMS, BMS, and other relevant stakeholders, helps ensure that we capture accurate and actionable requirements from the start of the project.

The final implementation verification and validation steps will occur just before and after the Go-Live event. Prior to Go-Live, we will develop implementation checklists to ensure the hardware, environment, software, documentation, training, and support are ready for production. Operational testing is performed and provides a view of the Go-Live status. After Go-Live, HMS, BMS and other relevant stakeholders, will verify that all defined requirements were achieved and provide a baseline for enhancements in the future. This will determine a successful implementation.

7.3.5.18 MEETING ACCEPTANCE CRITERIA (APP 1, PM051)

HMS affirms our understanding that this Implementation Plan deliverable must meet the acceptance criteria established between our organization and BMS.

7.3.5.19 COMMUNICATING PROJECT STATUS (APP 1, PM052)

Regular communication between stakeholders during the Implementation phase is essential for a successful project. We affirm that we will communicate project status information to BMS regularly, in an agreed-upon format, and within the State's required timeframes of weekly and

monthly as per RFP Appendix 2, Deliverable D068. As reflected in our Initial Work Plan, found in **Section 5.0 Initial Work Plan,** this communication includes Weekly Project Status Reporting during the Implementation phase, and Monthly Project Status Reporting beginning during Implementation and extending through the life of the contract.

During the Implementation phase, we strongly recommend that key BMS and HMS staff meet at least weekly to discuss the project's progress and to assure adherence to BMS' implementation schedule requirements. HMS will develop the agenda for each meeting and distribute it to all parties prior to the meeting. We will also take meeting minutes and distribute them after the meeting with specific assignments identified, as appropriate.

At each meeting, HMS will report milestones achieved, recent progress, updated timelines, and any risks to successful and timely completion of project goals. These meetings may include all team members, or they may be split into sub-teams relative to a specific functional areas or initiatives. Our assigned Account Manager, Michelle Hayes, along with the project implementation lead, will facilitate these meetings.

7.3.5.20 Proposal Format (App 1, PM053—PM055)

To create our proposal, HMS leveraged the format, contents, and structure in the RFP attachments, and uses identifiable tab sheets to precede each section of the proposal. The proposal follows all formatting requirements including sequentially numbered pages.

HMS' in-line responses provide a concise and detailed description of our ability to provide for all BMS specifications included in the RFP. To support the evaluation process while limiting our response to 400 pages total, our proposal includes the text of the RFP reference for each BMS specification to which we respond. The proposal uses appropriate, RFP-compliant font sizes and does not exceed 400 pages. Each separate page has been numbered sequentially with content on only one side of each page in order to best support the evaluation process.

7.4.0 PROGRAM INTEGRITY

7.4.0.1 AUDIT PROGRAM (APP 1, PI001)

HMS will offer BMS audit solutions, where applicable, applying to all scopes of services proposed in this RFP. Please refer to the individual proposal sections for a description and step-by-step process for each scope of work. HMS will collaborate with BMS to ensure all department appeal processes are incorporated in our solution. Our customizable appeal approach is described in detail further below within this section.

Two of our current scopes of work currently provide specific audit solutions related to program integrity- Credit Balance Audits and RAC Services. As part of our proposed audit programs, we support provider disputes and appeals. We provide a description of the process for each of the two current solutions below.

CREDIT BALANCE AUDITS

HMS offers BMS a comprehensive program design for provider credit balance reviews and overpayment identifications. We have developed our procedures based on best practices and our success working with a multitude of provider types, including hospitals, dialysis clinics, physician groups, long term care providers, and mental health providers.

We describe our approach and step-by-step process for credit balance audits in **Section 7.1.5 Credit Balance Audits**. Through our CBA process, we work closely with provider staff, which includes obtaining provider sign-off and approval of all identified overpayments discovered and documented during the CBA reviews. By doing so, the HMS team identifies and resolves any issues prior to a recovery attempt by BMS.

In cases in which there is a provider dispute, we will review the provider's supporting documentation and compare the procedures used with BMS' reimbursement guidelines and policies and procedures. If after review, HMS and the provider continue to disagree on the findings, the account will be noted as an exception on the Final Audit Report, which will include the appropriate documentation related to the provider appeal. All exceptions will be reviewed with the project manager, and a recommended action report will be sent to the BMS contract manager for review. BMS' ruling will then be communicated to the provider in the form of an approved letter with the option to request an administrative review if applicable. HMS will maintain a complete case file and retain all work papers related to the provider audit for BMS review.

RECOVERY AUDIT CONTRACTOR (RAC) SERVICES

Through this RFP response, HMS offers BMS an optional Medicaid RAC service. We design our program integrity services, including those delivered under RACs, to help ensure that healthcare claims are paid correctly and according to contract terms, are free of error or duplication, and do

not contain fraudulent, wasteful, and abusive behaviors. Our proposed full-service RAC service capabilities encompass comprehensive data analysis, clinical/coding review, and recovery services that effectively identify, recover, and further prevent improper payments made to Medicaid providers. HMS' has national experience as a program integrity vendor, including our background as a long-standing RAC services provider for CMS and 13 other state Medicaid agencies. We are the leader of RAC services for state and federal government agencies. We fully describe our RAC program and end-to-end process in **Section 7.2.4 RAC Services.**

HMS designs our payment analytics and clinical/coding reviews to minimize appeals; however, appeals may still occur as the provider may disagree with the results of our overpayment analysis and findings. Our approach to RAC Services supports the provider's the right to appeal regardless of the review type performed. Providers may appeal findings for determinations performed through payment analytics or a clinical/coding review.

A Customizable Appeals Approach

Most of our clients have their own unique appeals process, with state-specific nuances that may require a different level of appeals support. HMS has years of experience working with appeals for Medicaid agencies and has the ability to support BMS' appeals process, at any level, from initial review and disputes through hearings and case resolution, as needed and depending on client needs.

To meet these needs, HMS offers a wide range of appeals support services that can be customized for each contract. Our team may be asked to conduct any or all the services listed below, though this list is not exhaustive.

- Support providers on pre-appeal review and determinations (e.g. submitting appeal requests, etc.) through our HMS Provider Services team
- Examine all appeal requests and the additional documentation submitted from the provider
- Prepare and submit all supporting documentation required for the appeals process
- Organize and present references to applicable Medicaid statutes, regulations, manuals, and instructions
- Participate in pre-hearing conferences (e.g. provide clinical support)
- Participate in court and hearings (e.g. provide clinical support)
- Prepare case summaries
- Secure expert witnesses for conferences, hearings, and depositions

HMS is prepared to support BMS with appeals at any level and stands ready to provide the appropriate notification, data, documentation, case file and summary preparation, and participation by our audit staff and/or medical professionals when needed. For the forthcoming engagement, we will work with BMS to further evaluate and develop this process. Based on this

direction, we will collaborate with BMS to obtain further requirements and tailor our approach to the appropriate support levels needed.

7.4.0.2 NOTIFICATION OF CHANGES (APP 1, PI002)

Our in-house Government Relations team monitors federal and State regulations applicable to our clients and reviews all rule changes reflected in CMS and state manuals, policies, and bulletins.

HMS affirms that we will notify BMS of all changes in federal regulations affecting both the proposed TPL Services and Optional Services programs, within two business days of publication. We will do this through an email by the assigned HMS Account Manager. Within five (5) business days of issuance, we will develop and provide BMS staff with a summary of how the Proposed and Final Rules and Regulations will affect these programs and identify any implementation or procedural changes.

7.5 Information Management Systems

7.5.0 Information Management Systems Overview

In this section, we introduce our HMS programs for maintaining business continuity and security. We also respond to RFP requirements and provide a description of our plans in **Sections 7.5.1 Business Continuity and Disaster Recovery Plan** and **7.5.2 Security Plan**.

Business Resilience Program Summary

Disasters can interrupt a company's ability to provide consistent and reliable services – often without warning. While unlikely, they afford little opportunity for cautious or intelligent reaction immediately following their occurrence. As a leader in the healthcare marketplace, we recognize the importance of maintaining the integrity of our clients' data with plans in place to address unexpected events or disasters. We proactively develop plans and procedures to manage a disaster situation, and regularly practice them to stand ready should a disaster occur.

HMS' Business Resilience Program (BRP) provides the management structure, key responsibilities, emergency assignments, and general procedures to follow during and immediately after a crisis. We established our BRP to address the immediate requirements for a crisis, disaster, or emergency in which normal operations are interrupted and special measures taken to:

- Protect and preserve human life, health, and personal well-being
- Minimize loss, damage, or disruption to HMS facilities, resources, and operations
- Provide essential services and operations
- Provide and analyze information to support decision-making and action plans

HMS uses a systematic approach to the management of incidents or issues that may seriously affect the company's staff, operations, or reputation. Where possible, this approach uses existing infrastructure and procedures. We developed this approach to meet legal requirements, standards of effective governance and more importantly, to minimize the risk to its staff, partners, and communities. HMS' approach brings together four core elements:

- Crisis Management, to address strategic business and reputation issues
- Emergency Response, to ensure people are safe and minimize damage to assets
- Emergency Management, to coordinate the emergency response and manage the recovery
- Business Continuity, to maintain business operations and communicate updates to affected audiences

The application of these four elements will depend on the situation and the sound judgment of HMS managers and staff. For example, a major fire would involve all four elements while a

major public controversy may only involve the element of crisis management and the crisis management team.

HMS' BRP is a certified 'Resilient Enterprise.' We achieved this certification in 2017 from the Disaster Recovery Institute International (DRII) and were recently recertified through 2022 following a biannual review by DRII. HMS demonstrated extraordinary commitment to Business Continuity Management (BCM), including emergency management, business continuity, disaster recovery, and crisis management. A Resilient Enterprise designation follows stringent accreditation criterion that identifies core factors of extraordinary commitment and demonstrated capability to advocate for resilience. This accreditation demonstrates HMS' commitment to being prepared by contributing personnel, materials, technical, and management advice.

HMS also meets the International Organization for Standardization (ISO) for the following:

- 22301: Use of Societal Security, as well as Preparedness and Continuity Management Systems standards
- 31000:2009: Use of Risk Management, as well as Principals and Guidelines standards

Disaster Recovery Infrastructure

HMS' disaster recovery infrastructure is a central component of our Business Resilience Program and consists of two hosted colocation data centers. These enterprise-class centers are in Richardson, TX (primary), and Las Vegas, NV (secondary). Rated as Tier IV Design Ready, they meet all industry standards, as well as regulatory and compliance obligations. Additionally, the data centers have a rating of N+4, which is a fully redundant enterprise solution. If a disaster occurs, HMS helps ensure activities for the Irving office, including the restoration of files and databases, are operational within three business days. They provide the following benefits:

- On-site engineers to manage the centers 24 hours a day, 7 days a week
- Dedicated team focused on our clients' needs
- 100% Service Level Agreement (SLA) for power, bandwidth, and network services availability
- 27 telecommunication carriers to certify a carrier-neutral position regarding network connectivity

Information Security

As with business continuity, security is extremely important to HMS, and we apply best practices and rigorous policies to provide the highest level of security possible in the areas of:

- Data (information) and systems
- Physical information (infrastructure) security
- Personnel information security awareness and training

- Personnel information security awareness and training

Security is a complicated, vital, and multi-level concept. While our IT landscape explodes with new technology, cyber criminals look for new ways to disrupt our systems and intrude on our personal information. Although not a public servant, HMS does serve the needs of public healthcare and government entities across the country, and so recognizes the importance of protecting our clients' sensitive information.

HMS, a nationally recognized and trusted steward of healthcare data, proudly serves the needs of public healthcare and government entities across the nation. We recognize the importance of protecting sensitive information our clients entrust to us as well as the systems that process the data and physical infrastructure in which the data is housed and transmitted. Our data-security measures result from proven, tested methodologies designed to safeguard the data of government and public health clients. We protect the integrity of their data and the health information of the citizens that each program serves. Our dedication to security has produced awards internally and externally, described in **Section 3.0 Vendor Qualifications and Experience,** earning HMS the honor of being HITRUST CSF-certified.

We are committed to ensuring appropriate access to protected health information (PHI) by adhering to applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA) and our client contracts. Our data-security measures are the result of proven, tested methodologies designed to safeguard the integrity of government and public health clients and protect the vulnerability of the citizens each program serves. HMS' information-security practices comply with applicable federal and state laws, regulations, security standards, and corporate policies that are designed to protect individuals, ourselves, and our partners against the unauthorized disclosure of information that could compromise identity or privacy.

COMPLIANCE WITH APPLICABLE SECURITY STANDARDS

Given the extent of our business and vast client portfolio in the healthcare industry, HMS' information-security practices must comply with applicable federal and state laws, regulations, security standards, and corporate policies. This includes those set forth by the Centers for Medicare and Medicaid (CMS) Services, the Federal Information Processing Standards (FIPS), and the National Institute of Standards and Technology (NIST). We acknowledge that we must also continue to comply with the acceptance criteria between BMS and HMS that we work with today in the current contract.

HMS' information-security practices comply with a variety of federal and state laws, regulations, security standards, and corporate policies. Generally, the purpose of these regulations and standards is to protect individuals and organizations against the unauthorized disclosure of information that could compromise their identity or privacy. Information security regulations cover a variety of types of information, including personally

HMS adheres to and supports all security risks, standards, policies, and procedures of BMS, the State, and the West Virginia Office of Technology (WVOT). HMS ensures compatibility with the most current WVOT supported versions and standards. (MR021)

identifiable information (e.g., Social Security Number, driver's license number), personal financial information (e.g., credit card numbers), medical information, and confidential employee information.

As a data fiduciary trusted by our clients to securely handle and store their confidential project-related data, we have adopted several guidelines to enhance our security policy. Some of the more notable ones include:

- **Health Insurance Portability and Accountability Act (HIPAA) (Public Law 104–191, 110 Statute 1936, enacted August 21, 1996).** We have implemented and maintain our services, as appropriate, to meet standards mandated by the HIPAA Privacy Rule. Our HIPAA security-compliance methodology goes beyond the requirements of the HIPAA Security Rule; it works to safeguard not just electronic Protected Health Information (ePHI) but company information assets as a whole. The domains defined in the International Organization for Standardization 17799, British Standard 7799, and Control Objectives for Information and Related Technology security standards influenced this methodology.
- **Health Information Technology for Economic and Clinical Health (HITECH) (enacted February 17, 2009).** We implement and maintain our services, as appropriate, to meet standards mandated by HITECH legislation. We adopted HITECH to help ensure that our handling of Compliance or Security incidents specific to PHI conforms to the HIPAA Privacy Rule as well as the HIPAA provisions in the American Recovery and Reinvestment Act (ARRA) as dictated by HITECH.
- **HIPAA Security Rule. As part of the HIPAA Law,** the HIPAA Security Rule establishes national standards to protect individuals' electronic personal health information that is created, received, used, or maintained by a covered entity. The Security Rule requires appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and security of electronic protected health information.
- **Sarbanes Oxley (SOX) Act.** We implement and maintain our services, as appropriate, to meet standards mandated by SOX legislation, which oversees corporate accounting.
- **Health Information Trust Alliance (HITRUST) Common Security Framework (CSF).** HITRUST is a prescriptive framework for complying with security requirements that affect the healthcare industry. The initial development of the CSF leveraged nationally and internationally accepted standards including International Organization for Standardization (ISO), National Institute of Standards and Technology (NIST), PCI, and HIPAA to provide a comprehensive set of baseline security controls. This framework provides assurance to our clients that we follow an industry-managed approach to meeting HIPAA requirements for the Security and Breach Notification rules. All our employees, consultants, and business associates must fully comply with our security policy by participating in security training. We also require these individuals to understand our policies and procedures sufficiently enough to carry out their duties in conformity with the HIPAA Privacy Rule and HIPAA provisions of ARRA. We continue to maintain our HITRUST CSF Certification, earned in August 2014.

HMS' Information Security Program

HMS' established Corporate Information Security Program, provides direction for managing and protecting the integrity, availability, and confidentiality of corporate information assets (IAC). In accordance with our security policy, described in **Section 7.5.2 Security Plan**, the ISP contains administrative, technical, and physical safeguards to protect information assets. Unauthorized modification, deletion, or disclosure of information assets can compromise our mission, violate individual privacy rights, and constitute a possible criminal act. Our ISP works to manage and protect the integrity, availability, and confidentiality of information assets, including data acquired from clients to fulfill service requirements. Its purpose is to:

- Document information-security roles and responsibilities for HMS employees and other parties as applicable
- Provide for IAC of information assets, regardless of holding/transmission type (e.g., paper or electronic)
- Document risk-management strategies to identify and mitigate threats and vulnerabilities to information assets
- Document incident-response procedures
- Document procedures for ongoing security awareness and training provided to HMS employees and other parties as applicable
- Provide descriptions of business resilience resources that respond to disasters

It is the collective responsibility of all HMS employees and other parties as applicable to safeguard the following:

- Confidentiality of all information assets
- Integrity and availability of information assets stored on or processed by our systems
- Compliance with applicable laws, regulations, corporate policies, and security policy governing information security and privacy protection

We do not intend our ISP and security standards to prevent, prohibit, or inhibit the sanctioned use of information assets as required to meet our core mission and business goals.

7.5.1 Business Continuity and Disaster Recovery Plan

7.5.1.1 Business Continuity and Disaster Recovery Plan (App 1, IS001)

Business continuity is extremely important to HMS, so our clients can remain confident that our proposed solution will remain secure, available, and reliable to support their healthcare programs for the life of the contract, including during unforeseen events. As per the RFP, BMS requests that HMS have a Business Continuity and Disaster Recovery Plan (BCDR) in place that defines the resources, actions, and tasks required to protect and recover data and the data infrastructure in the event of a disaster. HMS will provide a BDCR plan, based on the principles and components contained within our established HMS Business Resilience Plan (BRP), which we describe herein. HMS affirms the BCDR plan deliverable will meet the acceptance criteria established between BMS and HMS for the new contract.

HMS has a Business Resilience Plan (BRP) that allows us to respond quickly and consistently to any critical event prohibiting HMS' participation in normal business activities as well as identifies and mitigates potential risks to secure business continuity, should a disaster interrupt our services. It provides the management structure, key responsibilities, and procedures to follow during and immediately after a crisis. The BRP, as well as the business continuity and disaster recovery activities that it encompasses is reviewed, updated, tested, and validated regularly and/or as recovery technologies change.

We established the BRP to address the immediate requirements for a crisis, disaster, or emergency, in which normal operations are disrupted and special measures need to be taken to accomplish the following:

- Protect and preserve human life, health, and personal well-being
- Minimize loss, damage, or disruption to HMS facilities, resources, and operations
- Provide essential services and operations
- Manage against negative or adverse national/international media coverage that may also affect our clients
- Provide and analyze information to support decision-making and action plans

Our Approach

HMS uses a systematic approach to the management of incidents or issues that may seriously affect the company's staff or our clients' operations. Where possible, this approach uses existing infrastructure and procedures. We developed this approach to meet legal requirements,

standards of effective governance and more importantly, to minimize the risk to staff, partners, and communities. HMS' approach brings together four core elements:

- Crisis Management, to address strategic business and reputation issues
- Emergency Response, to ensure people are safe and minimize damage to assets
- Emergency Management, to coordinate the emergency response and manage the recovery
- Business Continuity, to maintain business operations and communicate updates to affected audiences

The application of these four elements will depend on the situation and the sound judgment of HMS managers and staff. For example, a major fire would involve all four elements while a major public controversy may only involve the element of crisis management and the crisis management team. Similarly, the plan accommodates different levels of disasters (e.g. affects all business units versus one or more business unit(s) only).

The BRP covers all sites where we perform BMS' activities and/or store data and documents our local contingency planning for the recovery and/or maintenance of the current business and business support activities in the event of disruption caused by natural disaster or an operational crisis. It incorporates a comprehensive set of policies and procedures to recover all information systems, telecommunications, and business processes in the event of a natural or man-made disaster. Our BRP and program also address issues that could arise from, but are not part of, a disastrous event that would mandate transfer of operations from their original locations. For example, if an extended communications outage occurs, we can switch from one line/vendor to another because we have redundancy built into our telecommunications infrastructure.

DISASTER RECOVERY CERTIFICATION

Additionally, HMS' Business Resilience Program is a certified 'Resilient Enterprise,' certified in 2017 by Disaster Recovery Institute International. HMS demonstrated extraordinary commitment to business continuity management (BCM), including emergency management, business continuity, disaster recovery, and crisis management. A Resilient Enterprise designation follows stringent accreditation criterion that identifies core factors of extraordinary commitment and demonstrated capability to advocate for resilience. This accreditation demonstrates HMS' commitment to being prepared by contributing personnel, materials, technical, and management advice. **HMS also meets the International Organization for Standardization (ISO) for the following:**

- 22301: Use of Societal Security, as well as Preparedness and Continuity Management Systems standards
- 31000:2009: Use of Risk Management, as well as Principals and Guidelines standards.

In the following sections, we describe various aspects of our BRP, as required.

7.5.1.2 HMS' Disaster Communication Plan (App 1, IS002)

Crisis communications are a vital component to Crisis Management and help ensure HMS can respond promptly, accurately, and confidentially during an emergency or crisis.. Communications protocols are established to ensure the core of each message is consistent, while addressing the specific questions from each audience. Our BRP accounts for efficient and effective communication during any disaster or crisis. Through the crisis communications portion of our BRP, we have internal and external processes in place to keep all project stakeholders informed regarding company actions following a business interrupt. As such, the BRP also identifies a notification process, a means to minimize the impact of business, and procedures to quickly return to full operation.

The HMS Crisis Management Team (CMT) provides the management structure, key responsibilities, emergency assignments, and general procedures to follow during and immediately after a crisis. HMS' overall priorities during a crisis are to protect lives, valuable assets and property, the company's reputation, the community, and the environment. These procedures spell out the immediate actions and operations required to respond to a crisis, emergency, or disaster. The overall objective is to respond quickly and effectively manage the critical process of Business Resilience (i.e., restoring HMS business functions and services).

Our HMS Crisis Management Team, Communications Group, Compliance team, and Legal team are all responsible for developing pre-scripted messages for potential impacts and scenarios including:

- Accidents that injure employees or others
- Property damage to company facilities
- Liability associated injury to, or damage sustained by others
- Production or service interruptions
- Workplace violence
- Product quality issues
- Events that potentially involve mandatory reporting to government and/or regulatory agencies

Broadcast communication messages (e.g. telephone, text, and our HMS "In Case of Crisis" app) are the primary means of notification and will be used to contact CMT members, as well as other HMS staff. As an example, back in 2018, several HMS employees were impacted by Hurricane Michael. Members of our Crisis Management team prepared crisis response plans for each affected region and pushed them to the employees via the In Case of Crisis app. These plans included emergency evacuation, safety, and check-in procedures. Use of this app allowed HMS to remain in near constant contact with our employees to ensure their safety and minimize disruption to business operations by engaging back-up staff.

HMS' Emergency Communications "In Case of Crisis" Mobile Application

Our "In the Case of Crisis" mobile application enables HMS to better care for the well-being of our people and maintain continuity of our services to our clients by offering an easy and secure way to access our emergency procedures and safety guidelines by:

- Expediting the Recovery Team Activation process, allowing staff to be alerted real-time
- Helping HMS maintain ongoing contact with clients immediately at declaration and throughout the duration of a service interruption requiring the implementation of a back-up facility (call center).
- Enabling our HMS Project team account manager, who will work in conjunction with the designated Disaster Recovery team lead during all recovery activities, including periodic and ongoing communications with internal departments and external clients, to direct the conduction of current business operations, project reporting, supervision, and management

The "In Case of Crisis" notification system provides emergency notification capabilities based on the crisis level and broadcast as follows:

- Crisis Management Team - Policy and Operations Groups
- Other HMS contingent staff
- Employees (resident and virtual)

Crisis and emergency management information and communication allows better care for the well-being of our staff by offering an easy, secure way to access our emergency procedures and safety guidelines. Our all-in-one solution includes incident reporting, push notifications, the ability to build and support multiple plans for preparedness, and the ability to manage different use cases, groups, or locations.

7.5.1.3 Backup and Protection Plans (App 1, IS003-IS004)

HMS' BRP includes extensive procedures that take a preventative stance to possible data disasters.

Data Backup and Management

HMS follows detailed data-management procedures that address files and tapes that clients entrust to us. These methods also address the work products associated with our ongoing performance of contracted tasks. We regularly perform both incremental and full-system back-ups of our critical system and application infrastructure. Real-time data replication between our primary and secondary data centers also occurs regularly. In addition, our solutions include specific measures to protect the integrity of the data that our clients entrust to us.

The Information Technology Services (ITS) department uses a comprehensive back-up methodology to protect our systems from failure or disaster and provides fast recovery in the event of a loss or outage. This process is managed at HMS' Irving headquarters, covers all of our remote locations, and covers all Health Management Systems, Inc. entities.

HMS uses an off-site storage provider network for tape rotation. Back-ups are rotated to highly secure, fireproof climate-controlled locations. Recovery of data tapes from these facilities occurs within four hours of declaration of a disaster.

Autoloader systems (robots) help automate HMS' back-up procedures. All locations use either Digital Linear Tape (DLT) format or replicate their data to our corporate data center. Data is replicated nightly through our private network to our SSAE16 compliant data center. It is then captured at the data center through a multi-tiered back-up process. The live replication serves as an on-disk copy. The nightly back-up routine captures that copy to disk, which is transferred to tape and rotated off site to another storage facility.

Our standard back-up rotation is as follows:

- Friday – Full back-up of all systems
- Saturday – Full off-site copy, tapes are stored off-site for 12 weeks, then rotated back
- Sunday through Thursday – Differential, overwrite protected for four weeks
- Quarterly back-up occurs the first Saturday of every quarter; tapes are stored off -site indefinitely
- Annual back-up done the last day of each year; tapes are stored off-site indefinitely
- Mission critical systems, such as SQL database and email servers, are fully backed up nightly
- Real-time Data Replication: Source data is replicated to the D/R Hot-site at time of internalization

INFORMATION SYSTEMS TECHNICAL INFRASTRUCTURE

HMS' BRP includes extensive procedures that take a preventative stance to possible data disasters. ITS consistently builds and maintains technological infrastructure to proactively avoid possible data disasters. This infrastructure includes but is not limited to network operations, security policy and practice, technical support, advisory services, training and awareness, data redundancy (replication) and data back-up. HMS maintains a portfolio of preferred technology vendors to maintain high availability of replacement equipment to help provide the highest levels of system continuity.

HMS' networks are wired to industry standard specifications by a single vendor and use consistent brand and model switching equipment to provide a uniform environment. Every computer and server is protected from computer viruses using uniform, multi-level anti-virus platform that is centrally managed on a corporate-wide level. This allows us the ability to react quickly if virus outbreaks occur. HMS' network is protected from unlawful intrusion with centrally managed, industry-leading firewall appliances and routing equipment using access control lists.

ITS uses a comprehensive back-up methodology to protect all our information systems and networks from failure or disaster and provides fast recovery in the event of a loss or outage. This process is centrally managed and covers all of our locations and company entities. As data

is received from the client, it is catalogued accordingly to enable us to track the data while in our control.

Network and mainframe data is secured and replicated to our secondary data center in Las Vegas, NV, and is supported by our off-site storage vendor. Our back-up program consists of daily snapshots to provide the protection of all data used in the course of our workday. A weekly systems back-up is run for rotation and then sent offsite. The daily differential back up is run at the end of each business day and the weekly back up is run at the end of business every Friday. For offsite data back-ups, only authorized data center management is given unique authorization cards to enter off-site data storage facilities and the web-based management facility called SecureSync. Copies of source data are replicated to the Disaster Recovery Hot-site real-time. This data is retained for 7-10 years, unless otherwise instructed by our client contract.

INTERNAL SYSTEM CONTROLS

Additionally, the internal control systems within HMS protect highly sensitive data. We currently protect information systems from unauthorized access using both routers and firewall technologies that are centrally managed. Routers are configured with access control lists as a first measure of limiting access to our network. The existence of firewalls helps prevent and reduce the likelihood of unauthorized access, whether internal or external by using network address translation (NAT), state inspection, attack defenses, content security and authentication.

Access to all firewall rules and logs is restricted to ITS management staff. Our internal firewall technology also provides audit information on network traffic, used for intrusion detection and is instrumental in containing virus outbreaks or security breaches – both of which are vital to protecting the interconnected networks of our clients and business partners. ITS provides audit and intrusion detection/prevention with dedicated intrusion detection system (IDS) appliances at all our locations. In addition, we have dedicated hardware, which hosts the firewalls built to protect our internal control systems.

APPLICATIONS SECURITY

HMS recognizes that certain applications are essential to completing business-critical services and satisfying the requirements of the TPL Services contract. HMS' IT department, and Corporate Disaster Recovery Coordinator, as well as key members of the HMS Project team for BMS, have evaluated the full scope of mission-critical applications that HMS employs. We group them in the following manner based on importance in a disaster recovery situation: Critical, Sensitive, and Non-Critical. The three categories and the applications that fall under each are further explained in the following paragraphs.

CRITICAL

Critical applications and/or business operations cannot be replaced with manual systems under any circumstances and are the primary business focus necessary for contractual operations. The following key applications and services are identified as being critical, whereas in the event of a disaster would need immediate attention to maintain compliance under the Cost Avoidance and Post-Payment Recovery contract:

- Telecommunications
- Reconnection to the databases
- Reconfiguration of eCenter application systems and databases
- Reinstallation of data files
- Customer Service operations redirection of toll-free numbers to alternate site
- Mail retrieval and processing

SENSITIVE

Sensitive applications and/or business operations can be replaced with acceptable systems for an extended time period:

- Cost avoidance and post-payment recovery billings, rebillings, and follow-up
- Post-payment recovery recoupments and re-pricing
- Provider overpayment and credit balance audits
- Reconfiguration of PIER to provide HIPAA reimbursement checks

Non-Critical

Non-critical applications and/or business operations can continue manually and may be resumed within twenty-four (24) hours:

- Contract management reporting
- Invoicing
- Phone/Online Verifications
- Quality Control

Data information systems distributed as an e-business application are key elements to the operations of this contract. Currently, we leverage extensively certified, financially viable, Tier 1 co-location facilities to house and maintain mission critical and client-services. Our data centers conform to, or exceed SSAE16 audits, and other industry standard certification standards. Our firm has contracted co-location facilities, in Richardson TX, and Las Vegas NV, which regularly undergo extensive standards-based risk assessments to make sure that they are at low risk of

outages, as well as flood, earthquakes, wind, and other physical risks. These co-locations are equipped with racks and cages to host our equipment in a secure environment. The environment is temperature and humidity controlled. These facilities are secured 24 hours a day, seven days a week with an on-site security guard. Indoor and outdoor security monitoring is always in place. Each hosting center can withstand disastrous conditions pertinent to their locations. This verifies that our systems and equipment will not fail under extreme conditions.

The e-business hosting centers are also equipped to provide our system's Internet protocol (IP) connectivity to HMS' ISP fiber network. There is a built-in redundancy through router and switch configuration of the LAN design with dual ports utilized from unique switches. Scalability is through 10 Mbps to 1000 Mbps bandwidth ports. Web hosting support systems are always available. HMS designed the hosting facilities for redundancy and high availability of power for our critical server systems.

HMS' Disaster Recovery Team reviews and tests the disaster recovery plan annually to successfully identify changes in personnel and determine if recovery stages are current and adequate.

7.5.1.4 Disaster Classes (App 1, IS005)

HMS' Crisis Management Team (CMT) Leader assesses the incident and determines the impact of the situation, identifying operations affected by the disaster, and the duration of time the local office could not continue to operate under the disastrous conditions. At this stage of the DR Plan implementation, it is the CMT Leader's responsibility to categorize the impact of the disaster into one of three severity levels: Level 1, Level 2, or Level 3. These severity levels provide consistency in the assessment of any crisis, so that we provide the proper level of communications response. We describe each disaster class, or severity level, in **Exhibit 7.5.1-1**.

Exhibit 7.5.1-1 Anticipated Disaster Classes
These severity levels provide consistency in the assessment of any crisis, so that we provide the proper level of communications response.

Level	Description	Examples
Level 1	Level 1 indicates a major crisis. A major crisis, within the scope of this plan, is an incident posing significant risk to HMS personnel, visitors, or resources that has caused or has the potential to cause fatalities or injuries, major facility damage, resource loss and/or reputational loss. Such an incident is equivalent to a campus-wide state of emergency and requires activation of the full HMS EOC and Crisis Management Teams to provide an immediate emergency response. HMS may request assistance from the City and/or State agencies or request federal assistance through the state Emergency Operations Center (EOC). A Level 1 crisis may develop from incidents beginning at the Level 3 or 2 stages	◉ Fire ◉ Explosion ◉ Severe weather conditions ◉ Flood ◉ Chemical release, radioactive contamination ◉ Major civil disturbance, bomb threat ◉ Aircraft emergency (flight path) ◉ Confirmed major data breach ◉ Active shooter ◉ Major government investigation/search of an HMS facility ◉ Data Center outage ◉ Life safety threat (personnel, travelers, guests) ◉ Loss of building, critical operations, or systems ◉ Widespread power outage
Level 2	Level 2, within the scope of our plan, includes issue-driven situations that may negatively affect HMS. The incident may be severe and may cause damage and/or have a reputational impact to HMS' operations. A partial or full activation of the HMS EOC may be needed.	◉ Unscheduled or planned protests or disruptions; civil disturbances; unauthorized occupancy of campus areas; sexual assaults; controversial speakers; and hate crimes ◉ Internet activism ◉ Confirmed data breach ◉ Computer system or data center interruption ◉ Natural disasters ◉ Potential life-safety threats related to personnel, travelers, and guests ◉ Unplanned building evacuation ◉ Fraud or theft (large volume or felony value)
Level 3	A Level 3 crisis, or "Limited Crisis," within the scope of this plan, is any incident, potential or actual, foreshowed by a series of events that are not part of a pattern, and do not seriously affect the overall functional capacity of an HMS business office, but nevertheless requires some degree of action. While some damage and/or interruption may occur, the conditions are localized.	◉ Fraud or theft (minor volume or value) ◉ Legal inquiry into HMS or its business operations ◉ Non-critical public health issue ◉ Localized operational or technical disruption ◉ External incident – evaluate newsworthiness ◉ False alarms

7.5.1.5 Risk Analysis and Risk Mitigation (App 1, IS006)

The Business Continuity portion of HMS' BCDR plan includes identification of the core business processes involved in the production solution. HMS uses a systematic approach to the

management of incidents or issues that may seriously affect the company's staff, operations, or reputation. Where possible, this approach uses existing infrastructure and procedures. For each core business process, our BCDR plan includes the following:

- Risk analysis
- Impact analysis
- Definition of minimum acceptable levels of service/output
- Definition of triggers for activating contingency plans
- Procedures for activating any special teams for business continuity
- A plan for recovery of business functions, units, processes, human resources, and technology infrastructure in a timely manner
- Set RPO and RTO targets as defined by BMS
- Communication protocols when restoring operations in a timely manner

The Business Continuity section of our BCDR Plan for BMS will contain the following information for each core business process:

- **Risk and impact analysis.** HMS incorporates a bottom-up approach - Assess, Remediate, Monitor, and Report -- to risk-based probability by instituting a proactive approach to events (such as weather, technology and environmental) that could adversely affect HMS' business. Our Business Continuity Management (BCM) team performs Business Impact Analysis (BIA) routinely to determine how quickly essential services and/or processes would be able to return to full operation following a disaster event. The HMS BCM team understands financial and operational impacts are associated with any type of unplanned outage, and therefore identifies these risks to develop strategies to mitigate them. The BIA process helps determine operational and financial impacts to HMS by analyzing the impact of an interruption to HMS' business functions. This process utilizes specific time frames to measure the restoration times of those critical business functions. To identify the effects of an interruption to HMS, the BCM team documents and analyzes the financial and operational impacts of each critical department and service area including the core critical system and application requirements and dependencies. The purpose of this effort is to prioritize business recovery objectives by developing a comprehensive understanding of the impacts involved when a disruption to HMS' critical business functions occurs.
- **Definition of minimum acceptable levels of service/output and of triggers that activate contingency plans.** As described above, our Crisis Management Team (CMT) Leader assesses incidents and determines the impact of the situation and categorizes the impact of the disaster into the three severity levels: Level 1, Level 2, and Level 3.
- **Procedure for activating special teams for business continuity.** The HMS Disaster Recovery team includes operations, project reporting, supervision, and management under the direction of the disaster recovery coordinator. This person oversees the development, maintenance, and testing of recovery plans. In the event of a disaster, the disaster recovery team leader manages the back-up and recovery efforts and facilitates the support for key

business functions and restoration of normal activities. Numerous special teams comprise our full business continuity/disaster team, such as information technology, telecommunications, local operations, and crisis management. Our plan includes clearly defined tasks and procedures each team must perform in the event of an interruption to business operations.

- **A plan for recovery of business functions, units, processes, human resources, and I technology infrastructure in a timely manner.** HMS' plan calls for the rapid resumption of business functions regardless of the area affected. We base our plan on pre-determined recovery priorities and the nature of the disaster. Our strategy is to recover critical business functions at our alternate site location with a focus on reestablishing client services and business processes. We will work closely with the Agency to prioritize business functions and other elements that could be impacted by a disaster.
- **Set RPO and RTO targets as defined by BMS.** Our system backup procedures are configured to continuously replicate data to achieve near-zero loss. To minimize the potential impacts of data loss between backup periods, HMS will work with BMS to establish acceptable Recovery Point Objective (RPO) and Recovery Time Objective (RTO) targets. As a standard, HMS strives to maintain an RPO of 72 hours and an RTP of 72 hours, but we will work with BMS to establish acceptable targets under this engagement.
- **Communication protocols when restoring operations in a timely manner.** Crisis and emergency management information and communication allow better care for the well-being of our personnel by offering an easy, secure way to access our emergency procedures and safety guidelines. Our all-in-one solution includes incident reporting, push notifications, the ability to build and support multiple plans for preparedness, and the ability to manage different use cases, groups, or locations. For example, if an extended communications outage occurs, we can switch from one line/vendor to another because we have redundancy built into our telecommunications infrastructure.

7.5.1.6 Business Continuity and Disaster Recovery Plan Testing and Reporting (App 1, IS007-IS014)

Conducting regular BCDR exercises is the most efficient and proactive way to plan for adverse situations that might affect the TPL solution. We designed these exercises to validate our processes, create awareness, and identify and remediate any gaps that might exist. To adequately prepare for disaster recovery and secure continuity of operations, our business-resilience team conducts the specific, mutually agreed upon exercises. **Exhibit 7.5.1-2** provides an example of the internal recovery exercises HMS performs.

Exhibit 7.5.1-2 Recovery Testing Exercises HMS Performs
Recovery Testing Exercises are the most effective and proactive way to prepare for adverse situations

Exercise Type	Description
Workspace Disaster Recovery	Our business resilience team conducts workspace disaster recovery exercises to prepare for any disaster through our business office disaster recovery solutions. We collaborated with Agility Recovery for full business office recovery and protection. When a disaster strikes, we mobilize our resources and provide four key elements of recovery: office space, power, communications, and computer systems.
Tabletop Disaster Recovery	We conduct tabletop, discussion-based session exercises to validate the content of procedures for information technology (IT) recovery. Such procedures include contingency plans and incident-response plans. These exercises also verify that our plans are viable and implementable in an emergency. An additional objective is to make sure that we meet regulations and other requirements associated with exercising plans. Each year, we randomly select one of the following categories in which to conduct a tabletop exercise: ◉ Business unit: A test of a specific business unit's continuity plan for the operation of that department ◉ IT: A simulation of a network or other infrastructure component failure ◉ Cyber threat: A simulation of an attempted hack from outside the network perimeter

HMS will conduct annual drill/test of the Business Continuity and Disaster Recovery Plan and will submit the Disaster Recover/Business Continuity Test Report to BMS. The Test Report will include the test outcomes and any corrective action plan items identified during the testing period. In each test conducted, we will test our ability to successfully restore BMS TPL systems and application infrastructures. For each exercise, we evaluate results and lessons learned for risk and impact to determine any necessary remediation treatment. During the testing exercises, we compile the process incidents and situations. After testing, we conduct response and recovery debriefing meetings on lessons learned. These meetings allow us to continually assess and improve our established procedures. We report the results in the Disaster Recover/Business Continuity Test Report which we will deliver to BMS. We then incorporate results-based changes into our overall program, so the BCDR Plan will operate efficiently if a real disaster occurs.

The HMS Disaster Recovery team, under the direction of the Disaster Recovery (Disaster Recovery) Coordinator and the Disaster Recovery Team Leader, oversees the development, training, maintenance, and testing of recovery plans. In the event of a disaster, the Disaster Recovery Team Leader manages the back-up and recovery efforts and facilitates the support for key business functions and restoration of normal activities.

7.5.2 SECURITY PLAN

7.5.2.1 SECURITY PLAN (APP 1, IS015)

A security plan is a documented, systematic set of policies and procedures that details how security policies will be implemented to achieve security goals and protect assets. HMS maintains an industry-compliant, National Institute of Standards and Technology (NIST)-based Security Plan that meets the guidance provided by the Centers for Medicare & Medicaid Services (CMS). Based on the template provided by CMS, our System Security Plan (SSP) includes our policy and control standards, complies with applicable federal and state laws, regulations, security standards, and corporate policies. As described in the requirements further below, our SSP for BMS will also include our policies and procedures for securing our computers, systems and facilities as well as our security incident handling protocols. Our HMS Security Organization has primary responsibility for overseeing and implementing the HMS Information Security Program (ISP) introduced in **Section 7.5.0 Information Management Systems Overview**, and the individual SSPs.

To maintain critical confidentiality of our SSP, in **Exhibit 7.5.2-1,** we provide a snapshot of the Table of Contents from our SSP customized for a recent government healthcare client TPL implementation. We will discuss the West Virginia-customized SSP with BMS during the Implementation.

Exhibit 7.5.2-1 Sample HMS System Security Plan – Table of Contents
Our SSP addresses numerous areas related to security processes and controls.

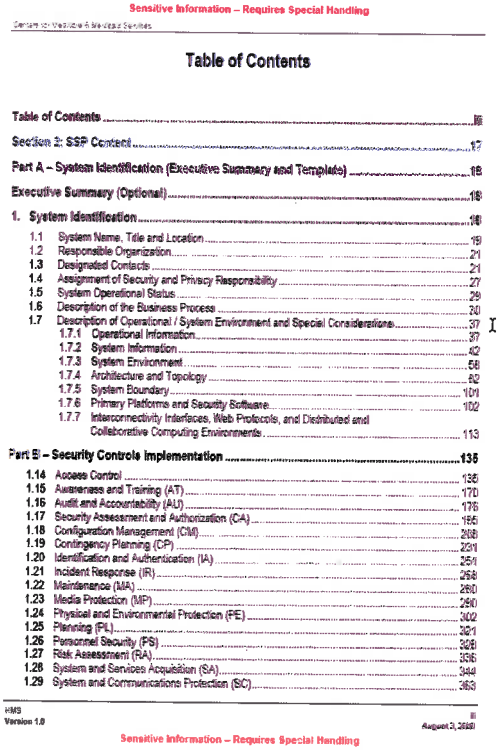
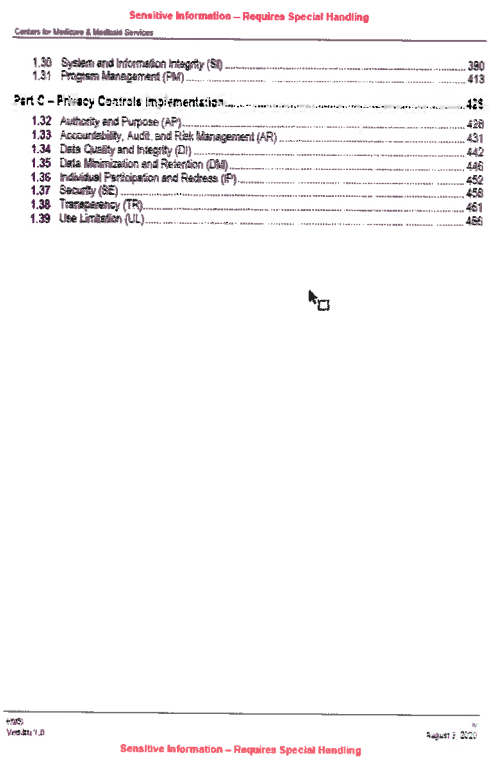

Sensitive Information – Requires Special Handling

Table of Contents

HMS Version 1.0 ii August 3, 2020
Sensitive Information – Requires Special Handling


Sensitive Information – Requires Special Handling

HMS Version 1.0 iii August 3, 2020
Sensitive Information – Requires Special Handling

7.5.2.2 Security Controls (App 1, IS017 and IS018)

Security controls exist to reduce or mitigate risk to assets – computers, systems, and facilities. They can be categorized by type: technical/logical, physical, or administrative. Security controls include any type of policy, procedure, technique, method, solution, plan, action, or device designed to help accomplish that goal. In the RFP, BMS requests information about the following, which we describe further below:

- Logical security controls (e.g., privacy, user access and authentication, user permissions)
- Technical security controls (e.g. communications, hardware, data, physical access, software, operating system, encryption)
- Security architecture
- Security processes (e.g., security assessments, risk assessments, incident response)

LOGICAL SECURITY CONTROLS

As a healthcare services company, HMS is required to maintain a secure processing environment that meets or exceeds the standards of our state, federal, and commercial clients. Logical security controls are hardware or software mechanisms used to protect assets.

PRIVACY

HMS responsibly manages confidential data in every client engagement. We classify all patient protected health information (PHI) and personally identifiable information (PII) as confidential by default. Per HMS' Information Security Program, we also classify all information confidential regarding clients, personnel, payroll, medical, and the company business we must protect. As a respected steward of sensitive health and personal information related to the services we offer, HMS incorporates confidentiality-protection measures into each of our systems and processes. Our policies and procedures capture protocols on safeguarding confidentiality, and we ensure that team members are familiar with these policies and procedures. This process includes, but is not limited to, confirming we do not inappropriately share participant and policyholder information. Our architecture, technology, and applications adhere to state and federal guidelines related to confidentiality. We have implemented and currently maintain our services to meet standards mandated by the HIPAA Privacy Rule.

As part of our Information Security Policy, HMS has protocols in place for how we actively address privacy and protect personal health information (PHI) and other confidential information for clients. In addition to following the HIPAA guidelines, for the purpose of responding to the RFP, our security policies direct how we control user access to the systems that house protected data. We also handle privacy and protect PHI through authentication, user permissions (role-based), and other factors. We have a strong access control policy to trace both physical and system access as well as uncover unauthorized access.

ACCESS

Our proposed solutions and systems provide multiple levels of role-based access, depending on security role and functionality, for user access to our systems. Permissions vary depending on solution and the role of the user and follow the principle of least-privilege access. The role-based security of our applications allows us to fine-tune access for each type of user. Through CA® Single Sign-On, we restrict access to data based on a person's defined role. This tool also supports federated log-in, which allows more integration flexibility for authentication.

Additionally, our identity management (IdM) system provides workflow-driven user provisioning and application access based on the user's role at HMS—whether an employee, contractor, client, or business partner. Through this IdM application and associated processes, we can restrict the system functions and data accessible to a user. Using one set of centrally managed access and automation policies allows us to improve operational efficiency. Most importantly, this approach reduces security risks and/or misuse of our IT assets.

Active Directory is our primary method of governing system and application access. Logging and monitoring access attempts—both successful and unsuccessful—to data stored in HMS' processing facility helps us ensure that only authorized personnel have access. Our security apparatus allows us to set limits on unsuccessful access attempts. We define the following limits, along with our control points and policies, in documents on information technology (IT) policies and procedures:

- After three unsuccessful log-on/sign-in attempts within a 24-hour period, automatic suspension of the identification in question and sending of an error message to the platform administrator occurs. After a failed log-in attempt, the system presents the user with a message that only states that the log-in was unsuccessful.
- If system users attempt to access data to which they do not have permission, the system immediately generates a violation message. Platform administrators review these records and send findings to our Chief Information Security Officer (CISO) for disposition, further action, and/or sanctions.
- Review of all network-security logs occurs daily, and our CISO reviews the mainframe-security logs on a weekly basis. These logs are then subject to our Statement on Standards for Attestation Engagements (SSAE) 16 Service Organizational Control (SOC) Type 1 (SOC1) audit.

After detecting a predefined limit of failed attempts to access restricted/controlled data, our security systems notify the appropriate support personnel of the attempts. The security systems lock down future access until we can investigate and resolve the circumstances.

Multi-Factor Authentication

HMS utilizes a combination of both user credentials and machine certificates to satisfy multi-factor authentication (MFA) requirements. For example, a machine certificate answers "something a user has." The machine is assigned to them and the machine must be domain-joined to obtain a machine certificate. The machine certificate template is configured to not allow export of the private key. This identifies the device as being an HMS-provided device.

- Something a user has – HMS machine
- Something a user knows – A password. Our device certifications have been accepted by HITRUST as a valid form of authentication. HMS is HITRUST certified and adheres to the HITRUST CSF control framework. HITRUST has become the accepted standard for healthcare industry security; a number of notable clients mandate HITRUST certification as a requirement for doing business.

Remote users are required to authenticate to the corporate VPN gateway using HMS-managed user credentials and managed devices with valid device certs.

User IDs and Passwords

HMS is dedicated to the protection of project-related data information and associated resources. We ensure that only authorized personnel have access to project-related data. To accomplish this, we require the use of a company-issued username and company-approved password.

To ensure the strength and security of employee passwords:

- Each password must contain a minimum of eight (8) characters
- Passwords expire if not changed after 60 days
- Accounts disable after three failed logon attempts
- Passwords should be a minimum of eight (8) characters and contain at least three (3) of the following four (4) classes
  - English uppercase letters (e.g., A, B, C, ...Z)
  - English lowercase letters (e.g., a, b, c, ...z)
  - Westernized Arabic numerals (e.g., 1, 1, 2, ...9)
  - Non-alphanumeric (special characters) (e.g., ?, ! , %, $, #, etc.)

User selections for new passwords are checked against the history and rejected if there is a match. Users are not allowed to change their password more than once in a 24-hour period, without the intervention of a security administrator. Additionally, if a user forgets their password and must reset it, our Identity Management (IDM) system poses various questions to the user to confirm their identity before the password change is accepted.

Access Monitoring

HMS employs an enterprise-class Security Incident and Event Management (SIEM) program to monitor access to sensitive data and critical functions. A managed security service provider monitors the SIEM 24 hours per day, 7 days per week, 365 days per year. The SIEM maintains logging of authentication and access attempts with date/time stamps. Transmission of information, such as email and files, is logged through an email security system and firewall activity tracking (respectively). HMS maintains policies on confidential information that stipulate encryption as a requirement.

Logged activities include, but are not limited to:

- All successful and unsuccessful login attempts
- All logoffs
- Login attempts using invalid passwords
- Additions, deletions, and modifications to user accounts/privilege
- Users switching IDs during an online session
- Attempts to perform unauthorized functions
- Activity performed by privileged accounts Modifications to system settings (parameters)
- Access to restricted data

- Additions, deletions and modifications to security/audit log parameter
- User account management activities
- System shutdown
- System reboot
- System errors
- Application shutdown
- Application restart
- Application errors
- File creation
- File deletion
- File modification
- Failed and successful log-on
- Security policy modifications
- Use of administrator privileges and
- File access

All systems forward logs of required event types (privileged operations, authorized access, unauthorized access attempts, and system alerts or failures) to QRadar. QRadar retains these logs for 13 months, per configuration settings. Audit log access is restricted to authorized users.

TECHNICAL CONTROLS

Technical controls are safeguards that are incorporated into computer hardware, software, or firmware. The **controls** can provide automated protection from unauthorized access or misuse, facilitate detection of **security** violations, and support **security** requirements for applications and data.

COMMUNICATIONS, INCLUDING THOSE OVER THE INTERNET

During day-to-day TPL operations, including interactions with entities outside HMS, we take additional measures to help ensure the secure handling of personal health information and other confidential information for clients. Our qualified and experienced team members often receive leads and inquiries through email, telephone, and fax requests from providers, WV Medicaid members, and State personnel. We handle requests securely through these methods as follows:

- **Secure email transmissions.** HMS uses Proofpoint Enterprise Protection™ encryption software to secure the encryption of email messages, including those that contain PHI. In addition, HMS Project team members can access email messages and calendars through personal mobile devices, as needed. We use Microsoft Office 365, coupled with Microsoft InTune Company Portal technology, to create an encrypted, remotely "scrub-able" container on portable devices such as smartphones, tablets, and laptops.
- **Secure phone transmissions.** The HMS phone system encrypts all call recordings for PHI purposes.
- **Secure fax transmissions.** All transmissions meet our HIPAA-compliant policies and protocols.

Security Architecture

HMS' enterprise security architecture (ESA) ensures that our data security processes align with all applicable security requirements. It achieves security objectives by providing systematic guidance on analyzing, developing, and implementing a logical program to secure our clients' data. The following list includes several networks, computer systems, network resources, software applications, and data security technologies and software that we use to protect this data:

- Veracode℠ for vulnerability scanning of internal application assets
- Rapid7® Nexpose® Vulnerability Scanner for scanning infrastructure assets
- Proofpoint Enterprise Protection™ for enforcing encryption of PHI sent through email
- McAfee® ePolicy Orchestrator® for enforcing host-based, virus-protection policies
- Absolute® Computrace for enforcing administration of laptops
- Cisco® Adaptive Security Appliance and Palo Alto Networks™ for firewall protection
- IBM® QRadar® Security Intelligence Platform for event logging and monitoring
- Cisco Sourcefire® Intrusion Prevention System for network-intrusion prevention
- Crowdstrike® Falcon Host Endpoint protection for malware prevention and protection
- SA® Archer Governance, Risk and Compliance Framework for managing compliance and risk
- CA® Identity Management for managing authorization, authentication, and user provisioning
- Exabeam® User Behavior Analytics tools for evaluating information and communication from a user and system perspective
- Imperva® Database monitoring tool to screen, evaluate information on databases, and manage access to database systems
- Zscaler® Secure Web Gateway for enforcing internet and web security protection

Maintenance of the Security Infrastructure

HMS maintains a secure processing environment. Through annual and as-necessary reviews of our policies and procedures, as well as exercises designed to test our secure environment, we continually build on our ESA. Our policy is to handle all data according to strict protocols, document and maintain that information in a central database, and update it as necessary.

Physical Security Controls

Our IT infrastructure includes two data processing centers: one located in Richardson, TX, and a secondary hosted center in Las Vegas, NV. The dual-connected centers have dedicated

network service connections to one another to provide interconnectivity and provide the processing power and connectivity for all our major business applications.

The physical configurations of our data processing centers are within secure, access-controlled facilities that provide operating capabilities 24 hours a day, 7 days a week. These centers have automatic fire-suppression capabilities and emergency uninterruptible power supplies.

Our physical-security systems (i.e., Electronic Access card and video) comply with all applicable regulations, including, but not limited to, building and fire-prevention codes. All employees wear identification badges, and we have secured entry points at all locations that require an electronic access card to enter. Security cameras monitor employee and visitor activity as well as access. We document unauthorized access attempts and research them for further actions.

Physical Security Controls:
- Office floor access
- Employee work areas
- Vendor/contractor access
- Sensitive-area control
- Video surveillance and access-point control

We supplement the electronic access cards with policies and procedures requiring the following actions:

- Clear marking of restricted areas and facilities
- Signage for restricted areas and facilities
- Every individual granted physical access to restricted information resources or facilities receives training on emergency procedures for the facility
- Access to information resources or facilities that follows the principle of least-privilege access. Personnel, including full- and part-time team members, contractors, and vendor service personnel, only receive access to the facilities and systems necessary for the fulfillment of their job duties.
- The process for granting physical access to information resources or facilities includes the approval of authorized managers.
- Handling of access management occurs at the manager level. Each individual granted physical access to information resources or facilities must sign appropriate access, information-protection, and nondisclosure agreements. Managers are responsible for keeping track of and informing the appropriate party of the access rights of individuals who leave or change roles. Furthermore, our Security and Compliance Department reviews all card- and/or key-access rights for a facility on a periodic basis and removes access for individuals who no longer require it.
- Access re-certification to sensitive facilities and rooms occurs every 90 days.
- Authorized visitors to our work sites must present valid identification with the office receptionist before signing in to visit. The visitor receives a temporary identification badge that he/she must wear at all times while in our office. He/she receives escort from an authorized employee.

In addition, security cameras monitor our offices, and it is the policy to review all videos and store them for 90 days.

Secure Transmission and Storage of Data

Our protocols include secure handling of BMS data while in transit, in transit, at rest, and when archived.

Data Transmission

The secure transmission of our clients' data is one of our primary areas of focus. We want to safeguard PHI and personal data appropriately in accordance with each client's guidelines. Our long history of maintaining the privacy of this type of information has given us extensive experience in the secure handling of client information. We securely transfer data to all clients through AES 256-bit, IPsec-encrypted VPN tunnels. Use of IBM data-encryption hardware and software technologies protects our transfer of physical media (e.g., magnetic tapes). We also support the following:

- Secure web mailbox for Hypertext Transfer Protocol Secure file exchanges via web browser
- File Transfer Protocol (FTP) Secure for file transfers via TLS
- Secure Shell FTP for file transfers via Secure Shell and Connect:Direct® (formerly Network Data Mover)

Our Production Control Department follows our acceptable data-use policy when transmitting data. The team takes particular care when transmitting confidential or client-sensitive data and complies with the following measures:

- All confidential or client-sensitive data transmitted through email requires encryption. We use Proofpoint as a secure enterprise email solution.

Any confidential or client-sensitive data transmitted through a public network (e.g., the Internet) to and from vendors, clients, or entities doing business with us requires encryption or transmittal through an encrypted tunnel or secure web portals. For data encrypted at rest, AES 256-bit-encrypted tape or Pretty Good Privacy–type encryption software is acceptable.

Data at Rest/Stored

We understand the importance of securely handling and storing project-related data, including PHI and other information that must remain secure at all times. We protect confidential healthcare data at rest on computer systems owned by and located within HMS' controlled spaces and networks by at least one of the following methods:

- Encryption
- Firewalls with strict access controls that authenticate the identity of those individuals accessing the HMS network

- Securing the data requiring protection during storage to prevent unauthorized exposure. All data is secured within a physical space that is controlled and managed by an electronic key card system.
- Other compensating controls, including complex passwords and physical isolation/access
- HMS password policies and guidelines stating that password protection, if used alone, is not an acceptable alternative to protecting confidential PHI data; but when combined with all controls, including encryption, is a viable security method
- Data server segregation by company

Portable devices may contain data at rest. A well-known security risk in the healthcare industry involves incidents of unauthorized exposure of confidential, or PHI, data resulting from stolen or lost Portable Computing Devices (PCDs). The most effective means to prevent these exposures is to avoid storing confidential data on those devices. However, in limited situations that require storing confidential or BMS-sensitive data on such devices, HMS enforces our security policy that requires encryption to reduce the risk of unauthorized disclosure if the device is lost or stolen.

CONTROLS TO MONITOR PHYSICAL AND SYSTEM ACCESS

A proactive approach to physical asset management ensures we follow best practices for access automation, the ability to manage guidelines holistically, and to perform continuous monitoring. We have a strong access controls policy to trace both physical and system access as well as uncover unauthorized access. To safeguard client information, our access audit-control methods include the following:

- Reviewing our processes on a regular basis to determine effectiveness, and then making any necessary enhancements
- Conducting monthly internal audits for both physical and logical access
- Producing reports by each authenticating system
- Continuous monitoring of all physical access points

7.5.2.3 SECURITY PROCESSES (APP 1, IS019)

We continuously assess the stature of our business applications, infrastructure, and connected systems. This is necessary to maintain the diverse network of systems accessible by our clients and business partners.

Security Assessments

HITRUST® Certification and Assessment

HMS became HITRUST CSF certified in August 2014, and continues to maintain our certification in good standing, including the maturity of our Security/IT posture with annual assessment benchmarks and recertifications every two years as required by the HITRUST Alliance.

During this assessment, evaluation of compliance for each HITRUST CSF-control specification occurs. In addition, this assessment works to validate that none of the material changes to our core IT infrastructure and/or other technology components made since the previous assessment/certification will fail to meet the current certification criteria.

Developed by security professionals in the healthcare industry, the HITRUST CSF integrates a diverse set of control requirements by eliminating inconsistent and duplicate requirements among various compliance frameworks.

Integration of HITRUST CSF standards into our security risk management and assurance program includes a comprehensive assessment process that reviewed 299 controls across 19 assessment domains. These assessment controls spanned five key areas that resulted in less ambiguity during the assessment and helped reduce subjective interpretation:

- Policy
- Process
- Implementation
- Measurement
- Management

Our security risk management and assurance program, backed by the HITRUST certification, enables us to balance a centralized approach while continually innovating. Our HITRUST certification encompasses the following frameworks:

- Health Information Technology for Economic and Clinical Health (HITECH) (enacted February 17, 2009)
- Health Insurance Portability and Accountability Act (HIPAA) (Public Law 104–191, 110 Statute 1936, enacted August 21, 1996)
- HIPAA Security Rule

Service Organization Control (SOC) Type 2 Audit

A service organization control (SOC) 2 is an audit that ensures that a service organization can securely manage data to protect the interests and privacy of its clients. Developed by the American Institute of CPAs (AICPA), it sets criteria for managing client data based on trust service principles of data — availability, confidentiality, processing integrity, privacy, and security. The Type 2 report provides a management description of a service organization's system, and the suitability of the design and operating effectiveness of controls.

An independent, third-party organization conducts an annual SOC 2® audit on HMS. Our most recent report covers the period from January 1, 2019 through December 31, 2019, which we can provide to BMS upon request.

RISK ASSESSMENTS

We continuously assess the status of our business applications, infrastructure, and connected systems. This is necessary to maintain the diverse network of systems accessible by our clients and business partners. We recognize the risks that our network and applications face each day, so we employ leaders who are highly experienced and who specifically focus on threat and vulnerability management. Following are several types of risk assessments and tests that HMS conducts regularly.

PENETRATION ASSESSMENTS AND TESTING

A penetration test, also known as a pen test, is a simulated cyberattack against a computer system to check for exploitable weaknesses in the architecture of our IT network and determine the degree to which a malicious attacker can gain unauthorized access to our assets. The process involves gathering information about the target before the test, identifying possible entry points, attempting to break in -- either virtually or for real -- and reporting back the findings.

Through a series of internal and external penetration assessments, we identify and remediate issues for timely resolution and then update our processes and standards so we can avoid future institutionalized vulnerabilities.

VULNERABILITY ASSESSMENTS AND SCANNING

Vulnerability assessments are an important component of the vulnerability management and IT risk management lifecycles, helping protect systems and data from unauthorized access and data breaches. They provide security teams and other stakeholders with the information they need to analyze and prioritize risks for potential remediation in the proper context. Vulnerability assessments refer to the process of identifying risks and vulnerabilities in computer networks, systems, hardware, applications, and other parts of the IT ecosystem. This is done proactively through vulnerability scanners, both internal and external, that identify threats and flaws in our systems that represent potential vulnerabilities or risk exposures. The scans report these potential exposures, which HMS can rectify through techniques such as patch management.

HMS' APPROACH TO CYBERSECURITY

Taking risk assessment a step further, HMS' Information Technology (IT) Security team leverages cyber threat intelligence (CTI) against increasingly sophisticated attack scenarios that require a preemptive stance to avoid victimization. The CTI provides an accurate, in-depth understanding of the potential threats. Our cyber threat intelligence information is brought into multiple security technologies with multiple sources. Internet Protocol (IP) address information routes through our Intrusion Prevention System. Malicious systems and users route through our

Security Information and Event Management System to allow them to detect how and where threats occur, vulnerabilities at risk of exploitation, parties who might be responsible for threats, and the threat motivators. Finally, we have courses of action in place to address these threats (i.e., how to prevent, detect, respond to, and recover from attacks). Examples of our in-place measures include:

- Deployment of the **Defense in Depth strategy**
- Employment of **geolocation blocking** to restrict access to our networks from specific geographic locations identified as potential threats
- Incorporation of **automatic threat-intelligence feeds** into our Security Information and Event Management (SIEM) program from trusted sources such as Health Information Trust Alliance (HITRUST), Cisco®, IBM®, Intel®, and the Centers for Medicare & Medicaid Services (CMS)
- Continuous **vulnerability assessments** designed to keep us abreast of vulnerabilities from misconfiguration, system malfunctions, unpatched systems, or sensitive data exposures

Geolocation blocking, the process of using geolocation techniques such as verifying Internet Protocol (IP) addresses against a blacklist or whitelist, allows us to perform the following actions:

- Prevent users from accessing our websites and systems when we deem the access invalid
- Control malicious traffic on our networks

We implemented geolocation blocking on our network entry point following a detailed analysis that identified the geographic origin of the most security events. These protection rules block all traffic based on specific IP addresses of concern uncovered through our analysis efforts.

To identify correlating external threats, we integrate IBM® X-Force℠ threat information into the SIEM program. This expanded logging included for forensics and analysis incorporates network traffic, operating-system platforms (Windows® and Linux®), web traffic, and Database Logs.

INCIDENT RESPONSE

HMS remains committed to maintaining the integrity of the data stored and processed within the HMS network infrastructure at all times. HMS ensures that we meet the incident response requirements levied by the HIPAA, Sarbanes-Oxley Act, and other data security regulations in the healthcare environment.

HMS promotes a well-defined, documented approach for managing communications in the face of potential threats, including hacker attacks, to computer systems and the data processed by and stored on those systems.

This commitment extends to our processes and resources used to respond to potential threats to data or systems. HMS uses our well-defined Computer Security Incident Response Plan (CSIRP), which is a thoroughly documented approach for managing communications when a threat is identified or suspected (i.e., "incident"). The HMS CSIRP is the process through which

we respond to computer security incidents. This process applies to all network infrastructures, system, and devices that we manage and administer.

HMS' Incident Response Manager oversees the CSIRP and is the key decision-maker throughout the duration of all computer security incidents. In consultation with our Security Manager, the Incident Response Manager determines whether to raise or lower the severity level during an incident.

7.5.2.4 Technical Controls Documentation (App 1, IS020 -IS030)

As noted, technical controls are security controls, hardware or software mechanisms, used to protect assets. Technical controls can provide automated protection from unauthorized access or misuse, facilitate detection of security violations, and support security requirements for applications and data. HMS maintains several items that together document our various security controls, including technical controls. These include our Information Security Overview, System Security Plan, HITRUST Certification Assessment Report, Information Security Policy, etc. As requested in the RFP, and in accordance with the information provided above, we affirm that our SSP (provided to BMS during Implementation Task Group 2), documents and addresses the following security controls, at minimum.

- Networking segmentation
- Perimeter security
- Application security
- Intrusion management
- Monitoring and reporting
- Remote access
- Encryption of data at rest, in transit, and in use on servers, databases, and personal computers
- Interface security
- Secure, over-the-Internet communications

In addition to those described in **Section 7.5.0 Information Management Systems Overview**, we also affirm that our security practices are based on FIPS 200 and NIST Special Publications 800-53, and the Gramm-Leach-Bliley Act (GLBA). We conduct annual evaluations and updates (as necessary) to all our security policies, controls, processes, and documentation based on these current standards.

7.5.2.5 Security Policies (App 1, IS016)

Our HMS Information Security Policy, which serves as the foundation for our ISP, identifies the rules that will be followed to maintain security in our systems. These define the fundamental principles for the protection of HMS information resources, the proper controls needed to ensure compliance with internal and external regulations, and to uphold our company's reputation with clients. Also known as our administrative security controls, our various security policies consist of detailed descriptions of administrative, technical, and physical safeguards to protect information assets.

All HMS personnel are responsible for ensuring compliance with this policy. In accordance with the regulations of our Governance Board, we have adopted security policies based on industry standards and best practices. They comply with federal regulations, such as HIPAA and HITECH security rules.

Our comprehensive Policies and Standards document, reviewed and updated annually in October, captures the security policies HMS has adopted and that are based on industry standards and best practices. In **Exhibit 7.5.2-3**, we include a Table of Contents for our most recent 2019 HMS Information Security Policy Overview. This document lists the various topics that underpin our ISP and provide the security standards of operation employed by HMS and any subcontractors we engage to assist in providing services to our clients.

Exhibit 7.5.2-3-HMS' Policy Center Overview Document – Table of Contents
The HMS Policy Center Overview Document lists the various topics that underpin our ISP.

October 31, 2019 **POLICY CENTER OVERVIEW**

Table of Contents

Due to the sensitive nature of the data that our clients entrust to us—and our commitment to protecting this information—HMS cannot provide our full Corporate Security Policies Document. However, we will provide a more detailed overview and answer any additional questions if needed via a telephone and/or WebEx® meeting. To further enhance our Security policy, HMS earned our HITRUST Common Security Framework (CSF) Certification in August 2014, which we currently maintain and describe in **Section 7.5.0 Information Management Systems Overview**.

7.5.2.6 MEETING THE ACCEPTANCE CRITERIA (APP 1, IS031)

HMS affirms our understanding that the Security Plan deliverable should meet the acceptance criteria established between BMS and HMS.

7.6.0 CRITICAL SERVICES

7.6.0.1 TPL WEB PORTAL (APP 1, CS001)

We understand that BMS requests we maintain a TPL web portal that supports the State's TPL programs with the following functionality:

- A vehicle for distribution of reports by HMS to BMS-approved stakeholders, for both standard and ad hoc reporting
- Ability to view and update insurance policy verifications
- Ability to search and track TPL functions
- TPL programs for BMS
- Access to live, updated information on all cases.

OUR APPROACH TO PROVIDING THE REQUESTED WEB PORTAL FUNCTIONALITY

HMS will create and maintain a TPL web portal in accordance with the requirements of this RFP. HMS has robust tools, many already in use by BMS, which will provide the needed oversight into the activities performed for the TPL Services scope of work. During the Planning and Design phase of the new contract term, we will review the requirements and identify and plan for any new development needed to fulfill the goals for the web portal. As BMS refines their MES Strategy and engages a system integrator (SI), we will work to ensure our web portal is integrated and allows for single sign-on capability as directed by the SI.

HMS provides BMS stakeholders access to the requested information and functionality through the following means listed in **Exhibit 7.6.0-1**. These systems, in operation today or approved and scheduled for full deployment no later than 90 calendar days of contract award, provide the transparency desired by BMS and include all the capabilities listed above.

Exhibit 7.6.0-1 HMS Systems that Provide Transparency and Requested Capabilities
HMS already has robust tools, many already in use by BMS, which will provide the needed oversight into the activities performed for the TPL Services scope of work

Function/Capability	Our Approach	See these Proposal Section(s) for More System Details
Distribution of reports to Bureau-approved stakeholders; comprehensive, ad hoc and standard reporting	HMS Portal A streamlined, single-interface system that allows clients and providers to manage the entire claim identification and recovery process ◉ Manage the entire claims process through a single portal for enhanced efficiency and productivity. ◉ Access a complete list of patients, claims and primary insurance information with just one click. ◉ Maintain Protected Health Information compliance through a secure paperless system. ◉ Users can view data and run on demand reports associated with WV Medicaid reclamation billing and collection. ◉ Our ReSults platform (described in **Section 7.2.4**) houses the data from our program integrity services under a RAC program. BMS will have access to ReSults data and reports through the HMS Portal ◉ Review, acknowledge, report and upload claims information in real time. HMS 360 ◉ Currently deployed for a dozen HMS clients already, BMS is in UAT testing for HMS 360, scheduled for full deployment by end of this year. ◉ HMS 360 will be integrated with the HMS Portal within 90 days of contract award ◉ HMS 360 provides a complete view of the full value of HMS products and services. ◉ Developed in collaboration with our clients using design thinking principles, HMS 360 provides financial savings and recovery data for each product currently enrolled ◉ Integrated with data analytics providing additional performance and operational metrics	HMS Portal ◉ 1.4 TRICARE, Medicare, and Commercial Recoveries ◉ 2.4 RAC HMS 360 ◉ 1.0 TPL Services Overview
Insurance Verifications	eValidate and eReferral Insurance coverage verification tools are in use today by BMS and will continue to be available during this contract term. ◉ **eValidate** is a web portal that BMS can use to re-verify cost avoidance records, previously delivered by HMS, that conflict with what is in the MMIS. Our HMS team receives BMS' request submitted through the portal and reverifies the policy within three business days to ensure the most accurate information is available to BMS. The updated record is then transmitted on the next cost avoidance deliverable. ◉ **eReferral is a web portal that** allows BMS to submit policy leads that we have not yet delivered to the State through our weekly cost avoidance file and will inform HMS. These are policies that we may not have coverage information on in our NEDP; or, we may have the coverage, but BMS has specific edits in place that prevent our team from delivering the coverage in our cost avoidance file.	◉ 1.6 TPL Adds

Function/Capability	Our Approach	See these Proposal Section(s) for More System Details
Search, View and Track TPL Functions Related to BMS' TPL Program	HMS Portal As described above – HMS Portal will provide full oversight into functions related to BMS TPL Programs. Additionally, we provide detailed financial data in our A/R Claim Tracker. A/R Claim Tracker Our A/R system that houses 24 months of insurance data and allows for effective financial controls and complete tracking and reporting capabilities. It includes robust view, track and search capabilities. ◉ Maintains a record for every claim billed on BMS' behalf along with posting claims activity (payments and denials) at the claim level ◉ Comprehensive audit trail for State and federal documentation requirements that provides the adjudication status—and subsequent follow-up activity—through closing of each claim.	◉ 1.4 TRICARE, Medicare, and Commercial Recoveries ◉ 2.4 RAC
View Live, Updated Case Information	Maestro ◉ Our Maestro tracking and case management system maintains a history of all case activities for Estate and Casualty-Trauma cases. ◉ Maestro includes details from our *Solaris Plus* web portal. Through Solaris attorneys can register and sign up for a Solaris account whereby they can create their own cases directly in Maestro. PIER ◉ Our web-based Premium Identification, Evaluation, and Reimbursement (PIER) Case Management System, specifically designed for Medicaid HIPP programs ◉ Pier manages and tracks all aspects of the WV HIPP program, from enrollment through premium reimbursement, including case management and reporting.	Maestro ◉ 1.2 Casualty-Trauma Recovery ◉ 1.3 Estate Recovery PIER ◉ 2.1 Premium Reimbursement Program ◉ 2.2 Work Incentive Premium Program

As a trusted steward of the TPL data our clients entrust to us, we have developed our web portals to be compliant with all applicable federal and State laws, regulations and guidelines as well as those that govern the security of PHI found on the CMS website.

We will also provide user documentation and appropriate training on any systems, or functionality, noted above that are not currently utilized by BMS or its stakeholders.

7.6.0.2 Go-Live Requirements (App 1, CS002)

HMS' proposed solution will meet the core TPL services requirements requested in the RFP, as agreed upon with BMS, and the requirements will be operational for Go-Live within 90 business days from contract award. We will also meet with BMS during project initiation to gather any additional requirements that we need to incorporate for implementation. During the contract term, we will make any necessary enhancements to these requirements, as the State finalizes its MES strategy. We will also collaborate with BMS to identify any additional proposed enhancements that the WV TPL program can benefit from in the new contract, and we will implement these requirements within a timeline agreed upon with BMS.

7.6.0.3 Submission of A/R Files (App 1, CS003)

As part of our standard TPL program operations in WV, HMS sends recovery and accounts receivables (A/R) files to BMS monthly. Upon commencement of the new contract implementation, we will send recovery and A/R files to BMS within 90 calendar days following the effective date of the contract. For subsequent receipts of recoveries, we will continue to send the A/R files to BMS monthly. Please refer to **Section 7.1.4 TRICARE, Medicare, and Commercial Recoveries** for more information about our A/R and collections process.

7.6.0.4 Reporting Unidentifiable TPL Recoveries (App 1, CS004)

HMS affirms that we will report records of not found/unidentified third-party recoveries to BMS, in an agreed-upon format, within 90 calendar days after the contract effective date and as part of the monthly invoice thereafter. We cover this item in Step 4: Balance and Reconcile Current Month Receipts of our Collections process found in **Section 7.1.4 TRICARE, Medicare, and Commercial Recoveries.**

Instructions for Completion of Appendix 1 - Detailed Specifications

1. The Vendor should provide the Section, and Page Number(s) where its detailed narrative response for each specification resides, providing the Department with a crosswalk, ensuring that each specification is addressed. It is up to the Vendor to update the Section, and Page Number(s) columns.
2. Using Tab 3 - Specifications & Responses, the Vendor should provide the Attachment, Section, and Page Number(s) where its detailed narrative response or acknowledgement for each specification resides.
3. **Hierarchy Level:** The hierarchy level column defines relationships between parent and child specifications. The Department refers to parent specifications as specifications that rely on the content of a subset of related specifications (children) to fully define the scope of the requirement. The Department refers to child specifications as specifications that rely on additional context provided by a higher-level specification (parent) to fully define the scope of the specification. A hierarchy value of 1 denotes the highest level specification. A hierarchy level 2 is a child to the nearest prior hierarchy level 1.
4. Each Vendor's Technical Proposal should contain responses as indicated within the RFP as "<Response>" and two (2) completed Microsoft Excel® workbooks or in two (2) tables consistent with the RFP: Attachment 6: Mandatory Requirements and Appendix 1: Detailed Specifications. Each Technical Proposal should include a response to every request for information in this RFP whether the request requires a simple "yes" or "no" or requires a detailed explanation. When a detailed response is required, simply repeating the RFP's requirement and agreeing to comply may be an unacceptable response. As per Attachment 6: Mandatory Requirements and Section 6.5.2 Failure to Meet Mandatory Requirements, the Vendor should describe how it will comply with the mandatory requirements and include any areas where its proposed solution exceeds the mandatory requirement.
5. To ensure that each Technical Proposal addresses the required sections of the RFP, Vendors should identify and address each RFP specification in ***Appendix 1: Detailed Specifications*** using the associated specification identification number and language. The Vendor should provide its proposed solution or response to the specifications in-line. Note that Vendors are expected to provide a "one-to-one" response; in other words, each specification should be easily identifiable with a corresponding response. Vendors should review the example of an expected RFP response format below.

APPENDIX 1: DETAILED SPECIFICATIONS APPROACH

Instructions: The Vendor must provide a narrative overview of how the proposed system will meet the detailed specifications. Use the response sections to provide specific details of the proposed approach to meeting the detailed specifications in each subject matter area. Responses should reference specifications using the appropriate specification IDs from ***Appendix 1: Detailed Specifications***. The Department also expects the Vendor to propose its approach for meeting any narrative included in Section 4 of this RFP. Responses in this section must be highly focused on the business processes and specifications and not simply provide generic or marketing descriptions of solution capabilities.

If the Vendor is proposing a phased implementation, they must indicate how that approach may or may not affect functionality. Additionally, the Vendor should indicate exception handling processes where appropriate and any dependencies on existing systems or components of the new system to provide the specified functionality.

TPL Management

Refer to the relevant detailed specifications located in Appendix 1: Detailed Specifications and pertinent narrative in Section 4 in this RFP to cover solution capabilities in this area. The Vendor must describe its approach TPL Management below. The narrative response for this category must be organized using the appropriate subject matter area as per Appendix 1: Detailed Specifications.

TM001	The Vendor should describe how it will recover funds only from the portion of a member's settlement/judgment intended to cover medical items or services, including pharmacy.

<Response>

Tabs in this spreadsheet	
1. Worksheet Instructions	Contains instructions for completion of this RFP supplement.
2. Worksheet Information	Contains information about the contents of this workbook.
3. Specifications & Responses	Contains the specifications and all related data.
4. Code Values	Contains coded values for use in the specifications and response tab, and explanations as

Columns on the Specification & Responses Tab		
Section	**Column**	**Description**
Specifications	*Req ID #*	The unique ID of the specification.
	Hierarchy Level	The hierarchy of the specification.
	Specification Text	The text of the specification.
	Subject Matter Area	How the specification is categorized in the RFP.
Vendor Response Area	*Section and Page Reference*	Vendor is expected to provide a reference to its RFP response by Section and Page Number where more detailed information about the specification can be found.

Detailed Specifications Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
CS001	1	The Vendor must maintain a Third-Party Liability (TPL) web portal that is approved for operations no later than ninety (90) calendar days of contract award date. The system must have capability for distribution of reports to Bureau-approved stakeholders; comprehensive, ad hoc and standard reporting; insurance verifications; searching and tracking of functions; and TPL programs for the Bureau. In addition, the system must provide live update information on all cases.	Critical Services	7.6.0.1	7.6-1
CS002	1	The Vendor must have a set of requirements operational for go-live, as agreed upon with the Bureau, within ninety (90) business days of contract award. The remaining requirements must be implemented within a timeline agreed upon by the Bureau.	Critical Services	7.6.0.2	7.6-3
CS003	1	Send recovery and accounts receivable files to the Bureau within ninety (90) calendar days following the effective date of the contract and subsequent receipts of recoveries at least every thirty (30) calendar days thereafter	Critical Services	7.6.0.3	7.6-4
CS004	1	Report to the Bureau records of unidentifiable third-party recoveries in a format acceptable to the Bureau within ninety (90) calendar days after the effective date of the contract and at least every thirty (30) calendar days thereafter; the data will be reported within thirty (30) calendar days following discovery of the resource.	Critical Services	7.6.0.4	7.6-4
IS001	1	The Business Continuity and Disaster Recovery (BCDR) Plan defines the resources, actions, and tasks required to protect and recover data and the data infrastructure in the event of a disaster. The Vendor should describe their BCDR Plan, including, but not limited to, the following:	Information Management Systems	7.5.1.1	7.5-6
IS002	2	Vendor Disaster Communication Plan	Information Management Systems	7.5.1.2	7.5-8
IS003	2	Backup and protection plans and procedures, including data files and transaction logs from all environments, software, hardware, and network connectivity	Information Management Systems	7.5.1.3	7.5-9
IS004	2	Detailed backup and recovery procedures for all anticipated types of disasters to ensure that data maintained is properly and routinely purged, archived, and protected from loss, unauthorized access, or destruction, in accordance with all relevant Bureau policies and procedures	Information Management Systems	7.5.1.3	7.5-9
IS005	2	Description of each anticipated class of disaster	Information Management Systems	7.5.1.4	7.5-13
IS006	2	Risk analysis and risk mitigation for each core business process	Information Management Systems	7.5.1.5	7.5-14
IS007	2	Processes and procedures for testing and reporting for the Business Continuity and Disaster Recovery (BCDR) Plan, including, but not limited to, the following:	Information Management Systems	7.5.1.6	7.5-16
IS008	3	Failover/fallback functionality	Information Management Systems	7.5.1.6	7.5-16
IS009	3	Backup/recovery functionality	Information Management Systems	7.5.1.6	7.5-16
IS010	3	Plans detailing responsibilities, activities, and processes to be used in case of system failure at any time	Information Management Systems	7.5.1.6	7.5-16
IS011	3	Identification of potential go-live system failures and negative events with mitigation strategies and activities	Information Management Systems	7.5.1.6	7.5-16
IS012	3	Plans for training key project resources in recovery procedures	Information Management Systems	7.5.1.6	7.5-16

Detailed Specifications Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
IS013	3	Processes for updating each plan as necessary throughout the life of the contract	Information Management Systems	7.5.1.6	7.5-16
IS014	3	This deliverable should meet the acceptance criteria established between the Bureau and the Vendor.	Information Management Systems	7.5.1.6	7.5-16
IS015	1	The Security Plan defines the Vendor's plan of action to secure computers, systems, and facilities. The Security Plan provides a systematic approach and techniques for meeting all security controls to protect computers from being accessed by unauthorized users, to guard against worms and viruses, and to identify and respond to any security incident, event, or process that could jeopardize the security of computers, systems, or facilities. Based on the template provided by Centers for Medicare and Medicaid Services (CMS) (https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/InformationSecurity/Downloads/CMS-Information-Security-Requirements.pdf), and in accordance with National Institute of Standards and Technology (NIST) guidelines (https://csrc.nist.gov/publications/detail/sp/800-53/rev-4/final), the Vendor should provide its Security Plan, including, but not limited to, the following:	Information Management Systems	7.5.2.1	7.5-18
IS016	2	Security policies	Information Management Systems	7.5.2.5	7.5-32
IS017	2	Logical security controls (e.g., privacy, user access and authentication, user permissions)	Information Management Systems	7.5.2.2	7.5-19
IS018	2	Technical security controls and security architecture (communications, hardware, data, physical access, software, operating system, encryption)	Information Management Systems	7.5.2.2	7.5-19
IS019	2	Security processes (e.g., security assessments, risk assessments, incident response)	Information Management Systems	7.5.2.3	7.5-27
IS020	2	Documentation that describes technical controls, including, but not limited to, the following:	Information Management Systems	7.5.2.4	7.5-31
IS021	3	Network segmentation	Information Management Systems	7.5.2.4	7.5-31
IS022	3	Perimeter security	Information Management Systems	7.5.2.4	7.5-31
IS023	3	Application security	Information Management Systems	7.5.2.4	7.5-31
IS024	3	Intrusion management	Information Management Systems	7.5.2.4	7.5-31
IS025	3	Monitoring and reporting	Information Management Systems	7.5.2.4	7.5-31
IS026	3	Remote access	Information Management Systems	7.5.2.4	7.5-31
IS027	3	Encryption of data at rest and in transit on servers, databases, and personal computers	Information Management Systems	7.5.2.4	7.5-31
IS028	3	Interface security	Information Management Systems	7.5.2.4	7.5-31
IS029	3	Secure communications over the internet	Information Management Systems	7.5.2.4	7.5-31

Detailed Specifications Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
IS030	3	Annual updates to all security policies, controls, processes, and documentation based on current National Institute of Standards and Technology (NIST) Special Publication (SP) 800-53 (https://csrc.nist.gov/publications/detail/sp/800-53/rev-4/final), all other relevant State and federal regulations, and State Information Security Standards and Policies	Information Management Systems	7.5.2.4	7.5-31
IS031	2	This deliverable should meet the acceptance criteria established between the Bureau and the Vendor.	Information Management Systems	7.5.2.6	7.5-33
OS001	1	The Vendor should propose its approach to operate the State's premium reimbursement program, that will enable the Bureau to purchase health insurance, if cost effective, under the authority of Section 1905(a) of the Social Security Act (SSA), by the use of data matches and Medicaid member files to identify potential resources. This is an optional service. The proposal should contain processes including, but not limited to, the following:	Optional Services	7.2.1.1	7.2-9
OS002	2	Verifiying members' eligibility for West Virginia Medicaid on a monthly basis	Optional Services	7.2.1.2	7.2-12
OS003	2	Verifying cost effectiveness by comparing the estimated costs of the policy to the estimated medial costs of the members	Optional Services	7.2.1.2	7.2-12
OS004	2	Validating insurance coverage and premium payment amounts to ensure eligibility	Optional Services	7.2.1.2	7.2-12
OS005	2	Forwarding health insurance with all types of coverage per approved members to the Bureau to be added to the Medicaid Management Information System (MMIS) system without additional costs to the State	Optional Services	7.2.1.2	7.2-12
OS006	2	Performing an annual comprehensive analysis and recertification of each enrolled member to ensure continued cost effectiveness	Optional Services	7.2.1.2	7.2-12
OS007	2	Handling all correspondence and inquiries regarding the premium reimbursement program	Optional Services	7.2.1.2	7.2-12
OS008	2	Coordinating benefits with the Third-Party Liability (TPL) Program	Optional Services	7.2.1.2	7.2-12
OS009	2	Notifying the Bureau of all approved and denied applicants	Optional Services	7.2.1.2	7.2-12
OS010	2	Providing reports with actual cost savings to the State for each enrolled member on a quarterly basis	Optional Services	7.2.1.2	7.2-12
OS011	2	Providing documentation (e.g., copies of Explanation of Benefits [EOBs] or paystubs) utilized to produce reports of actual cost savings to the Bureau	Optional Services	7.2.1.2	7.2-12
OS012	2	Marketing and outreach in surrounding communities to maximize efforts for recruitment and education of the premium reimbursement program	Optional Services	7.2.1.2	7.2-12
OS013	2	Providing a "premium reimbursement program Business Rule" file, documenting all requirements as agreed upon with the Bureau for the program	Optional Services	7.2.1.2	7.2-12
OS014	2	Operating a web portal for potential member application process.	Optional Services	7.2.1.2	7.2-12
OS015	1	The Vendor should describe its approach to providing Recovery Audit Contractor (RAC) services by auditing claims for Medicaid under/overpayment collections in accordance with Department, State, and federal requirements. This is an optional service. The description should contain processes including, but not limited to, the following:	Optional Services	7.2.4.1	7.2-39
OS016	2	Providing at all times trained medical professionals, to the satisfaction of the Bureau, who are in good standing with the relevant State licensing authorities, where applicable, to review Medicaid claims	Optional Services	7.2.4.6	7.2-54
OS017	2	Providing at all times certified coders, to the satisfaction of the Bureau, for effective review of Medicaid claims	Optional Services	7.2.4.6	7.2-54

Detailed Specifications Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
OS018	2	Working collaboratively with the Bureau to develop an education and outreach program that includes notification to providers of audit policies and protocols	Optional Services	7.2.4.7	7.2-57
OS019	2	Processes for data mining to target providers and claims for review that have not been subject to audit or are currently being audited by another entity, to identify potential coding and billing errors, and to provide trends and patterns analyses	Optional Services	7.2.4.3	7.2-48
OS020	2	Processes for provider medical record requests that includes the process for submission for electronic medical records	Optional Services	7.2.4.3	7.2-48
OS021	2	Refraining from auditing claims that have been audited or are in process of being audited by another entity	Optional Services	7.2.4.8	7.2-60
OS022	2	Aspects of clinical and coding review of medical records including, but not limited to, coding, and medical necessity	Optional Services	7.2.4.4	7.2-53
OS023	2	Reporting of results	Optional Services	7.2.4.10	7.2-62
OS024	2	Developing an Improper Payment Prevention Plan, for any RAC-identified vulnerability, to help prevent similar overpayments from occurring in the future	Optional Services	7.2.4.11	7.2-63
OS025	2	Examples of audit templates, protocols, and timeframes for identifying and auditing claims	Optional Services	7.2.4.5	7.2-53
OS026	2	Description of the case management system utilized for tracking audits through conclusion/collection and how it will interface with the State system	Optional Services	7.2.4.2	7.2-44
OS027	2	Deconfliction processes	Optional Services	7.2.4.8	7.2-60
OS028	2	Workflows for identifying and reporting potential fraud, waste, and abuse with the Bureau and the West Virginia Medicaid Fraud Control Unit (MFCU) and support.	Optional Services	7.2.4.9	7.2-62
OS029	1	The Vendor should propose a strategy that automates the Medicare Buy-In program by data matching with appropriate federal and State databases to create the Buy-In Export File consisting of six (6) different Medicare Buy-In categories for eligible clients. This is an optional service. The Vendor should describe their proposal including, but limited to, the following:	Optional Services	7.2.3.1	7.2-27
OS030	2	Evaluation of current process and recommendation for improvements	Optional Services	7.2.3.2	7.2-29
OS031	2	Technical support	Optional Services	7.2.3.4	7.2-33
OS032	2	Operational processes, including interfacing with Medicaid Management Information System (MMIS)	Optional Services	7.2.3.3	7.2-29
OS033	2	Reporting	Optional Services	7.2.3.5	7.2-34
OS034	2	Toll-free number and call center for members	Optional Services	7.2.3.4	7.2-33
OS035	2	Proposed Staffing Plan to fully administer the Buy-In program	Optional Services	7.2.3.4	7.2-33
OS036	1	The work incentive program is a work incentive for people with disabilities or chronic health conditions. It allows individuals who work to pay a monthly premium and keep or obtain Medicaid healthcare coverage. The Vendor should propose a strategy that automates the work incentive program process. This is an optional service. The Vendor should describe their approach to operating a work incentive program, including, but not limited to, the following:	Optional Services	7.2.2.1	7.2-21
OS037	2	Technical support	Optional Services	7.2.2.1	7.2-21
OS038	2	Operational processes, including interfacing with Medicaid Management Information System (MMIS)	Optional Services	7.2.2.1	7.2-21

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OS039	2	Reporting	Optional Services	7.2.2.1	7.2-21
OS040	2	Toll-free number and call center for members	Optional Services	7.2.2.1	7.2-21
OS041	2	Proposed staffing plan to fully administer the work incentive program	Optional Services	7.2.2.1	7.2-21
OS042	2	Cost effectiveness determination	Optional Services	7.2.2.1	7.2-21
OS043	2	Web portal for prospective member online application	Optional Services	7.2.2.1	7.2-21
PI001	1	The Vendor should describe its audit program design including, but not limited to, a process for appeals.	Program Integrity	7.4.0.1	7.4-1
PI002	1	The Vendor should describe its notification processes to the Bureau for all changes in State and federal regulations affecting services provided under this contract within two (2) business days of publication, including the development of a summary of Proposed and Final Rules and Regulations and an evaluation of program impact and implementation changes within five (5) business days of issuance.	Program Integrity	7.4.0.2	7.4-3
PM001	1	The Communication Management Plan is a document used to define stakeholder groups, outline key messages, and organize outreach and engagement activities to achieve intended communication objectives, and should detail the varying levels and needs of the project's stakeholders for information regarding the project, status, accomplishments, and impact on stakeholders. The Vendor should describe its Communication Management Plan, including, but not limited to, the following:	Project Management	7.3.1.1	7.3-4
PM002	2	Communication vehicles, participants, and schedules (e.g., standing project meetings, purpose, audience, frequency)	Project Management	7.3.1.3	7.3-5
PM003	2	Target stakeholders, maintenance of contact list, messaging preferences, and frequency of communication	Project Management	7.3.1.2	7.3-4
PM004	2	Reporting, required project communications, resolution approaches, and techniques to address stakeholder engagements	Project Management	7.3.1.4	7.3-6
PM005	2	This deliverable should meet the acceptance criteria established between the Bureau and the Vendor.	Project Management	7.3.1.5	7.3-7
PM006	1	The Vendor should propose a Documentation Management Plan that describes how project documentation will be managed, including, but not limited to, the following:	Project Management	7.3.2.1	7.3-7
PM007	2	Project types, deliverables, acceptance criteria, meeting materials, artifacts, operations manuals, training materials, and user guides	Project Management	7.3.2.1	7.3-7
PM008	2	Use, access, and management of document repositories	Project Management	7.3.2.1	7.3-7
PM009	2	Approach to document management and version control of all project and operational documentation	Project Management	7.3.2.1	7.3-7
PM010	1	The Staffing Management Plan documents the Vendor's approach to providing and managing qualified human resources for the project, and describes how the roles, responsibilities, and reporting relationships will be structured and addressed in support of the project and operations. Staff should have a working knowledge of the system operations prior to starting on the project. The Vendor should describe its Staffing Management Plan, including, but not limited to, the following:	Project Management	7.3.3.1	7.3-10
PM011	2	Organizational chart for each phase of the project, identifying all staff to be used for each phase of the project and clearly identifying on-site staff, off-site staff, and subcontractors	Project Management	7.3.3.2	7.3-10
PM012	2	Description of the roles, responsibilities, and skillsets associated with each position on the organization chart	Project Management	7.3.3.4	7.3-13

Detailed Specifications Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
PM013	2	For each key staff member, a brief summary description of the roles, responsibilities, and experience that qualify them for their role on this project	Project Management	7.3.3.4	7.3-13
PM014	2	If any of the work is performed off-site, including work of subcontractors, describe the assurance of quality and timeliness of the work performed off-site	Project Management	7.3.3.2	7.3-10
PM015	2	Resource calendar describing the staff required for each phase of the project, if the staff will be on-site or off-site, and the allocation percentage	Project Management	7.3.3.4	7.3-13
PM016	2	The Bureau's business and technical resources required to support the creation of all deliverables	Project Management	7.3.3.6	7.3-21
PM017	2	Description of the training personnel who will be used in support of training activities	Project Management	7.3.3.7	7.3-22
PM018	2	Description of business analyst personnel who will be used in support of this Request for Proposal (RFP)	Project Management	7.3.3.5	7.3-21
PM019	2	Process for transitioning essential knowledge to the Bureau technical staff and users.	Project Management	7.3.3.7	7.3-22
PM020	2	Approach to personnel management including hiring and terminations, staff retention and continuity, and employee relocation	Project Management	7.3.3.8	7.3-24
PM021	2	Staff training, both initial and ongoing, including transfer of system and business knowledge, project management methodologies and processes, and project status to new staff and incumbent staff transitioning between project roles and phases	Project Management	7.3.3.7	7.3-22
PM022	2	Staff performance monitoring	Project Management	7.3.3.9	7.3-25
PM023	2	Succession planning, staff replacement, and staff backup	Project Management	7.3.3.10	7.3-27
PM024	2	Staffing for optional services, as detailed in this RFP	Project Management	7.3.3.3	7.3-13
PM025	2	The Staffing Management Plan should support the project and operations while maintaining compliance with all staffing requirements set forth in the Appendix 1: Detailed Specifications and any RFP narrative.	Project Management	7.3.3.11	7.3-27
PM026	1	The Vendor should propose a Change Management Plan, including a description of the Vendor's approach for change management including, but not limited to, the following:	Project Management	7.3.4.1	7.3-28
PM027	2	Methodologies	Project Management	7.3.4.1	7.3-28
PM028	2	Tools	Project Management	7.3.4.1	7.3-28
PM029	2	Enhancements	Project Management	7.3.4.1	7.3-28
PM030	2	Modifications	Project Management	7.3.4.1	7.3-28
PM031	2	Processes required to appropriate manage and document changes to the system, such as impact analyses and change requests	Project Management	7.3.4.1	7.3-28
PM032	1	The Implementation Plan details the Vendor's approach to conducting the cutover from the existing solution to the new solution at go-live. This plan provides a detailed sequence of operations or steps that should be carried out to deliver the new solution. The Vendor should propose an Implementation Plan that is a comprehensive plan for rolling out the new solution to users, including, but not limited to, the following:	Project Management	7.3.5.1	7.3-32
PM033	2	Description of major tasks and each implementation step	Project Management	7.3.5.2	7.3-36
PM034	2	Explanation of the solution configuration	Project Management	7.3.5.3	7.3-38
PM035	2	Explanation of how all components of the solution will be installed and upgraded timely, and where the installation may be split up into multiple procedures	Project Management	7.3.5.4	7.3-38
PM036	2	Points of contact	Project Management	7.3.5.5	7.3-41
PM037	2	Implementation schedule	Project Management	7.3.5.6	7.3-42

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PM038	2	Security and privacy safeguards	Project Management	7.3.5.7	7.3-42
PM039	2	Implementation support procedures	Project Management	7.3.5.8	7.3-43
PM040	2	Implementation impacts	Project Management	7.3.5.9	7.3-43
PM041	2	Configuration management interfaces	Project Management	7.3.5.11	7.3-45
PM042	2	Applicable user documentation	Project Management	7.3.5.12	7.3-45
PM043	2	Personnel and staffing requirements	Project Management	7.3.5.13	7.3-46
PM044	2	Implementation staff training	Project Management	7.3.5.14	7.3-48
PM045	2	Outstanding issues	Project Management	7.3.5.15	7.3-49
PM046	2	Performance monitoring	Project Management	7.3.5.17	7.3-52
PM047	2	Risks and contingencies	Project Management	7.3.5.10	7.3-44
PM048	2	Implementation verification and validation	Project Management	7.3.5.17	7.3-52
PM049	2	Implementation roles and responsibilities for the Bureau, the Project Management Office (PMO), and other Vendors	Project Management	7.3.5.13	7.3-46
PM050	2	Approach to triaging issues and defects prior to, during, and subsequent to solution go-live	Project Management	7.3.5.16	7.3-50
PM051	2	This deliverable must meet the acceptance criteria established between the Bureau and the Vendor.	Project Management	7.3.5.18	7.3-53
PM052	1	The Vendor should describe how they will communicate project status information to the Bureau within the required timeframes and in the agreed-upon format, as defined in the approved Project Management Plan.	Project Management	7.3.5.19	7.3-53
PM053	1	The Vendor should leverage the format, contents, and structure in the RFP attachments, and an identifiable tab sheet should precede each section of the proposal, and each proposal should follow all formatting requirements. All pages, except preprinted technical inserts, should be sequentially numbered.	Project Management	7.3.0.1	7.3-54
PM054	1	The Vendor's in-line responses, inclusive of the text of BMS' specifications, should be as concise as possible and should not exceed 400 pages in total. Vendors should choose a similarly sized typeface (generally 11 point for text and 9 point for tables) for BMS specifications and not use smaller than 9-point fonts to work within the page limit. The page limit counts the front and back of each sheet as separate pages.	Project Management	7.3.0.1	7.3-54
PM055	2	The Vendor's page limit will not apply to administrative forms, resumes, representations and affirmations, response form(s), and other structured forms required under this RFP, specifically the following sections and attachments: Section 3, General Terms and Conditions; Attachment 3: Vendor Qualifications and Experience (only Section 6: Business Disputes and Section 9: Financial Stability); Attachment 4: Project Organization and Staffing Approach (only Section 3: Key Staff, Resumes, and References); and Attachment 5: Initial Work Plan.	Project Management	7.3.0.1	7.3-54
TM001	1	The Vendor should describe how it will recover funds only from the portion of a member's settlement/judgment intended to cover medical items or services, including pharmacy.	TPL Management	7.1.2.1	7.1-15
TM002	1	The Vendor should describe its process for conducting initial verification of the insurance coverage information using industry-accepted practices according to the Bureau's timeliness criteria, including, but not limited to, the following:	TPL Management	7.1.1.1	7.1-7
TM003	2	Return of verified and unverified referrals to the Bureau within three (3) business days of initial transmission and ninety (90) calendar days for trauma and/or casualty referrals	TPL Management	7.1.1.1	7.1-7
TM004	2	Return of verified or not verified direct entry referrals into the Vendor's web portal to the Bureau within three (3) business days.	TPL Management	7.1.1.1	7.1-7

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TM005	1	The Vendor should describe its process for conducting reverification of active coverage record information every three (3) months on a rolling three (3) month cycle based on the last verification date, or on another timetable, as defined by the Bureau.	TPL Management	7.1.6.3	7.1.0-91
TM006	1	The Vendor should describe its process for transferring all verified insurance information, as well as any updates thereto, to the Bureau electronically using the established Bureau Third-Party Liability (TPL) file layout, inclusive of the insurance carrier identification information.	TPL Management	7.1.6.4	7.1.0-92
TM007	1	The Vendor should describe its detail report for credit balance, including, but not limited to, management of accounts receivable.	TPL Management	7.1.5.3	7.1-73
TM008	1	The Vendor should propose its approach to provide customer service support to the West Virginia Third-Party Liability (TPL) program, including, but not limited to, the following:	TPL Management	7.1.1.2	7.1-8
TM009	2	Outreach and educational activities, including materials distribution	TPL Management	7.1.1.2	7.1-8
TM010	2	Reporting activities	TPL Management	7.1.1.2	7.1-8
TM011	2	Call tracking and complaint resolution	TPL Management	7.1.1.2	7.1-8
TM012	2	Complaint resolution processes and notification to the Bureau on a monthly basis.	TPL Management	7.1.1.2	7.1-8
TM013	1	The Vendor should propose a method for performing specific functions for identifying and recovering overpayments (credits owed to Medicaid) from providers via on-site audits and desk reviews, including, but not limited to, the following:	TPL Management	7.1.5.1	7.1-66
TM014	2	Identification of all refunds owed by Medicaid to third-party payors to correct recoveries or other overpayments with appropriate documentation; upon receipt of this information, the Bureau will verify the accuracy of the recovery and will submit refund to the third-party payor	TPL Management	7.1.5.2	7.1-72
TM015	2	Methodology for identification of provider overpayments.	TPL Management	7.1.5.1	7.1-66
TM016	1	The Vendor should propose a methodology and approach to develop, host, and manage an Estate Recovery Program consistent with State Plan provisions (https://dhhr.wv.gov/bms/CMS/SMP/Pages/default.aspx), including, but not limited to, the following:	TPL Management	7.1.3.1	7.1-35
TM017	2	Filing proofs of claim	TPL Management	7.1.3.1	7.1-35
TM018	2	Determining estate values	TPL Management	7.1.3.1	7.1-35
TM019	2	Referring cases to the Bureau for State resolution, as applicable	TPL Management	7.1.3.1	7.1-35
TM020	2	Producing and mailing all marketing materials at no cost to the Bureau, in accordance with Department, State, and federal requirements (https://www.ecfr.gov/cgi-bin/text-idx?SID=3940429768456a3ee990b8eed15a5cac&mc=true&node=se42.4.433_136&rgn=div8)	TPL Management	7.1.3.3.	7.1-47
TM021	2	Tracking capabilities	TPL Management	7.1.3.2	7.1-47
TM022	2	Reporting	TPL Management	7.1.3.1	7.1-35
TM023	2	Communication Plan	TPL Management	7.1.3.3	7.1-47
TM024	1	The Vendor should propose a method to provide maintenance of Third-Party Liability (TPL) policy and carrier information including, but not limited to, the following:	TPL Management	7.1.6.2	7.1.0-84
TM025	2	Term dates, changes in coverage, group information, and carrier information	TPL Management	7.1.6.2	7.1.0-84
TM026	2	Changes in coverage	TPL Management	7.1.6.2	7.1.0-84

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TM027	2	Mass TPL and/or carrier updates, due to changes in carrier status (i.e., office relocations, mergers, or acquisitions), sponsor changes, group number and/or policy number changes	TPL Management	7.1.6.2	7.1.0-84
TM028	2	Methods for correction related to previously transmitted information found to be erroneous.	TPL Management	7.1.6.2	7.1.0-84
TM029	2	Tracking Mechanisms	TPL Management	7.1.6.2	7.1.0-84
TM030	2	Interfaces with the Medicaid Management Information System (MMIS)	TPL Management	7.1.6.2	7.1.0-84
TM031	2	Reporting capabilities.	TPL Management	7.1.6.2	7.1.0-84
TM032	1	The Vendor should propose a method to identify Medicaid members with third-party commercial health insurance, then validate and upload this information to the Medicaid Management Information System (MMIS) for cost avoidance, thereby increasing the cost avoidance of claims and reduction of payments made by Medicaid. The Vendor is responsible for contacting the insurance organizations and arranging for data matches.	TPL Management	7.1.6.1	7.1.0-75
TM033	1	The Vendor should propose a method to transmit pharmacy policies in real time to the Bureau's Point of Sale (POS) system and how the information would be added into the State Medicaid Management Information System (MMIS) daily.	TPL Management	7.1.6.5	7.1.0-92
TM034	1	The Vendor should propose a method to identify Medicaid members with other insurance, including, but not limited to, the following:	TPL Management	7.1.4.1	7.1-49
TM035	2	Medicare, Tricare, and commercial insurance	TPL Management	7.1.4.1	7.1-49
TM036	2	Submission of claims to the appropriate source for recovery	TPL Management	7.1.4.1	7.1-49
TM037	2	A plan and approach to accomplish the work of post-payment recovery, including compliance with requirements for filing claims with third-party resources (e.g., Prescription Benefits Managers [PBMs], plan administrators); the approach for handling Medicare Parts A, B, and D recoveries; and a methodology that generates a posting transaction to the Medicaid Management Information System (MMIS) contractor	TPL Management	7.1.4.2	7.1-50
TM038	2	Processes to establish, maintain, and update an accounts receivable file for claims that the Vendor identifies and bills to other insurance carriers; the accounts receivable file should be sufficient to provide an audit trail for State and federal documentation requirements, and is to be transferred to the Bureau at its request or at the termination of the contract resulting from this Request for Proposal (RFP)	TPL Management	7.1.4.3	7.1-60
TM039	2	Processes for commercial and Medicare disallowance files to be sent to the Bureau every thirty (30) calendar days.	TPL Management	7.1.4.3	7.1-60
TM040	1	The Vendor should provide a solution to post recovery payments for claims identified. After the Third-Party Liability (TPL) information file has been used to successfully update the Medicaid Management Information System (MMIS) TPL file, and following the receipt of the individual paid claims history data, the Vendor should describe their recovery activities, including, but not limited to, the following:	TPL Management	7.1.4.4	7.1-62
TM041	2	Issuance of amounts recovered via check and submission to the Lockbox; the State's Accounts Receivables will work the check and the Bureau will be sent a copy of the check along with any paperwork	TPL Management	7.1.4.4	7.1-62
TM042	2	Post recoveries to accounts receivable files within seven (7) calendar days after recovery to allow for independent reconciliation by the Bureau of deposits to recoveries recorded	TPL Management	7.1.4.4	7.1-62

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TM043	2	Updating all recoveries in the accounts receivable file within forty-five (45) calendar days after receipt of recovery; any recoveries not updated after this time period should be transmitted to the Bureau in a format acceptable to Bureau for processing	TPL Management	7.1.4.4	7.1-62
TM044	2	Investigate reasons for non-payment by third-party payors and resubmit claims when appropriate. Specific reasons for non-payment will be included in the accounts receivable file.	TPL Management	7.1.4.5	7.1-64
TM045	1	The Vendor should describe their process for seeking reimbursement from a liable third party on all claims for which it determines the amount reasonably expected to recover will be greater than the cost of recovery. Recovery efforts must be suspended or terminated only if they are not cost effective as specified by the Bureau.	TPL Management	7.1.4.6	7.1-65
TM046	1	The Vendor is responsible for identifying members who have claims with specific trauma codes that are consistent with injuries that may be covered by liable parties. In accordance with 42 Code of Federal Regulation (CFR) 433.138(e) (https://ecfr.io/Title-42/sp42.4.433.d#se42.4.433_1138), the Vendor is required to identify claims that contain trauma codes utilizing claim information provided by the Bureau. The Vendor will treat all claims identified through this trauma code match process as a new trauma referral. The Vendor is responsible for processing all referrals and determining case type (mass tort case, joint liability case, or total plan case). Sources for referrals include, but are not limited to, the acute care contractors or long-term care contractors, attorneys, insurance companies, providers, and members. The Vendor should propose a strategy to develop, host, and manage a trauma/tort program, including, but not limited to, the following:	TPL Management	7.1.2.3 7.1.2.4	7.1-15 7.1-16 7.1-18
TM047	2	Workers' compensation, Department of Motor Vehicles (DMV) match, and trauma diagnosis codes	TPL Management	7.1.2.4	7.1-18
TM048	2	A methodology to identify casualty/tort cases prior to or during litigation, and notice to the Bureau to join the underlying litigation and pursue potential Third-Party Liability (TPL) lien recoveries and subrogation	TPL Management	7.1.2.5	7.1-29
TM049	2	Tracking capabilities	TPL Management	7.1.2.6	7.1-30
TM050	2	Reporting	TPL Management	7.1.2.7	7.1-31
TM051	2	Communication Plan	TPL Management	7.1.2.8	7.1-31
TM052	2	Planned review of Medicaid Management Information System (MMIS) functionality.	TPL Management	7.1.2.9	7.1-32

APPENDIX 1. EXHIBITS

HMS includes the following exhibits, organized per proposal section, as referenced in our Technical Proposal.

3.0 EXPERIENCE AND QUALIFICATIONS

In this section, all exhibits are included in proposal **Section 3.0.**

4.0 PROJECT ORGANIZATION AND STAFFING APPROACH

In this proposal section, please see the key personnel resumes in proposal **Appendix 2**.

5.0 INITIAL WORK PLAN

In this proposal section, please see the Initial Work Plan Gantt Chart following the Initial Work Plan narrative in proposal **Section 5.0**.

6.0 MANDATORY REQUIREMENTS

In this proposal section, please see the Mandatory Requirements worksheet following the Mandatory Requirements narrative in proposal **Section 6.0**.

7.1.0 TPL SERVICES OVERVIEW

In this section, please see the following exhibits referenced in proposal **Section 7.1.0:**

- Additional Sample Designs for HMS 360 (**Exhibits 7.1.0-3 – 7.1.0-6**).

Exhibit 7.1.0-3 HMS 360 Sample Landing Page

Exhibit 7.1.0-4 HMS 360 Sample Design for Dashboard Page

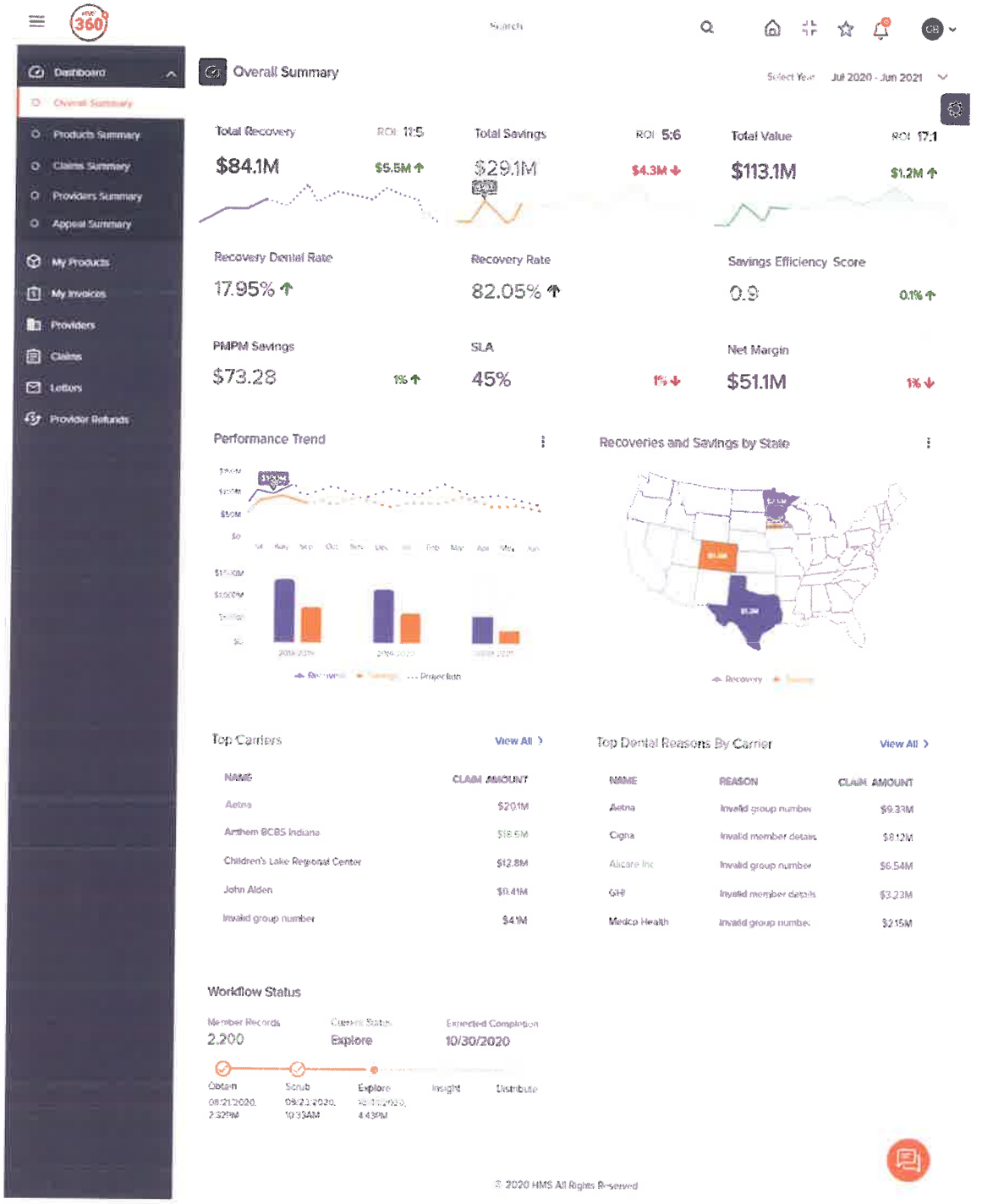


Exhibit 7.1.0-5 HMS 360 Sample Design for Product Drilldown Page

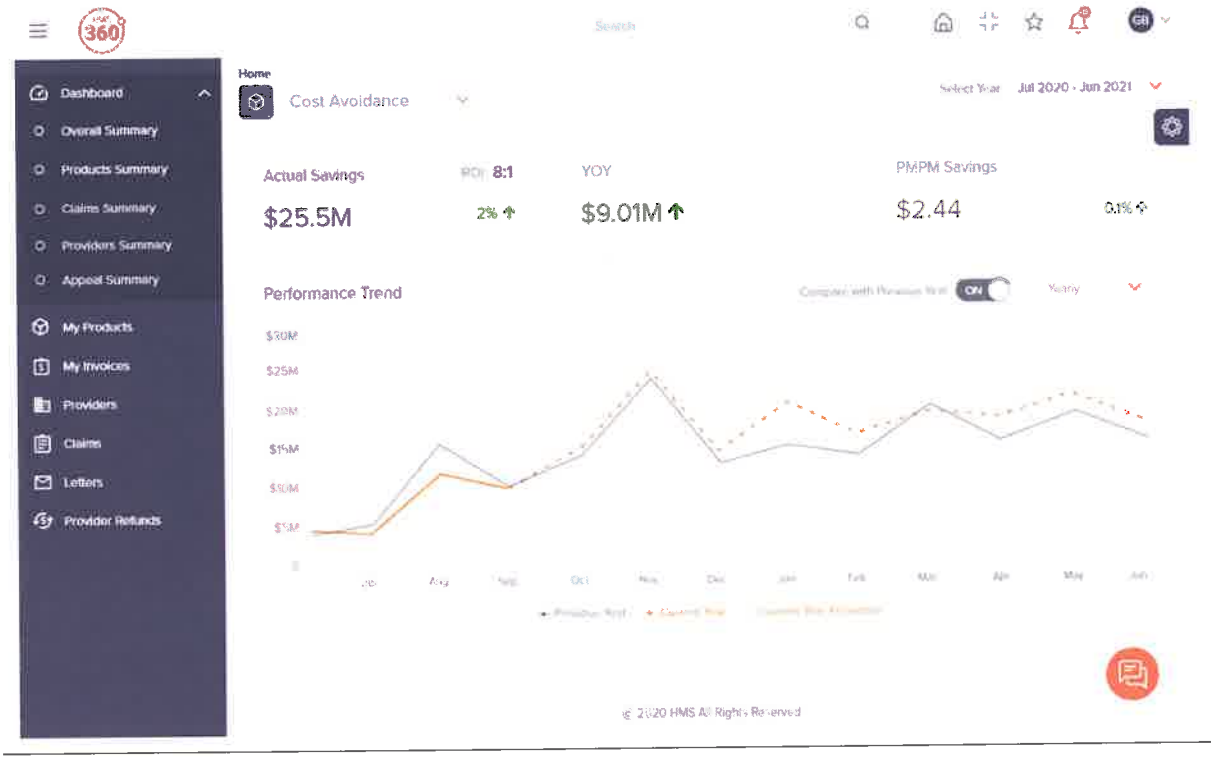
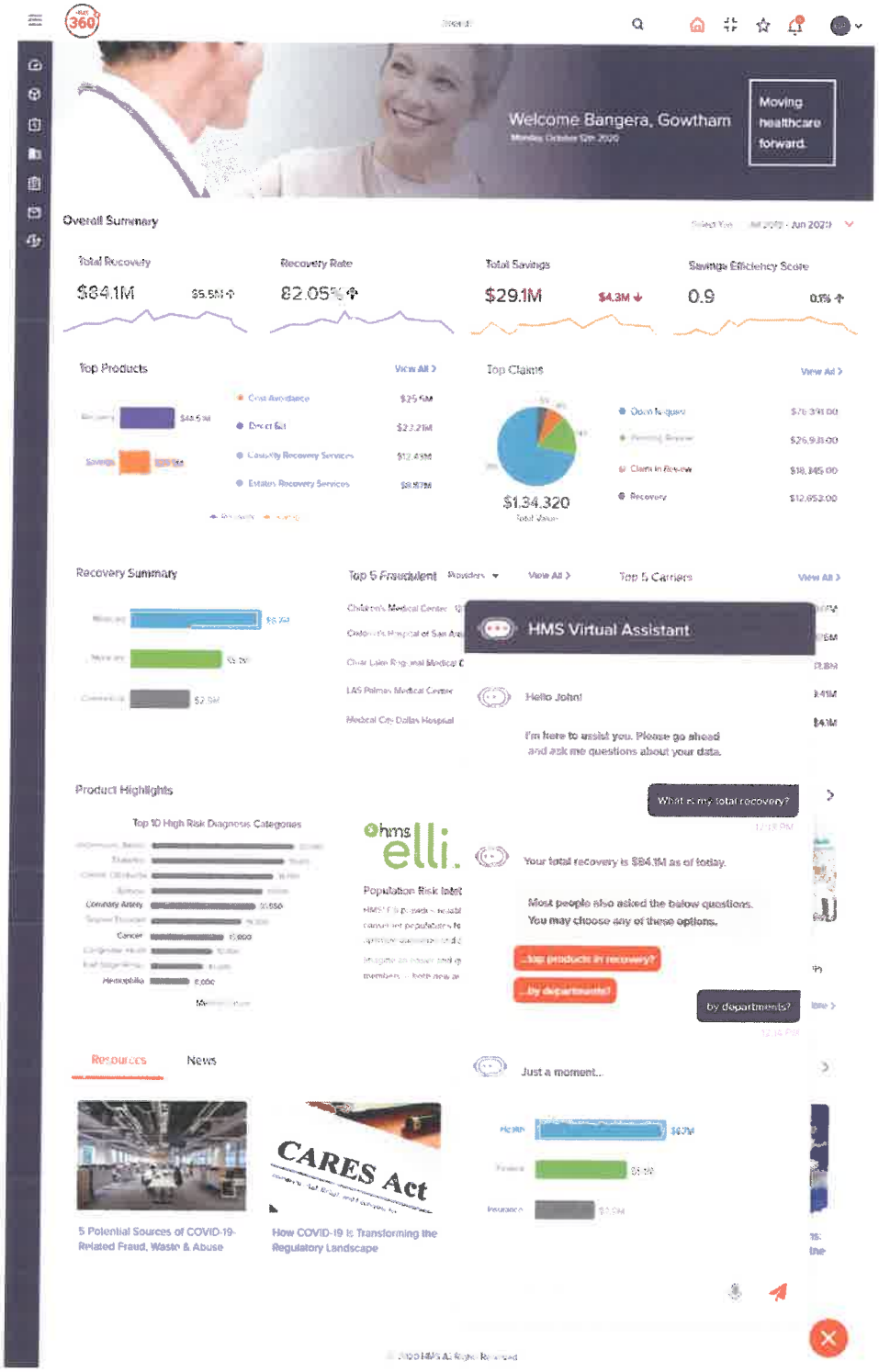


Exhibit 7.1.0-6 HMS 360 Dashboard Sample Showing Chat Interface



7.1.1 TPL MANAGEMENT

In this section, all exhibits are included in proposal **Section 7.1.1.**

7.1.2 CASUALTY-TRAUMA

In this section, please see the following exhibits referenced in proposal **Section 7.1.2:**

- Statement of Aid Paid (SOAP) Update Letter Sample (**Exhibit 7.1.2-3**)
- Monthly Casualty Report Layouts
  - Trauma Invoices Claims (**Exhibit 7.1.2-4**)
  - Type_1d_Trauma (**Exhibit 7.1.2-5**)

Exhibit 7.1.2-3 Statement of Aid Paid (SOAP) Update Letter Sample

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Bureau for Medical Services

Bill J. Crouch
Cabinet Secretary

Cynthia E. Beane
Commissioner

HMS
9015 High Point Drive, Suite 100
Irving, Texas 75063

Phone: 855.386.4133
Fax: 877.757.7261
Email: WestVirginiaCasualty@hms.com

September 23, 2020

[redacted]
Charleston, WV 25338

Case Number: 148403
Recipient: [redacted]
Recipient ID:
Date of Incident: 01/09/2020
Claim #:

RE: INTERIM Statement of Aid Paid

Dear R. Chad Duffield:

Pursuant to WV Code § 9-5-11, Medicaid has statutory assignment rights to recover its lien from liable parties having liability and/or medical insurance. Enclosed herein please find a summary of charges paid by DHHR/HMS TORT RECOVERY in evidence of Medicaid expenditures made incidental to a legal action or claim involving the above named beneficiary. The amount of the medical expenditures to date is:

$36,973.12

This is an INTERIM amount.

Please find enclosed a copy of the claim detail, showing related medical payments made by Medicaid. Additional bills may be paid before settlement is finalized. Before paying our lien, please call us to request the final lien. Please allow 10 to 20 days for us to provide you the required information. As claims accrue, we will continue to send an updated status report of the amount due. Please note that you can submit lien update requests and documentation through our web portal at submissions.hms.com.

If there are any disputes with the Department's lien, please justify your dispute in writing. Pursuant to both Federal and State laws, Medicaid must be paid before the recipient and before a Special Needs Trust or annuity is established. Based on WV Code § 9-5-11, Medicaid's lien is reduced by the Pro Rata share of a recipient's contractual attorney fee and the appropriate ratio of a recipient's attorney expenses. If an reduction is requested, please provide us a copy of the original fee agreement, expenses, and settlement amount.

If you have any questions, please contact the DHHR/HMS TORT RECOVERY Unit at 855.386.4133. Thank you for your cooperation in this matter.

350 Capitol Street, Room 251 • Charleston, West Virginia 25301 • 304-558-1700 • 304-558-1451 (fax) • dhhr.wv.gov

Exhibit 7.1.2-3 Statement of Aid Paid (SOAP) Update Letter Sample (continued)

Please make check(s) payable to: DHHR/HMS TORT RECOVERY

Send Payments to: DHHR/HMS TORT RECOVERY
PO BOX 11073
CHARLESTON, WEST VIRGINIA 25339

Please include our file number 148403, or claimant's name on the check(s).

Respectfully,
Amber Lacy

Enclosure: (s)

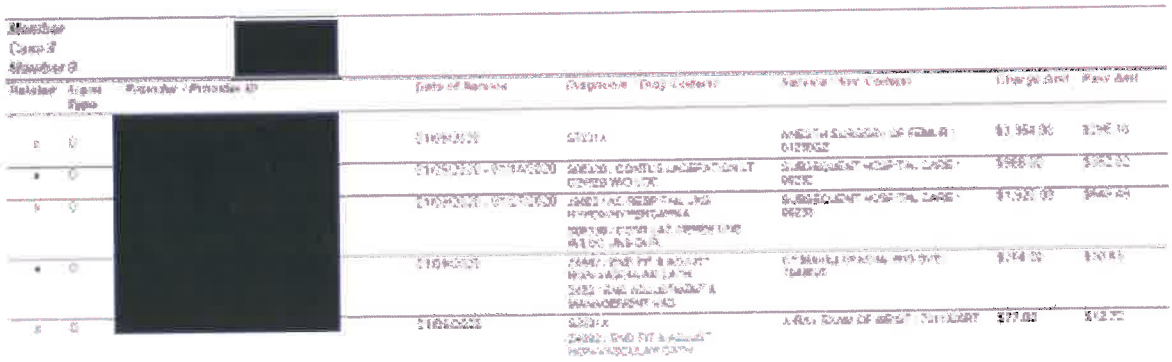


Exhibit 7.1.2-4 Monthly Casualty Report Layouts: Trauma Invoices Claims

TYPE:	ARCN	Paid By	Ck #	Ck Date	Amt
Trauma					
				COLLECTION AMOUNT:	$0.00
				CASES:	0
				INVOICE COLLECTION TOTAL:	$0.00

Exhibit 7.1.2-5 Monthly Casualty Report Layouts: Type_1d_Trauma

Invoice Date	Type	Paid By	Ck #	Ck Date	Check Amount	AHCN	Member ID	ICN Number	Paid Claim Date	Medicaid Paid Amount	Monthly Total	Case	Check #	Check Date	HMS Amount

7.1.3 ESTATE RECOVERY

In this section, please see the following exhibits referenced in proposal **Section 7.1.3:**

- Notice of Intent to File and Estate Questionnaire (**Exhibit 7.1.3-2**)
- Proof of Claim (**Exhibit 7.1.3-4**)
- Monthly Estate Recovery Report Layouts: Recoveries (Type 1c_Estate) **(Exhibit 7.1.3-5**)
- Claim Details (Estate Backup Report) **(Exhibit 7.1.3-6)**

Exhibit 7.1.3-2 Notice of Intent to File and Estate Questionnaire

This letter indicates there is a claim against the estate, explains the program, and includes a questionnaire requesting information regarding exemptions, property, assets, and intent to open probate.

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Bureau for Medical Services

Bill J. Crouch
Cabinet Secretary

Cynthia E. Beane
Commissioner

October 05, 2020

Mary Smith
123W 5th ST
City, WI 80110

Re: John Doe

Dear Mary Smith:

The Recovery Unit, on behalf of the West Virginia Department of Health and Human Resources (DHHR) is enclosing a questionnaire requesting information on the possible estate of a Medicaid recipient.You are receiving this request as we show a time span where the recipient was enrolled in Medicaid. If the estate owner was not a Medicaid recipient, please contact us directly prior to completing any paperwork.

For our case file, the Department is determining the value of the recipient's estate, if any, and the date the estate will be probated. Please take time to complete the questionnaire. In addition, if real property is involved, we will need an official appraisal or tax statement within 30 days of receipt of this letter. If the appraisal or tax statement is not received, we will proceed with filing a proof of claim against the estate.

Included with the questionnaire is a Request for Hardship form. Along with this form are the various types of hardships and a short description to help you determine whether you may qualify for that particular hardship. If you are not sure whether you need to fill out the hardship, please do so anyway.

****** If there is no property or an estate of any kind, please fill out the first page of the questionnaire. The questions on the *right* hand side of the form should be answered with the appropriate response circled. After the first page is completed, please return the first page only to the estate recovery unit. Thank you in advance for your assistance ******

As a reminder, once the estate's appraisal is completed, we request that a copy be sent to the Recovery Unit, regardless of the value of the estate. If you have any questions, please do not hesitate to call me at 304-342-1604. Thank you very much for your cooperation with this matter.

Health Management Systems
Contractor for Bureau for Medical Services
DHHR/HMS Estate Recovery
ATTN: Subrogation Agent
Po Box 11073
Charleston, West Virginia 25339
304-342-1604
wvestaterecovery@hms.com

Sincerely,
Subrogation Agent

350 Capitol Street, Room 251 • Charleston, West Virginia 25301 • 304-558-1700 • 304-558-1451 (fax) • dhhr.wv.gov

Exhibit 7.1.3-2 Notice of Intent to File and Estate Questionnaire (continued)

ESTATE QUESTIONNAIRE

1. DECEDENT'S INFORMATION

Name: John Doe

Birth Date: 01/01/2010

Date of Death:

Medicaid ID #:

Social Security Number: ***-**-8777

2. SURVIVING SPOUSE'S INFORMATION

Name: _____

Address: _____

_____

Phone: _____

Birth Date: _____

Social Security Number: _____

3. CHILDREN UNDER THE AGE OF 21, OR CHILDREN BLIND, OR PERMANENTLY AND TOTALLY DISABLED INFORMATION

Name: _____

Address: _____

_____

Birth Date: _____

Social Security Number: _____

Name: _____

Address: _____

_____

Birth Date: _____

Social Security Number: _____

4. ASSET INFORMATION

Has any real or personal property been transferred or sold since Medicaid eligibility was determined?

YES NO

If yes, please complete the following:

Date of Sale or Transfer: _____

County where recorded: _____

Did the decedent own a house or other real estate?

YES NO

If yes, please complete the following:

Address: _____

_____

Appraised or Tax Assessment Value (Please include appraisal or latest tax statement):

_____

5. ATTORNEY INFORMATION (OR PERSONAL REPRESENTATIVE)

Name: _____

Address: _____

_____

Phone #: _____

Has there been (or will there be) a petition for probate of the estate filed?

YES NO

If yes, please complete the following:

Date filed: _____

County Court: _____

If additional space is need, please use the back of this form. Please complete all requested information as promptly as possible and return this form to:

RECOVERY UNIT
ATTN: ESTATE DIVISION
ATTN: Subrogation Agent
Po Box 11073
Charleston, West Virginia 25339
304-342-1604
wvestaterecovery@hms.com

_____ _____
Preparer's Signature Date

CTSESTWV *100002* *16*

Exhibit 7.1.3-2 Notice of Intent to File and Estate Questionnaire (continued)

REQUEST FOR UNDUE HARDSHIP WAIVER

The Department of Health and Human Resources, Bureau of Medical Services requires full payment of its claim unless estate recovery would cause an undue hardship for the recipients and beneficiaries of an estate. The recipients and beneficiaries may request to have the recovery waived or compromised based upon the hardship. Please return this form after completing the following information.

Please note that a will bequeathing specific property to beneficiaries cannot be used as evidence of undue hardship. Additionally, if circumstances which caused the undue hardship were created by the recipient's use of an estate planning method which was designed to avoid estate recovery, the State will not grant a request for waiver.

Recipient's Name: John Doe

Recipient's Medicaid ID #:

Total amount of the estate: $.00

1. Has any adult child of the deceased recipient resided in the home continuously for a two (2) year period immediately prior to the parent becoming a recipient? YES NO

Name: _____

Address: _____

_____

Phone #: _____

Date of entry into the home: _____

Is the adult child still residing in the home? YES NO

Has the adult child provided care to the recipient which permitted the parent to remain at home without Medicaid assistance for at least that two (2) year period? YES NO

Please provide documentation of the support claim
(i.e., income and/ or property tax records, proof of payment for medically necessary supplies, affidavit)

2. Has the adult child maintained continuous employment in the family business for at least three (3) years prior to the parent becoming a recipient of Medicaid? YES NO

Name: _____

Address: _____

_____

Date employment began: _____

Date employment ended: _____

Is the property a main part of the business? YES NO

If yes, please explain how the property is a continued requirement for the existence of the business.

Location of Property: _____

Plot Description: _____

Exhibit 7.1.3-2 Notice of Intent to File and Estate Questionnaire (continued)

3. Has an adult child provided monetary support for the parent for medical care and other necessities prior to the date the parent became a recipient? YES NO

Name: _____

Address: _____

_____

Amount of support provided: _____

(please attach proof of these monies provided)

Date support began: _____

Date support ended: _____

4. Has any grandchild whose parents are both deceased prior to the date the grandparent became a recipient provided monetary support for the grandparent for medical care and other necessities prior to the date the grandparent became a recipient? YES NO

Name: _____

Address: _____

_____

Amount of support provided: _____

(please attach proof of these monies provided)

Date support began: _____

Date support ended: _____

5. Has a sibling provided monetary support for his/her sibling for medical care and other necessities prior to the date the parent became a recipient? YES NO

Name: _____

Address: _____

_____

Amount of support provided: _____

(please attach proof of these monies provided)

Date support began: _____

Date support ended: _____

Exhibit 7.1.3-2 Notice of Intent to File and Estate Questionnaire (continued)

6. Please provide any relevant circumstances and evidence that recovery from the recipient's estate will jeopardize the survival of the family unit or severely disrupt the family's income. Please use the back of this form if necessary.

Preparer's Signature

Date Requested

Party Requesting Waiver

Relationship to Deceased Recipient

Address

Telephone Number

PLEASE RETURN THIS FORM TO:

DHHR/HMS Estate Recovery
ATTN: Subrogation Agent
Po Box 11073
Charleston, West Virginia 25339
304-342-1604
wvestaterecovery@hms.com

CTSESTWV *100007* *16*

Exhibit 7.1.3-4 Proof of Claim
Once the personal estate representative has opened probate, HMS files a claim against the estate.

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Earl Ray Tomblin
Governor

Michael J. Lewis, M.D., Ph.D.
Cabinet Secretary

August 08, 2019

TO:

In the Matter of the Estate of

Pending before Fiduciary Supervisor/
Fiduciary Commissioner

John Doe,
Deceased

BARBOUR -, County, W. Va

Our File #
Date of Death

PROOF OF CLAIM - AGAINST DECEDENT'S ESTATE

The undersigned, being first duly sworn, says:
That he/she is a duly authorized agent of a creditor of the estate of the above named decedent; that the character of this claim is:

Pursuant to W. VA. code § 9-5-11c, The West Virginia Department of Health and Human Resources (WVDHHR)/Medicaid is filing a proof of claim against the above named decedent's estate. According to the records of the Department, the above mentioned was a recipient of Medicaid benefits. The Department is therefore, seeking reimbursement from the estate for Medicaid payments made on the recipient's behalf.

The Department furnished medical assistance for the above named decedent. Recovery will be sought from the assets which remain in the estate after payment of all ordinary expenses of administration and funeral costs.

That the amount thereof is $0.00, until paid. That a summary of nursing care and medical bills relating to said claim is hereto attached, that the said claim is just and true and that the said creditor, or any prior owner of the claim, if any there was, hath not received any of the money stated to be due, or any security or satisfaction for the same except that which is credited.
Sincerely,

Nancy French-Mack
Caseworker

_____
Affiant

Taken, sworn to and subscribed before me this _____ day of _____

_____
Notary Public

My commission expires: _____

Exhibit 7.1.3-5 Monthly Estate Recovery Report Layouts: Recoveries (Type 1c_Estate)

TYPE	ARCN	PaidBy	Ck #	Ck Date	Amt
Estate					
				Collection Amt	$0.00
				Cases	0.00

Exhibit 7.1.3-6 Monthly Estate Recovery Report Layouts: Claim Details (Estate Backup Report)

Invoice # & Invoice Date
Month Year Estate claims back up
Date Range

# Claims	# Checks	Invoice & Date	Type	ARCN #	Medicaid #	CK Number	CK Date	Claim ID	Paid Date	Recovered	MED Paid	Link for Attachemtns
						$0.00						
		MONTHLY COLLECTION TOTAL										

Reduction from Month Year Collections

ARCN #	Member I.D.	Paid Claim Date	Claim #	Amount Paid	Medicaid Pd Amount
				$ -	
	Monthly Refund Total				

INVOICE TOTAL $ -

7.1.4 TRICARE, MEDICARE, AND COMMERCIAL INSURANCE RECOVERIES

In this section, please see the following exhibits referenced in proposal **Section 7.1.4:**

- Direct Bill Report Layouts:
  - WVCI Report for Direct Bill (**Exhibit 7.1.4-10**)
    - Carrier Summary
    - Lockbox Summary
    - Unidentified Funds "Not Founds"

- WVT_Recoveries Report (**Exhibit 7.1.4-11**)

- For Provider Disallowance:
  - Disallowance Through WV Lockbox Report (**Exhibit 7.1.4-12**)
  - Reversal Import Files Report (**Exhibit 7.1.4-13**)

Exhibit 7.1.4-10 Direct Bill Report Layouts: WVCI Report for Direct Bill

WVCI Report: Carrier Summary, Lockbox Summary, Unidentified Funds "Not Founds"

ATTACHMENT 1
COMBINED RECOVERY REPORT
SUMMARY BY CARRIER
(DEPOSIT DATES MM/DD/YYYY to MM/DD/YYYY)

CARRIER	CARRIER PAYMENT	OVER PAYMENT	CURRENT REFUNDS	PRIOR REPORT REFUNDS	NET RECOVERY	RATE	AMOUNTS DUE TO HMS
Total	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00

LOCKBOX SUMMARY

DEPOSIT DATES	TOTAL RECOVERIES RECEIVED IN LOCKBOX	LOCKBOX PAYMENTS NOT IDENTIFIED BY HMS	LOCKBOX PAYMENTS BILLED BY HMS	STATE PAYMENTS BILLED BY HMS	STATE PAYMENTS NOT IDENTIFIED BY HMS	OVER-PAYMENTS	*TOTAL REFUNDS	NET RECOVERY	PERCENTAGE TO HMS	DOLLARS DUE TO HMS

ATTACHMENT 4
SUMMARY OF CHECKS NOT IDENTIFIED BY HMS

DEPOSIT DATE	REMIT DATE	CARRIER	CHECK NUMBER	ORGINIGAL AMOUNT	AMOUNT NOT IDENTIFIED	COMMENTS
						CARRIER PAID MORE THAN BILLED AMT NOT IDENTIFIED BY HMS MISSING EOB
Total				$0.00	$0.00	

ATTACHMENT 4A
SUMMARY OF CHECKS NOT IDENTIFIED BY HMS

DEPOSIT DATE	REMIT DATE	CARRIER	CHECK NUMBER	ORIGINAL AMOUNT	AMOUNT NOT IDENTIFIED	COMMENTS
Total				$0.00	$0.00	

Exhibit 7.1.4-11 Direct Bill Report Layouts: WVT_Recoveries

SOURCE	CHECK NUM	CHECK DATE	ICN	SEQUENCE NUMBER	PATIENT LAST NM	PATIENT FIRST NM	FROM DOS	THRU DOS	MAPAID	CARRIER PAYMENT	CARRIER ADJUSTMENT	CARRIER ADJ PAYMENT	REFUND AMOUNT	REMIT AMT	MEDICAID PAID DATE	MEDICAID #

Exhibit 7.1.4-12 Disallowance Through WV Lockbox Report

INVOICE # - INVOICE DATE:
Month Year - DISALLOWANCE Thru WV Lockbox
MM/DD/YYYY to MM/DD/YY

MEDICARE A

Invoice #	Date	Type	Deposit Date	Ck Number	Refund Amount	Medicaid Paid Amount	Type Disallowance	Client Provider #	Provider Name	Recipient Name	Medicaid ID	ICN	DOS	DHHR REMIT DATE	refund amt	%
			TOTAL													

MEDICARE B

Invoice #	Date	Type	Deposit Date	Ck Number	Refund Amount	Medicaid Paid Amount	Type Disallowance	Client Provider #	Provider Name	Recipient Name	Medicaid ID	ICN	DOS	DHHR REMIT DATE	refund amt	%
			TOTAL													

COMMERCIAL

Invoice #	Date	Type	Deposit Date	Ck Number	Refund Amount	Medicaid Paid Amount	Type Disallowance	Client Provider #	Provider Name	Recipient Name	Medicaid ID	ICN	DOS	DHHR REMIT DATE	refund amt	%
			TOTAL													

Disallowance Collections	
Adjustments	
Disallowance Invoice Total	
Invoice 11.45 % Totals	

Exhibit 7.1.4-13 Reversal Import Files Report

Reversal Claim Number	Provider Number	NPI	BMS Provider name	Member MAID	Member Name	Original Paid Amount	Reversal Amount	Cycle

7.1.5 CREDIT BALANCE AUDITS

In this section, please see the following exhibits referenced in proposal **Section 7.1.5:**

- Provider Review Notification Letter (**Exhibit 7.1.5-4**)
- Credit Balance Audit (CBA) Report Layouts
  - CBA Invoice (**Exhibit 7.1.5-5**)
  - BI Back-up (**Exhibit 7.1.5-6**)

Exhibit 7.1.5-4 Provider Review Notification Letter

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

James C Justice
Governor

Bill J. Crouch
Cabinet Secretary

September 29, 2020

War Memorial Hospital
Attn: Patient Accounts Manager
103 War Memorial Drive
Berkeley Springs, WV 25411

Re: Medicaid Credit Balance Review

Dear Patient Accounts Manager,

The West Virginia Department of Health and Human Resources (WVDHHR), Bureau for Medical Services, has contracted with Health Management Systems (HMS) to review provider reports and records to determine if overpayments made to your facility involving Medicaid accounts exist. As an agent of WVDHHR, HMS has authorization to access and review patient financial records involving Medicaid accounts.

As you are aware, Section 1902(a) (25) of the Social Security Act provides, "State agencies administering their Medicaid program will take all reasonable measures to determine the legal liability of third parties to reimburse for services arising from injury, disease or disability." Pursuant to Title 42 Chapter IV Part 433.139 of the Code of Federal Regulations and the authority cited therein, Medicaid providers are subject to reviews in order to ensure compliance with State Medicaid third party liability recovery requirements.

HMS's review will consist principally of inquiries of hospital personnel and analytical review of transactions affecting the financial accounts of selected Medicaid recipients. HMS will inform WVDHHR of overpayments and third party payments made to the hospital and not credited to Medicaid. The review will take approximately one to two days to complete depending upon various factors such as the availability of hospital personnel and records. In order to complete the review as expeditiously as possible, please ensure that your patient accounting personnel are available during the review. In preparation for the review please have the items on the enclosed listing available and forward the pre-review items to my attention at the HMS address listed below by **October 13, 2020.**

Health Management Systems
Auditor Name
Credit Balance Services Box #14
5615 High Point Drive
Irving, TX 75038

HMS will contact you to confirm the review dates and time. Should you have any questions, please feel free to contact Auditor Name at Auditor Phone Number or via email me Auditor E.mail

Sincerely,

Auditor Name
Provider Service Analyst, Credit Balance Services

Exhibit 7.1.5-4 Provider Review Notification Letter (continued)

Attachment A
West Virginia Medicaid Provider
Documentation Request and Review Process

Prior to On-Site

In order to expedite the on-site review process, HMS requests certain documents and information be provided to us one week prior to the scheduled on-site date. Below is the list of information that must be provided:

1. A detailed listing of all Medicaid accounts in a credit balance status. The list should include all accounts in which Medicaid has made any payments (primary, secondary, tertiary) – regardless of the current financial class of the account. The report should minimally include the patient name or account number and the credit balance amount. The timeframe for this report is the last closed fiscal month or the most current report available.

2. Provider's credit balance policies and procedures.

3. List of all subcontractors who bill Medicaid on behalf of the provider (if applicable). For example, the names of vendors who bill Medicaid for specific clinics or patient types should be included.

4. Name of Patient Accounting Billing systems used to bill the West Virginia Medicaid (e.g., Meditech, SMS, etc.).

5. Debit Adjustment Report for specified date parameters.

On-Site Process

The on-site review consists of the following:

1. Credit Balance Reconciliation: HMS will review claims identified on the credit balance listing report to determine if any Medicaid overpayments exists. If an overpayment is identified, HMS will document the overpayment utilizing Medicaid Remittance Advice (RA's), Explanation of Benefits (EOB's) and, as necessary, account detail information from the patient accounting system.

2. Reconciliation of Credit Balance Listing Report: HMS will review source documents and/or general ledger information to ensure the credit balance listing report includes *all* Medicaid credit balance accounts.

3. Unposted Cash: HMS will review posting processes to ensure all Medicaid payments have been either posted to the correct claim or returned to Medicaid.

4. Check Reimbursement: If the provider refunds overpayments to Medicaid via check, HMS will sample the refund checks to ensure they have been received and processed by Medicaid.

5. While on-site, HMS will need access to the following: patient accounting system; Medicaid RA's; EOB's; and appropriate staff to answer questions about specific accounts or processes.

Please forward pre-review documentation via email to _____Auditor Email_____, via fax to 214.313.1679 or standard mail to the following address: DO NOT staple accounts together if mailing hardcopy.

Health Management Systems
Auditor Name
Credit Balance Services Box #14
5615 High Point Drive

Exhibit 7.1.5-5 Credit Balance Audit (CBA) Report Layouts: CBA Invoice

[illegible]				
Provider		Invoiced Amount	Audit Type	Status
				Total

[illegible]				
Current Back Audits			Amount Recovered	Status

[illegible]				
Last Supported Invoice or Back Audits	[illegible]		[illegible]	

Dates of Service	Charges	Medicaid Paid Amount	Paid Date	Refund Reason	Refund Amount	Request Date	Provider ID #	Provider Name
				Total	$0.00			

Exhibit 7.1.5-6 Credit Balance Audit (CBA) Report Layouts: BI Back-up

Month Year Billing Irreg.
Invoice Date: MM/DD/YY

# Claims	CKS	INVOICE & DATE	TYPE	ARCN #	Medicaid #	Facility Name	CK NUMBER	CK DATE	CLAIM #	RECOVERED	MED PAID

REDUCTION MONTH YEAR COLLECTIONS

INVOICE & DATE	TYPE	ARCN #	Medicaid #	Facility Name	CK NUMBER	CK DATE	CLAIM #	RECOVERED REFUND AMT.	MED PAID
					TOTAL				

INVOICE TOTAL $0.00

7.1.6 THIRD PARTY ADDS

In this section, please see the following exhibits referenced in proposal **Section 7.1.6:**

- Sample Monthly Cost Avoidance Report Layouts
  - Carrier Counts (**Exhibit 7.1.6-8**)
  - Lead Source Counts (**Exhibit 7.1.6-9**)
  - Master Report (**Exhibit 7.1.6-10**)

Exhibit 7.1.6-8 Sample Monthly Cost Avoidance Report Layouts: Carrier Counts

Health Management Systems
Month Year
Adds and Updates
Carrier counts

Carrier Name	State Code	Count

Exhibit 7.1.6-9 Sample Monthly Cost Avoidance Report Layouts: Lead Source Counts

Health Management Systems
West Virginia TPL Adds
Month Year
HMS Lead Source Counts

DataSource	Type	Action	Count
MATCHCOB	MAJOR	ADD	
MATCHCOB	MINOR	ADD	
MATCHCOB	UPDATE	UPDATE	
REFERRAL	MAJOR	ADD	
REFERRAL	MINOR	ADD	
REFERRAL	UPDATE	UPDATE	
	TOTAL:		0

Exhibit 7.1.6-10 Sample Monthly Cost Avoidance Report Layouts: Master Report

Health Management Systems
West Virginia HMS TPL Adds
Month Year
Master Report

	Action	Lastupdate Type	Count	INVOICE
BMS				
	Add			
		YYYY-MM-DD Major		$0.00
		Total:		$0.00
HMS				
	Add			
		YYYY-MM-DD Major		$0.00
		YYYY-MM-DD Major		$0.00
		YYYY-MM-DD Major		$0.00
		YYYY-MM-DD Major		$0.00
		Total:		
		YYYY-MM-DD Minor		$0.00
		YYYY-MM-DD Minor		$0.00
		YYYY-MM-DD Minor		$0.00
		YYYY-MM-DD Minor		$0.00
		Total:		
		Final Total Count:		$0.00

7.2.0 TPL Optional Services

In this section, all exhibits are included in proposal **Section 7.2.0.**

7.2.1 Premium Reimbursement Program

In this section, please see the following exhibits referenced in proposal **Section 7.2.1:**

- West Virginia HIPP Brochure (**7.2.1-5**)
- West Virginia HIPP Missing Enrollment Information Letter (**Exhibit 7.2.1-6**)
- West Virginia HIPP Acceptance Letter (**Exhibit 7.2.1-7**)
- West Virginia HIPP Denial Letter (**Exhibit 7.2.1-8**)
- HIPP PIER Report (**Exhibit 7.2.1-9**)

Exhibit 7.2.1-5 West Virginia HIPP Brochure

HAVING GREAT HEALTHCARE COVERAGE IS A KEY TO STAYING HEALTHY.

You never know when a healthcare issue will strike you or your family member. Having comprehensive health plan coverage is the best defense to maintaining good personal and financial health.

WV HIPP Program enables you to get more healthcare coverage with no cost to you.

WHY ENROLL?

- You may have more benefits by getting insurance through both your job and West Virginia Medicaid Coverage. For example, your employer's health plan may provide access to more healthcare providers, additional paid services and even wellness programs.
- Family members who are not eligible for West Virginia Medicaid Coverage may be able to get employer-sponsored insurance at no cost.
- If you lose your West Virginia Medicaid Coverage, you can keep your employer-sponsored insurance, so you will not go without health insurance.

WV HIPP

More Coverage, No Extra Cost

West Virginia Health Insurance Premium Protection Program

Exhibit 7.2.1-5 West Virginia HIPP Brochure (continued)

HOW IT WORKS

Once you are enrolled in your Employer Sponsored Insurance (ESI) you will receive a monthly check or a direct deposit for the health insurance premiums that will be deducted from your paycheck.

FREQUENTLY ASKED QUESTIONS

What if I cannot afford employer-sponsored insurance?

If you are eligible for the WV HIPP Program then you will still keep your original West Virginia Medicaid Coverage. The WV HIPP Program will help pay for all of the ESI premiums deducted from your paycheck. Additionally, West Virginia Department of Health and Human Resources will pay for any services not covered by your ESI, but covered by West Virginia Medicaid Coverage, along with qualifying out-of-pocket costs including copayments and deductibles.

Will my Medicaid coverage terminate if I enroll onto the WV HIPP Program?

No. Enrolling into the WV HIPP Program will not impact your Medicaid eligibility. If you enroll onto the program the insurance through your employer will be your primary insurance and Medicaid will your secondary insurance. Any copays, coinsurance or deductibles that are not paid for by your commercial insurance will be paid for by Medicaid.

Do I need to wait until open enrollment to enroll?

No. Per State laws and CHIPRA Premium Assistance/HIPP provisions, you and your family may enroll into the plan outside of open enrollment. If your employer has additional concerns, please have them contact us at 1-855-MyWVHIPP (1-855-699-8447) or CustomerService@MyWVHIPP.com.

When will I start receiving payments?

Once you are deemed eligible for WV HIPP Program and we have confirmed your enrollment onto the employer-sponsored insurance, you will receive a reimbursement check within 30-45 days.

My health insurance just ended because I lost my job. Can I still apply for the WV HIPP Program?

Yes. In some cases, health insurance is offered to recently terminated employees for up to 18 months. This extended coverage is known as COBRA coverage. For more information and to see if you qualify, contact the WV HIPP Program at 1-855-MyWVHIPP (1-855-699-8447).

DISCLAIMER: In order to receive reimbursement from the Premium Assistance program, you must remain enrolled into the ESI and you must remain in an eligible WV HIPP category of assistance.

WV HIPP

Exhibit 7.2.1-6 West Virginia HIPP Missing Enrollment Information Letter

WV HIPP
3501 MacCorkle Ave SE #201
Charleston, WV 25304

Bill J. Crouch, Cabinet Secretary
Cynthia E. Beane, Commissioner

32541 9

John Doe
1234 ADDRESS
CHARLESTON, WV 25301-1234

11/04/2020

Dear John Doe,

We are reviewing your application for the West Virginia Health Insurance Premium Payment (HIPP) program. In order to determine whether you qualify for benefits under the WV HIPP program, we need the following information or documentation:

- ✓ Your Medicaid Identification Number
- ✓ Your employer's: Company name
- ✓ Your employer's: Mailing address (street address, city and ZIP code)
- ✓ Your employer's: Phone number (with area code)
- ✓ Your employer's: Federal Employer Identification Number (FEIN)
- ✓ A copy of your insurance card (front and back)
- ✓ A copy of your most recent pay stub or other premium payment verification
- ✓ A copy of your summary of benefits: provided by your employer or insurance company.
- ✓ A health insurance rate sheet: provided by your employer or insurance company.
- ✓ A copy of your Explanation of Benefits (EOB)

You can either fax or mail a copy of the requested document(s) by 11/17/2020

Fax: 855-888-3003
Address: WV HIPP, 3501 MacCorkle Ave SE, Charleston, WV 25304

We will continue to process your application once we receive all documentation needed. Once it is determined, your eligibility letter will be sent to you by mail. If you have any questions or need additional information, you may call our office at our toll free number 1-855-MyWVHIPP (855-699-8447).

Sincerely,

Recipient Name: John Doe

The HIPP Team

Exhibit 7.2.1-7 West Virginia HIPP Acceptance Letter

WV HIPP
3501 MacCorkle Ave SE #201
Charleston, WV 25304

Bill J. Crouch, Cabinet Secretary
Cynthia E. Beane, Commissioner

John Doe
1234 ADDRESS
CHARLESTON, WV 25301-1234

11/04/2020

Dear John Doe,

Welcome to the West Virginia Health Insurance Premium Payment program!

As a member of the WV Health Insurance Premium Payment (HIPP) program, you will be reimbursed for the monthly cost of your group health insurance beginning with the month of November 2020.

Our records show that you have EMPLOYEE BENEFIT SERVICE CNTR-COUPLE-PLANOFFSHORE, and your monthly payment is $12.00. Please inform us if this is incorrect. Also, note that we reimburse for medical premiums only, no dental, vision, life or short-term disability premiums will be reimbursed.

Remember:
To continue receiving HIPP benefits. the health insurance policyholder (on file) must send a copy of his/her paystub to our program every month:

- Fax a copy of your paystub, or other verification of premium payments to 855-888-3003, or
- Mail paystubs or other verification of premium payments to:
  WV HIPP, 3501 MacCorkle Ave SE #201, Charleston, WV 25304

As a HIPP program member, you must tell us about changes such as:

1. Your insurance terminates (coverage ends).
2. Your insurance company changes.
3. Your employer changes.
4. Your insurance cost changes.
5. Your address changes.
6. Your bank account information changes and you are receiving payments through direct deposit.
7. You add or delete dependents from policy.

Your case will be reviewed from time to time to verify eligibility. In addition, the WV HIPP program will conduct twice-yearly checks for any changes in your insurance information. Feel free to call our office if you have any questions or if you need to report any changes to your personal information.

Sincerely,

Recipient Name: John Doe

The HIPP Team

Toll free phone: 1-855-MyWVHIPP (855-699-8447) | Monday to Friday 9am to 6pm
Fax: 855-888-3003 | Website: www.MyWVHIPP.com
West Virginia HIPP is a program of the Department of Health and Human Resources.

Exhibit 7.2.1-8 West Virginia HIPP Denial Letter

WV HIPP
3501 MacCorkle Ave SE #201
Charleston, WV 25304

Bill J. Crouch, Cabinet Secretary
Cynthia E. Beane, Commissioner

325417

John Doe
1234 ADDRESS
CHARLESTON, WV 25301-1234

11/04/2020

Dear John Doe,

After carefully reviewing your file, we have determined that you are no longer eligible for the West Virginia Health Insurance Premium Payment (HIPP) program for the following reason:

You did not complete the review process therefore, we cannot determine your eligibility. If you wish to be considered for the HIPP program in the future, please contact our office or visit us online to have a full list of what is needed to apply.

This determination does not affect Medicaid eligibility. We welcome you to contact the West Virginia Health Insurance Premium Payment (HIPP) program at our toll free phone number 1-855-MyWVHIPP (855-699-8447) if you have any questions about this determination or if you have any information that you feel would affect your WV HIPP eligibility.

Sincerely,

Recipient Name: John Doe

The HIPP Team

Toll free phone: 1-855-MyWVHIPP (855-699-8447) | Monday to Friday 9am to 5pm
Fax: 855-888-3003 | Website: www.MyWVHIPP.com
West Virginia HIPP is a program of the Department of Health and Human Resources.

Exhibit 7.2.1-9 Sample PIER Report for the West Virginia HIPP program

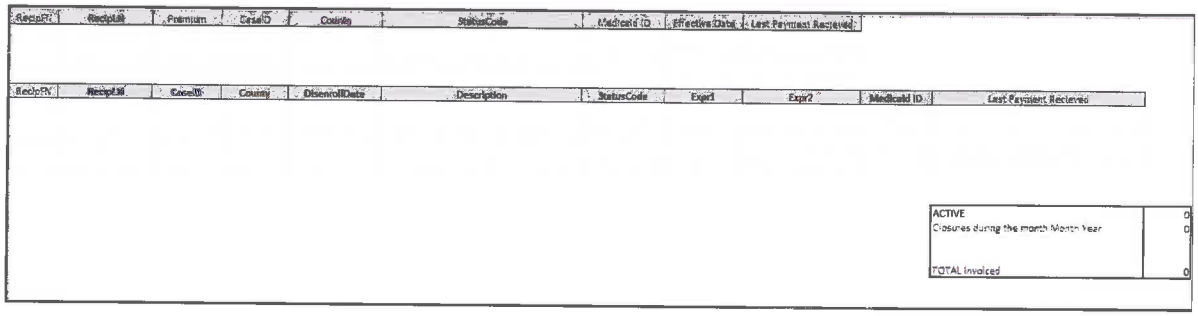
Sample HIPP PIER Report

Date	MCD - EFS	PCRS	# Prems	#	Policy Holder - Last Name	Policy Holder - First Name	MEDICAID	Member Last Name	Member First Name	Begin Date of Prem. Pd.	End Date of Prem. Pd.	Check #	Void Pd	Invoice Number	Prem. Date	Comment
Checks issued totals (Date Range)																
TOTAL STOP - VOID CHECKS - Date Range												VOIDED CHECK #				
TOTAL 1st Check run totals (Date Range)																
Date	MCD - EFS	PCRS	# Prems	#	Policy Holder - Last Name	Policy Holder - First Name	MEDICAID	Member Last Name	Member First Name	Begin Date of Prem. Pd.	End Date of Prem. Pd.	Check #	Void Pd	Invoice Number	Prem. Date	Comment
Checks issued totals (Date Range)																
TOTAL STOP - VOID CHECKS - Date Range												VOIDED CHECK #				
TOTAL 2nd Check run totals (Date Range)		0	0	0												
Total Number Of Direct Payment checks																
Total Number Of Checks																
Total number of Premiums																
HIPP Reimbursement - Funding Totals																
Recipients																
Recipient Invoice Totals																

7.2.2 Work Incentive Program

In this section, please see the following exhibits referenced in proposal **Section 7.2.2:** M-WIN Report Layout (**Exhibit 7.2.2-3**)

Exhibit 7.2.2-3 M-WIN Report Layout



7.2.3 Medicare Buy-In

In this section, all exhibits are included in proposal **Section 7.2.3.**

7.2.4 Recovery Audit Contractor (RAC)

In this section, please see the following exhibits referenced in proposal **Section 7.2.4:**

- **Sample Letter and Claim List Template** included with our Preliminary Findings Letter sent to providers; used to communicate the claims and used to communicate the details about our review findings (**Exhibit 7.2.4-9**)
- **Sample Medical Record Request Letter** sent to providers after claims are selected in order to request medical records for the review (**Exhibit 7.2.4-10**)
- **Sample Audit Concept Approval Form** used to submit audit concepts to BMS for approval prior to undergoing development approval (**Exhibit 7.2.4-11**)
- **Sample Provider Engagement Program Model** that describes Phases and General Activities (**Exhibit 7.2.4-14**)

Exhibit 7.2.4-9 Sample Letter and Claim List Template

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Bureau for Medical Services

Bill J. Crouch
Cabinet Secretary

Cynthia E. Beane
Commissioner

08/06/2020

ABCD MEDICAL INNOVATIONS OF WEST VIRGINIA
111 NORTH HAPPY STREET
CHARLESTON, WV 25301-1234

Certified Mail

Final Determination Notification – No Additional Documentation Received

RAC review: <<SCENARIO NAME>>
Billing Provider Name: ABCD MEDICAL INNOVATIONS OF WEST VIRGINIA
Billing Provider NPI: 123456789

Provider Response Required Within Thirty (30) Calendar Days from the Date of this Letter

Dear Medicaid Provider:

Health Management Systems, Inc. (HMS) is a Medicaid Recovery Audit Contractor (RAC) under contract with the West Virginia Department of Health and Human Resources, Bureau for Medical Services (BMS). HMS conducted a post-payment review of selected Medicaid claims and medical records submitted by ABCD MEDICAL INNOVATIONS OF WEST VIRGINIA - 123456789. You were notified in a letter dated 4/23/2020 of the preliminary findings, and you were allowed thirty (30) calendar days to supply additional documentation to support your Medicaid claims.

No additional documentation was received. The preliminary findings are upheld based on the available information.

As a result, you are hereby notified that you were overpaid by Medicaid in the amount of $211.15. Please see the attached listing which provides the recipient name, claim number, line item, type of service, date of service, policy violation, and the overpayment amount for each claim. BMS and the West Virginia Administrative Code support these findings.

This administrative action to recover Medicaid funds has no bearing on any criminal liability you may have incurred from any acts related to Medicaid billings.

350 Capitol Street, Room 251 • Charleston, West Virginia 25301 • 304-558-1700 • 304-558-1451 (fax) • dhhr.wv.gov

Exhibit 7.2.4-9 Sample Letter and Claim List Template (continued)

Please send a check in the amount of $211.15 payable to: West Virginia Medicaid

to: Bureau of Medical Services
PO Box 123456
Charleston, WV 25301

OR

If you would like to pay through a payment offset, please contact HMS Provider Services at: (877) 248222-4444 to discuss recoupment of the overpayment.

OR

If you disagree with this decision, you have the right to a hearing. You may request a Fair Hearing pursuant to the <<West Virginia Specific statute>> the Medicaid Provider Manual <<insert chapter>>. To request a Fair Hearing, you must submit your request in writing and include a copy of this letter and attachments, a contact phone number, and your reasons for disagreement with this decision. A request for a Fair Hearing must be received by BMS Hearings Unit within ninety (90) calendar days from the date of this letter. Requests are to be submitted to:

to: Bureau of Medical Services
PO Box 123456
Charleston, WV 25301

In the event you request a formal hearing, there will be an opportunity to resolve disputed issues in a pre-hearing conference prior to the formal hearing date.

Requesting a Fair Hearing does not suspend your obligation to repay this overpayment as directed above. Please refer to the <<Medicaid Provider Manual>> for the official policies governing Fair Hearings.

If you do not contact us, or make payment, within sixty (60) calendar days of the date of this letter, BMS will post the overpayment as a negative balance against future payments. If you do not submit sufficient valid claims to offset the negative balance, all, or part, of the negative balance may be transferred to any other active provider account with the same ownership. Your debt may also be turned over to the State Controller and/or to a collection agency for collection, pursuant to <<WV State Statute>>, without further notice. If your debt is turned over to the State Controller and/or a collection agency, you may be required to pay collections costs and additional fees.

If you have questions or need any additional information, please contact HMS Provider Services at: (877) 222-4444.

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Exhibit 7.2.4-9 Sample Letter and Claim List Template (continued)

For correct handling and delivery, you must enclose a copy of this letter with all correspondence related to this issue. HMS will not be responsible for inappropriate routing when a copy of the letter is not attached.

Sincerely,

Recovery Audit, HMS

Attachments

Exhibit 7.2.4-9 Sample Letter and Claim List Template (continued)

hms

8/9/2020

Dear PROVIDER:

The Department of Health and Human Resources, Bureau for Medical Services (BMS) has retained Health Management Systems (HMS) to identify and recover claim overpayments made to its contracted providers.

Enclosed you will find claim information associated with the following projects:

Provider NPI: 123456789
Provider Name: ABCD MEDICAL INNOVATIONS WV
Audit ID: 186621

Project | Cycle	Patients	Claims	Total Overpayment Amount
<<Scenario Name>>	2	2	$211.15
Summary	2	2	$211.15

It is important that you immediately review the attached listings, since recoupment of payments to your office or facility may be forthcoming.

Please follow the attached instructions carefully and forward the appropriate documentation to the office at the address included in the letter.

If you have any questions regarding this Medicaid recoupment project, please direct them to HMS Provider Services between 8AM and 5:00PM EST at (877) 222-4444. We ask that you include your name, title, and phone number (including extension) on all correspondence. We also ask that you do not contact BMS or the fiscal agent regarding the project as they will not be able to assist you.

350 Capitol Street, Room 251 - Charleston, West Virginia 25301 - 304-558-1700 - 304-558-1451 (fax) - dhhr.wv.gov

Exhibit 7.2.4-9 Sample Letter and Claim List Template (continued)

Provider NPI: 123456789 Audit ID: 186621
Provider Name: ABCD MEDICAL INNOVATIONS OF WEST VIRGINIA
Review: <<Scenario Name>>

For assistance, please call HMS Provider Services between 8AM and 5:00 PM EST at (877) 222-4444

Paid Claims Report	
Reason:	<<Scenario Name>> This section will provide the write up of the scenario, the codes, statutes, and approved audit structure. **Management Service by the Same**

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Exhibit 7.2.4-9 Sample Letter and Claim List Template (continued)

hms

Improperly Paid Claim										Overlapping Claims			
ICN	Line #	Service From Date – Service To Date	Overpaid Proc Code	Medicaid ID	Patient Name	DOS	Patient Acct Number	Medicaid Pmt Amt	Overpayment Amt	ICN	Proc Code	Medicaid Pmt Amt	Service From Date – Service To Date
[illegible]	1	07/01/2019 - 07/05/2019	99215	ABC123456	LOIS LANE	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible] - [illegible]
[illegible]	[illegible]	[illegible] - 10/29/2019	99232	DEG789101	[illegible]	[illegible]	[illegible]	$70.11	$70.11	[illegible]	[illegible]	[illegible]	[illegible] - 10/29/2019

Notice: This information is intended only for the use of the entity to whom it is addressed, and contains privileged or confidential information protected by law. All recipients are hereby notified that inadvertent or unauthorized receipt does not waive such privilege, and that unauthorized dissemination, distribution or copying of this information is prohibited. If you have received this listing in error, please destroy it and notify the sender.

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Exhibit 7.2.4-10 Sample Medical Record Request Letter

<Client Logo>

<Title>
<Dept.>
<PROVIDER NAME>
<ADDRESS>
<ADDRESS>
<CITY ST ZIP>

<MM/DD/CCYY>

Subject: Request for Medical Record Documentation
Note: The information in this letter is confidential and may contain Protected Health Information (PHI).*

Dear <Provider Name>:

Managing available resources to fund member care is a priority of <Client Name>. To help control costs, <Client Name> has retained HMS to periodically verify claims for healthcare services billed by providers. HMS is a national leader in payment integrity solutions.

The enclosed Medical Records Documentation Pull List provides a detailed list of the medical records we request on behalf of <Client Name>. Please provide this documentation within <timeframe> calendar days from the date of this letter. This request is in compliance with the agreement between your organization and <Client Name> and <applicable guidelines>.

Instructions for Submitting Records
<Insert instructions here for secure file transfer options>

About Medical Record Reviews
The reviews HMS conducts may focus on coding validation, payment accuracy and compliance with regulations, policies, contractual requirements and utilization standards.

After completing our review, HMS will send you a detailed report of our findings.

Thank you for your cooperation and prompt attention to this matter. You may contact HMS Provider Relations at <insert client specific 800#> with any questions.

Sincerely,

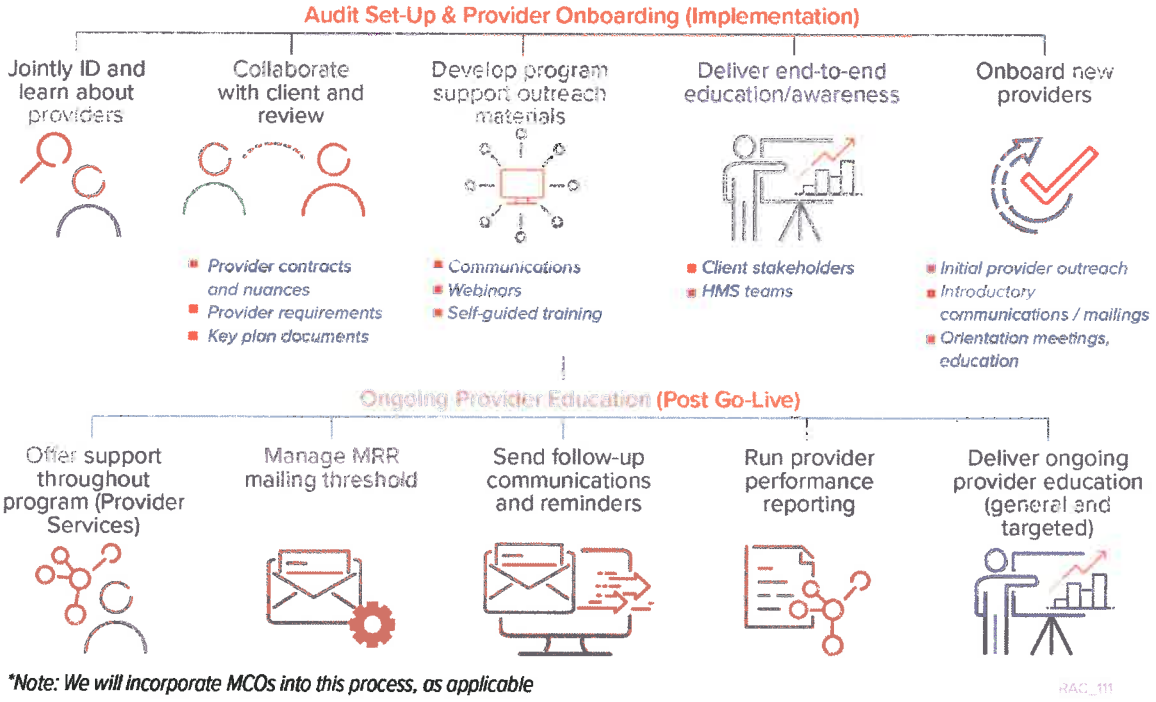
HMS Provider Relations

Enclosures:

Exhibit 7.2.4-11 Sample Audit Concept Approval Form

HMS CONCEPT APPROVAL REQUEST		
Client Name:	WV BMS	
CONCEPT INFORMATION		
Concept:	Concept Name	
Date Submitted:	Date submitted to BMS for review	
Concept Description:	Criteria for the requested audit	
Estimated Retrospective Savings:	Estimated savings to be supplied in dollars	
Estimated Retrospective Claim Impact:	Number of claims identified for audit	
Provider Type:	Identifies the provider group to be included in the audit	
Supporting Documentation:	This section will supply BMS will all pertinent documentation supporting the audit request.	
CLIENT REVIEW		
Review Date:	mm/dd/yyyy	
Reviewed By:		
Comments:		
CLIENT DECISION		
Concept Status:	☐ Approved ☐ Denied	☐ Customization Required; see explanation
Status Sign Off By:		
Date:		
Client Customization Request(s):		

Exhibit **7.2.4-14** Sample **Provider Engagement Program Model**



7.2.5 Additional Value-Add Services

In this section, all exhibits are included in proposal **Section 7.2.5.**

Additional Proposal Sections

For all remaining Technical Proposal sections, exhibits are included in the respective sections:

- **Section 7.3.0** Project Management Overview
- **Section 7.3.1** Communication Management Plan
- **Section 7.3.2** Documentation Management Plan
- **Section 7.3.3** Staffing Management Plan
- **Section 7.3.4** Change Management Plan
- **Section 7.3.5** Implementation Plan
- **Section 7.4.0** Program Integrity
- **Section 7.5.0** Information Management Systems Overview
- **Section 7.5.1** Business Continuity and Disaster Recovery Plan

- **Section 7.5.2** Security Plan
- **Section 7.6.0** Critical Services

Michelle Hayes

TPL Project Role: Account Manager

MICHELLE'S EXPERIENCE AND EDUCATION SERVE THE TPL NEEDS OF BMS

Michelle applies more than seven years of experience managing large-scale payment accuracy projects for HMS on behalf of Medicaid members. Her Bachelor of Finance degree enables her to analyze service issues and both research and apply best practice solutions to maximize TPL results for the State. She is currently managing our work with WV BMS and has experience providing TPL services for other state contracts including Pennsylvania, Maryland, Indiana, and Virginia. These services included cost avoidance, data matching, post-payment recovery, credit balance audits, carrier billing, HIPP and Medicare and commercial insurance disallowances. She also shares her knowledge to help clients efficiently work with providers, making sure they have a clear understanding of our other TPL services such as carrier billing, Medicare, and commercial disallowances. Michelle's auditing background with providers assists her in helping them complete disallowance projects. She has the scope-specific experience with an educational background to best manage the implementation and operation of all RFP requirements for the State.

CURRENT ROLE

Health Management Systems, Inc.

Program Director, January 2019–Present

- Responsible for the successful communication of solutions and delivery of HMS services to client
- Has overall responsibility for management of a state contract(s) and related contracts to support the primary clients; responsible for relationship management with stakeholders throughout the state
- Effectively budgets, forecasts, and meets/exceeds internal revenue targets as well as client account recoveries and savings
- Serves as primary liaison with clients
- Works with company-wide resources to ensure key client deliverables and SLAs are met
- Monitors legislative and regulatory initiatives and agency concerns and contracts
- Directly supervises account management staff and manages various internal resources to provide key client deliverables and meet revenue goals
- Leads team in procurement processes and solicitation responses
- Develops and presents reports and other written communication to the client and internal staff
- Interacts with HMS executives, supporting staff, and state constituencies including legislators and governor's staff, as necessary

- ✓ Currently serves as Account Manager of HMS' delivery of comprehensive TPL services to BMS
- ✓ Applies in-depth understanding of WV Medicaid operations and the State's payment accuracy needs

RELEVANT CAREER HISTORY

Health Management Systems, Inc.

Manager, Credit Balance, May 2015–January 2019

- Responsible for managing a state-wide Operations team throughout Ohio, playing an integral role in the production, creation, and delivery of health care products or services to internal and external clients
- Managed overall staff administration, including employee staffing models, recruiting, performance management, and salary administration, with oversight of 12 exempt employees
- Managed and maintained 80+ relationships with providers throughout the state; ensured adherence to departmental budget
- Determined and maintained appropriate organizational structure and staffing levels, achieved production goals and financial goals, and coordinated with other operational departments as needed
- Provided training, coaching, and mentoring to staff and fellow managers as needed
- Provided development opportunities to staff
- Acted as an escalation point for teams, supporting all clients to promote a high level of client satisfaction
- Prepared, produced, and delivered management reports on a daily, weekly, or monthly frequency

Auditor, Credit Balance, July 2013–May 2015

- Worked independently to identify and secure provider refunds
- Managed claims administration
- Developed and managed provider relationships
- Communicated field initiatives with internal and external clients
- Recovered client overpayments
- Interpreted contracts between client and provider
- Posted adjustments for providers
- Worked outstanding accounts receivable (A/R)
- Reviewed credit balance reports
- Worked in various computer systems on daily basis
- Assisted with training of new hires

EDUCATION

- Bachelor of Science in Business, Finance, Wright State University, Dayton, Ohio

HONORS AND AWARDS

- HMS Most Valuable Leader: 2015, 2016, 2017, and 2018

Lea Ann Duffield

TPL Project Role:

Project Manager

LEA ANN'S EXPERIENCE AND EDUCATION SERVE THE TPL NEEDS OF BMS

Accomplished professional with over six years of combined experience in the healthcare and Medicaid industry. Lea Ann's experience and education serve the TPL needs of BMS. She brings one year of experience managing large-scale cost containment projects for HMS on behalf of Medicaid customers. Lea Ann's past experience enables her to research and apply best practice solutions to maximize TPL results on behalf of her clients. Lea Ann's healthcare background includes experience working directly with Medicaid customers and educating them on programs such as the Premium Reimbursement Program. Within her Program Manager role, she works with our internal Operations team to promote understanding of the members' needs for the services we offer.

CURRENT ROLE

Health Management Systems, Inc.

Program Manager, Charleston, WV, 2019–Present

- Maintains client relationships with multiple state contracts
- Manages budget and revenue expectations and the implementation and ongoing execution of the contract
- Works closely with Account Management team generating sales opportunities and with the Operations team on successful delivery of services to the client
- Directs HMS contract operations to ensure successful delivery of services to client(s)
- Monitors state legislative, regulatory, and competitive environment and alerts management to risks and opportunities
- Creates and analyzes data with respect to the recovery program
- Creates monthly reporting on project performance for her clients
- Develops and maintains Operations Plan for the program to ensure compliance
- Builds relationships with internal and external staff to ensure client expectations are being met
- Recommends and implements workflow changes regularly to increase recoveries and performance
- Develops and maintains standard operating procedures for HIPAA recovery projects
- Works closely with and acts as a direct client liaison for the TPL program

RELEVANT CAREER HISTORY

Public Partnerships LLC

Resource Consultant, 2014–2019

- Provided information to help participants exercise choice and control over their community services and supports, including assisting participants who are household employers of their direct care workers
- Provided orientation and training on program rules

- Currently serves as Project Manager of HMS' delivery of comprehensive TPL services to BMS
- Applies six years of combined knowledge of healthcare and Medicaid experience

- Enrolled participants and service providers and developed a cash management plan for using their public benefit
- Monitored participant's health and safety and maintained progress notes for contacts' regularly scheduled visits
- Maintained client base of 89

McJunkin Redman Corporation

Pricing Specialist, 2012 –2014

- Maintained accurate and timely pricing data, including pricing matrix, library sheets, and market lists and multipliers
- Maintained tools that provided support documentation in customer price reviews, including notification letters, price sheets and pricing index/trends
- Worked with Supply Management and Pricing Group
- Performed related verifications and analytical processes

Supervalu, Milton Division

Accounting Office Supervisor, 2006–2012

- Supervised a staff of three employees
- Maintained accounts payable, accounts receivable, inventory controls and cashier functions
- Prepared yearly budgets for both accounting and sales departments
- Analyzed variances between actual and budget each period for performance of gross profit and expenses
- Prepared daily deposit and reconciled all credit card transactions processed

Innovative Mattress Solutions

Staff Accountant, 2004–2006

McJunkin Corporation

Corporate Cash Manager, 2002–2004

Supervalu, Milton Division 1998–2002

Staff Accountant, 1999–2002

Internal Auditor, 1999

EDUCATION

- Regents Bachelor of Arts. Marshall University, Huntington, West Virginia
- Certified Coding Specialist, Mountwest Community and Technical College, Huntington, West Virginia

Lara Wright Megless

TPL Project Role: Quality Assurance Manager

LARA'S EXPERIENCE AND EDUCATION SERVE THE TPL NEEDS OF BMS

Lara brings more than eight years of experience managing large-scale payment accuracy projects for HMS on behalf of our Medicaid customers. She has experience providing oversight to HMS Medicaid projects in nine states including West Virginia. These projects include TPL, RAC, Casualty Recovery and Estate Recovery services along with Cost Avoidance and Credit Balance auditing oversight. Lara's long career in healthcare allows her to bring a diverse background to the management and oversight of the HMS account team with responsibility for the West Virginia projects.

CURRENT ROLE

Health Management Systems, Inc.

Senior Regional Director, 2015–Present

- Provides quality assurance and project oversight and serves as the initial point of escalation for the client Account Management team
- Provides project oversight for Indiana, Oklahoma, Kansas, Missouri, Tennessee, Wisconsin, West Virginia and Michigan Medicaid Cost Avoidance and Recovery Services Contracts
- Provides project oversight and serves as a point of escalation for the Medicaid Recovery Audit Contractor (RAC) projects for Illinois and Wisconsin
- Certifies overall quality of service delivery and client satisfaction throughout assigned market
- Holds responsibility for stakeholder-relationship management and serves as a liaison for clients
- Develops and manages budget and revenue expectations for specific markets, often with full profit-and-loss (P&L) responsibility
- Works with companywide resources to confirm fulfillment of key client deliverables and revenue goals
- Identifies sources of revenue through identification of program innovations and improvements
- Introduces, negotiates, and ensures successful implementation of new projects to expand scopes of engagement
- Works with clients and stakeholders to shape procurements and identify opportunities for value-added services
- Monitors activity of other vendors, legislative and regulatory initiatives, and agency concerns and contracts
- Interacts with company executives, supporting personnel, and state constituencies, including legislators and governors' personnel
- Supports collaboration between Account Management and Operations teams to ensure quality deliverables and appropriate resources are assigned to projects

- Currently serves as Quality Assurance Manager of HMS' delivery of comprehensive TPL services to BMS
- Applies knowledge of Medicaid payment accuracy and payment integrity best practices to

RELEVANT CAREER HISTORY

Health Management Systems, Inc.

Program Director, 2012–2015

- Managed state agency contracts and related initiatives to support primary clients
- Managed Medicaid RAC, AVS, COB, DEVA, Estates, Casualty and TPL projects
- Served as a primary liaison with clients
- Certified overall service delivery, quality assurance, and client satisfaction throughout assigned market
- Monitored stakeholder-relationship management, revenue generation, quality improvement and client satisfaction
- Delivered reports and other written communications to clients and internal team members
- Developed budget and revenue expectations for specific markets, often with full P&L responsibility
- Worked with companywide resources to confirm fulfillment of key client deliverables and revenue goals along with maintaining quality and business optimization goals
- Identified sources of revenue through use of sales and marketing skills
- Led sales efforts throughout assigned market
- Led the team in the procurement processes and solicitation responses

Hewlett Packard

Business Analyst, 2010–2012

- Provided dedicated support for ePrescribe™ and provider portal solutions for prescription and medical claim processing for state-run Medicaid, Blue Cross® Blue Shield®, and Cigna® programs
- Managed customization of a client-based software solution to provide medical practitioners, pharmacists, and other stakeholders with accurate, complete drug references and formularies as well as drug utilization–review alerts at the point of service
- Served as a liaison between clients and technical solutions/support groups
- Elicited, documented, analyzed, and validated business processes, systems, and solution requirements
- Formulated and defined ePrescribe and portal system scope and requirements through knowledge of both technology and industry requirements

EDUCATION

Bachelor of Arts, University of Montana, Missoula, Montana