

STATE OF MICHIGAN
DEPARTMENT OF MANAGEMENT AND BUDGET
PURCHASING OPERATIONS
 P.O. BOX 30026, LANSING, MI 48909
 OR
 530 W. ALLEGAN, LANSING, MI 48933

September 15, 2009

CHANGE NOTICE NO. 9
TO
CONTRACT NO. 071B4200405
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR		TELEPHONE William Lucia (212) 857-5000 Fax (202) 429-0823	
Health Management Systems, Inc. 401 Park Avenue South New York, NY 10016			
		BUYER/CA (517) 241-4225 Kevin Dunn	
Contract Compliance Inspector: Tanya Lowers (517) 335-8989 Insurance Information Exchange for Medicaid Recipients – Department of Community Health			
CONTRACT PERIOD: From: November 1, 2004 To: December 31, 2009			
TERMS	SHIPMENT		
N/A	N/A		
F.O.B.	SHIPPED FROM		
N/A	N/A		
MINIMUM DELIVERY REQUIREMENTS			
N/A			

NATURE OF CHANGE (S):

Effective November 1, 2009, this Contract is hereby EXTENDED through December 31, 2009, and INCREASED by \$350,231.57.

All other terms, conditions, specifications, and pricing remain unchanged.

AUTHORITY/REASON:

Per DCH request (PRF dated 7/18/09), Ad Board approval on 9/1/09 and DMB/Purchasing Operations' approval.

REVISED CURRENT AUTHORIZED SPEND LIMIT: \$17,930,363.57

STATE OF MICHIGAN
 DEPARTMENT OF MANAGEMENT AND BUDGET
 PURCHASING OPERATIONS
 P.O. BOX 30026, LANSING, MI 48909
 OR
 530 W. ALLEGAN, LANSING, MI 48933

July 15, 2008

CHANGE NOTICE NO. 8
TO
CONTRACT NO. 071B4200405
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR		TELEPHONE William Lucia (212) 857-5000 Fax (202) 429-0823	
Health Management Systems, Inc. 401 Park Avenue South New York, NY 10016			
		BUYER/CA (517) 241-4225 Kevin Dunn	
Contract Compliance Inspector: Tanya Lowers (517) 335-8989 Insurance Information Exchange for Medicaid Recipients – Department of Community Health			
CONTRACT PERIOD: From: November 1, 2004 To: October 31, 2009			
TERMS		SHIPMENT	
N/A		N/A	
F.O.B.		SHIPPED FROM	
N/A		N/A	
MINIMUM DELIVERY REQUIREMENTS			
N/A			

NATURE OF CHANGE (S):

Effective immediately, this Contract is hereby **EXTENDED** through October 31, 2009, and **INCREASED** by \$3,000,000.00. All other terms, conditions, specifications, and pricing remain unchanged.

AUTHORITY/REASON:

Per DCH request, Ad Board approval on 7/1/08 and DMB/Purchasing Operations' approval.

REVISED CURRENT AUTHORIZED SPEND LIMIT: \$17,580,132.00

**STATE OF MICHIGAN
 DEPARTMENT OF MANAGEMENT AND BUDGET
 PURCHASING OPERATIONS
 P.O. BOX 30026, LANSING, MI 48909
 OR
 530 W. ALLEGAN, LANSING, MI 48933**

October 24, 2007

**CHANGE NOTICE NO. 7
 TO
 CONTRACT NO. 071B4200405
 between
 THE STATE OF MICHIGAN
 and**

NAME & ADDRESS OF VENDOR		TELEPHONE William Lucia (212) 857-5000 Fax (202) 429-0823	
Health Management Systems, Inc. 401 Park Avenue South New York, NY 10016			
		BUYER/CA (517) 241-4225 Kevin Dunn	
Contract Compliance Inspector: Tanya Lowers (517) 335-8989 Insurance Information Exchange for Medicaid Recipients – Department of Community Health			
CONTRACT PERIOD: From: November 1, 2004 To: October 31, 2008			
TERMS		SHIPMENT	
N/A		N/A	
F.O.B.		SHIPPED FROM	
N/A		N/A	
MINIMUM DELIVERY REQUIREMENTS			
N/A			

NATURE OF CHANGE (S):

Effective immediately, this Contract is hereby **INCREASED** by \$5,871,600.00. All other terms, conditions, specifications, and pricing remain unchanged.

AUTHORITY/REASON:

Per DCH request and DMB/Purchasing Operations' approval.

TOTAL ESTIMATED CONTRACT VALUE REMAINS: \$14,580,132.00

**STATE OF MICHIGAN
 DEPARTMENT OF MANAGEMENT AND BUDGET
 PURCHASING OPERATIONS
 P.O. BOX 30026, LANSING, MI 48909
 OR
 530 W. ALLEGAN, LANSING, MI 48933**

September 19, 2007

**CHANGE NOTICE NO. 6
 TO
 CONTRACT NO. 071B4200405
 between
 THE STATE OF MICHIGAN
 and**

NAME & ADDRESS OF VENDOR		TELEPHONE William Lucia (212) 857-5000 Fax (202) 429-0823	
Health Management Systems, Inc. 401 Park Avenue South New York, NY 10016			
		BUYER/CA (517) 241-4225 Kevin Dunn	
Contract Compliance Inspector: Tanya Lowers (517) 335-8989 Insurance Information Exchange for Medicaid Recipients – Department of Community Health			
CONTRACT PERIOD: From: November 1, 2004 To: October 31, 2008			
TERMS		SHIPMENT	
N/A		N/A	
F.O.B.		SHIPPED FROM	
N/A		N/A	
MINIMUM DELIVERY REQUIREMENTS			
N/A			

NATURE OF CHANGE (S):

Effective immediately, this Contract is hereby **EXTENDED** until October 31, 2008, and **INCREASED** by \$1,700,000.00.

The attached document dated July 9, 2007, modifies the pricing for the Paternity Confinement Data Warehouse project, retroactively, to June 1, 2007.

All other terms, conditions, specifications, and pricing remain unchanged.

AUTHORITY/REASON:

Per agency request and DMB/Purchasing Operations' approval

TOTAL ESTIMATED CONTRACT VALUE REMAINS: \$8,708,532.00

**STATE OF MICHIGAN
 DEPARTMENT OF MANAGEMENT AND BUDGET
 PURCHASING OPERATIONS
 P.O. BOX 30026, LANSING, MI 48909
 OR
 530 W. ALLEGAN, LANSING, MI 48933**

November 3, 2006

**CHANGE NOTICE NO. 5
 TO
 CONTRACT NO. 071B4200405
 between
 THE STATE OF MICHIGAN
 and**

NAME & ADDRESS OF VENDOR Health Management Systems, Inc. 401 Park Avenue South New York, NY 10016	TELEPHONE William Lucia (212) 857-5000 Fax (202) 429-0823
	BUYER/CA (517) 241-4225 Kevin Dunn
Contract Compliance Inspector: Tanya Lowers (517) 335-8989 Insurance Information Exchange for Medicaid Recipients – Department of Community Health	
CONTRACT PERIOD: From: November 1, 2004 To: October 31, 2007	
TERMS <p style="text-align: center;">N/A</p>	SHIPMENT <p style="text-align: center;">N/A</p>
F.O.B. <p style="text-align: center;">N/A</p>	SHIPPED FROM <p style="text-align: center;">N/A</p>
MINIMUM DELIVERY REQUIREMENTS <p style="text-align: center;">N/A</p>	

NATURE OF CHANGE (S):

Effective immediately the vendor mail code is changed from 001 to 004 to reflect correct address.

AUTHORITY/REASON:

Per agency request and DMB/Purchasing Operations approval

TOTAL ESTIMATED CONTRACT VALUE REMAINS: \$7,008,532.00

STATE OF MICHIGAN
 DEPARTMENT OF MANAGEMENT AND BUDGET
 PURCHASING OPERATIONS
 P.O. BOX 30026, LANSING, MI 48909
 OR
 530 W. ALLEGAN, LANSING, MI 48933

July 7, 2006

CHANGE NOTICE NO. 4
TO
CONTRACT NO. 071B4200405
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR		TELEPHONE William Lucia (212) 857-5000 Fax (202) 429-0823	
Health Management Systems, Inc. 401 Park Avenue South New York, NY 10016			
		BUYER/CA (517) 241-4225 Kevin Dunn	
Contract Compliance Inspector: Tanya Lowers (517) 335-8989 Insurance Information Exchange for Medicaid Recipients – Department of Community Health			
CONTRACT PERIOD: From: November 1, 2004 To: October 31, 2007			
TERMS		SHIPMENT	
N/A		N/A	
F.O.B.		SHIPPED FROM	
N/A		N/A	
MINIMUM DELIVERY REQUIREMENTS N/A			

NATURE OF CHANGE (S):

Effective immediately, the contract is hereby amended to expand the scope of work to include identifying paternity confinement expenditure requests. The details of the scope of work amendment are included in the attached documents dated December 16, 2005.

In addition this contract is amended to clarify pricing for the Casualty Recovery Services, which were incorporated into the contract, per change notice 3, on March 29, 2006. The attached letter dated February 16, 2006, provides modified pricing structure, with decreasing contingency fees as recoveries exceed certain thresholds. Please note all other terms, conditions, specifications and pricing remain unchanged.

Please note the buyer has been changed to Kevin Dunn.

AUTHORITY/REASON:

Per agency request and DMB/Purchasing Operations approval

TOTAL ESTIMATED CONTRACT VALUE REMAINS: \$7,008,532.00

**Agreement Between the Michigan Department of Community Health
(MDCH) and Health Management Systems (HMS)
to Process Confinement Expense Requests under the Medical Support
Enforcement Provisions of the Current Contract**

Chapter III of the Federal Social Security Act – Office of Child Support Enforcement (42 CFR 302.80) requires that state Offices of Child Support secure and enforce medical support obligations owed to the State Medicaid agency. The State of Michigan Paternity Act (Act 205 of 1956) requires fathers of children born out of wedlock reimburse the Medicaid program for reasonable and necessary expenses related to the mother's confinement and expenses in connection with her pregnancy and the birth of the child.

Project Scope

As of December 1, 2005, HMS and the Michigan Department of Community Health (MDCH) agree to utilize Maximus to identify Medicaid expenditures made by the MDCH that are related to confinement and birthing expenses in child support cases.

Maximus will identify expenditures through the use of policies and procedures established by the Court Originated Liability Section. Maximus will allocate the necessary resources to complete the reporting process as expeditiously as possible to accelerate recoveries and cash flow to MDCH.

Project Approach

MDCH expenditure data is stored in two mediums. Payments made prior to 2001 are stored on microfiche and payments made after January 1, 2001 are stored on the State of Michigan Data Warehouse. As such, review and identification of appropriate Medicaid expenditures will involve two separate processes. Because these are legal documents it is required that re-verification of amounts occur prior to submission to the court.

The detailed tasks for each process are listed below:

A. Microfiche Expenditure Review

- Initial entry of confinement expense request into the PCRS system.
- Location and printing of Medicaid expenditures from microfiche records.
- Review and highlighting of allowable confinement expenditures on microfiche reports.
- Re-verification of highlighted expenditures on microfiche reports.
- Calculation of allowable Medicaid expenditures including review for other insurance payments.
- Completion of the confinement expenses request and entry into the PCRS system.

B. Data Warehouse Expenditure Review

- Initial entry of confinement expense request into the PCRS system.
- Process of Data Warehouse expenditure search within the PCRS system.
- Review and printing of allowable confinement expenditures on the data warehouse.
- Re-verification of included data warehouse expenditures including review for other insurance payments.
- Completion of the confinement expenses request and entry into the PCRS system.

Expected Recoveries

The Michigan Department of Community Health currently receives approximately \$20 million in confinement expenditure recoveries through the child support system. This process will retain and enhance those recoveries.

Fees

As described above, the paternity confinement expenses information for dates of birth involving expenditures prior to January 1, 2001 is produced in a highly manual process. This project will require deployment of resources to the State of Michigan of trained and skilled technicians working with these requests on a daily basis. Accordingly, HMS proposes a fee of \$18.00 (\$9.00 per Mother and Child) for each request processed using expenditure information obtained from data sources outside of the data warehouse and \$5.50 (\$2.75 per Mother and Child) for each request processed using expenditure information located on the data warehouse. Fees are payable to HMS monthly, in accordance with established and agreed upon guidelines. A change order adding \$2.75 for specific components of this process will be submitted by MDCH.

This agreement applies to Contract Number 071B4200405, with a contract period from November 1, 2004 to October 31, 2007 with available extensions.

**STATE OF MICHIGAN
 DEPARTMENT OF MANAGEMENT AND BUDGET
 ACQUISITION SERVICES
 P.O. BOX 30026, LANSING, MI 48909
 OR
 530 W. ALLEGAN, LANSING, MI 48933**

March 29, 2006

**CHANGE NOTICE NO. 3
 TO
 CONTRACT NO. 071B4200405
 between
 THE STATE OF MICHIGAN
 and**

NAME & ADDRESS OF VENDOR		TELEPHONE William Lucia (212) 857-5000 Fax (202) 429-0823	
Health Management Systems, Inc. 401 Park Avenue South New York, NY 10016			
		BUYER/CA (517) 335-4804 Douglas Collier, CPPB	
Contract Compliance Inspector: Tanya Lowers (517) 335-8989 Insurance Information Exchange for Medicaid Recipients – Department of Community Health			
CONTRACT PERIOD:		From: November 1, 2004	To: October 31, 2007
TERMS	SHIPMENT		
N/A	N/A		
F.O.B.	SHIPPED FROM		
N/A	N/A		
MINIMUM DELIVERY REQUIREMENTS			
N/A			

NATURE OF CHANGE (S):

The following initiative is to be added to this Contract:

1. Services for casualty recover
2. The addition of subcontractor First Recovery LLC, a Michigan-based company

See attached statement of work and fee structure.

Please note that Health Management Systems and the State are working on a tiered pricing structure as additional details are presented by February 28, 2006. All other terms, conditions, specifications and pricing remain unchanged.

AUTHORITY/REASON:

Per agency request and letter from vendor dated 11/5/05.

TOTAL ESTIMATED CONTRACT VALUE REMAINS: \$7,008,532.00

Casualty Recovery Proposal for the Michigan Department of Community Health

November 9, 2005

HMS respectfully submits this proposal to perform specified casualty recovery services for the Michigan Department of Community Health as an enhancement to the Department's current casualty work. HMS will operate this project through a Southfield, Michigan based casualty recovery company, First Recovery Group, LLC (FRG).

HMS has unparalleled experience performing trauma/tort services—as demonstrated by the nearly \$160 million that we have recovered for seven state Medicaid agencies. FRG is a privately held healthcare subrogation company that provides subrogation recovery services to over one million Medicaid Managed Care lives in Michigan and over six million lives nationwide.

By combining HMS's expert knowledge of the Medicaid fee-for service market and rapid implementation capabilities, with FRG's existing Michigan experience and subrogation intelligence, our team will ensure early and ongoing recoveries for Michigan.

Project Scope

HMS/FRG proposes to assume specified responsibility for pursuing potential subrogation cases and realizing maximum collection. The Department would still be responsible for generating and mailing trauma leads letters based on diagnosis and procedure codes indicating a trauma as well as posting recoveries to its claims system. Threshold amounts, if any, will be determined by the Michigan Department of Community Health.

Methodology

HMS/FRG proposes to have the responsibility of following-up, recovering and reporting on potential subrogation cases identified by the Michigan Department of Community Health.

Until the Department's system is fully operational, HMS/FRG will manage all cases utilizing its SubroMAX® system. This will allow for a thirty-day implementation and maximize recoveries to the Department. SubroMAX® is FRG's proprietary data mining and case management system. The application runs on a Microsoft Windows Server system and utilizes SQL Server 2000 as its RDBMS. The system currently has over 100 gigabytes of additional fault tolerate storage available and is protected by an ICSA certified and fully inspected firewall.

After the Department's casualty recovery case system is ready for production, HMS/FRG will link into this system and utilize the application to its fullest extent.

The proposed process works as follows:

- HMS sends Medicaid paid claims and other data to FRG's secure FTP site weekly, monthly or as needed.

- Data is imported, analyzed, and associated with existing files.

- Questionnaires that have been sent by the Department are directed to FRG's Member Services Department. A toll free number in the letter will also direct questions to FRG's Member Services Department.

- Completed questionnaires and referral information received by FRG's Member Services staff are entered into SubroMAX®.

- FRG will pursue all referrals from the Department, attorneys, or insurance companies

- FRG's Investigators will obtain additional information if necessary to obtain third party recovery source information by calling members or mailing additional questionnaires.

- Third party information is captured in SubroMAX® and the file is forwarded to FRG's Recovery Team. This Team consists of attorneys and insurance adjusters experienced in handling Michigan Medicaid recoveries.

- Insurance carriers and attorneys are immediately put on notice of the Department's right of recovery, utilizing form letters approved by the Michigan Department of Community Health. These form letters initially request a medical authorization when necessary. If an appropriate release has been received, the request for

reimbursement letter contains language regarding Medicaid's right of recovery and includes all associated claims. These associated claims consist of ICD9 and CPT codes and their related descriptions, as well as the billed and paid amounts.

Cases have a diary/reminder system that automatically appears on the Recovery Specialist's computer. On diary dates, the Recovery Specialist will contact all appropriate parties to seek reimbursement of monies paid by the Department.

After a recovery is made or all potential sources of recovery specified by the Michigan Department of Community Health are exhausted, the case is closed.

Checks will be directed to a post office box designated by the Department.

Reports will be generated and submitted to the Department at the beginning of each month. Those reports typically consist of:

- Total Open Files
- Total Closed Files
- Total Recovered
- Opened Files During Month
- Closed Files During Month
- Recovered During Month
- Remittance for Claims Recovered During Month
- Recoveries YTD

Additional reports required by the Michigan Department of Community Health will be developed and submitted on a predetermined schedule.

HMS/FRG can export the data collected and electronically report back to the Department. This data can include claim numbers associated with the files, attorney information, and insurance carrier information.

Price

HMS/FRG proposes a contingency fee of 17% of recoveries, with a recovery run out period on open cases of 12 months after the contract termination date.

STATE OF MICHIGAN
 DEPARTMENT OF MANAGEMENT AND BUDGET
 ACQUISITION SERVICES
 P.O. BOX 30026, LANSING, MI 48909
 OR
 530 W. ALLEGAN, LANSING, MI 48933

January 24, 2006

CHANGE NOTICE NO. 2
TO
CONTRACT NO. 071B4200405
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR		TELEPHONE William Lucia (212) 857-5000 Fax (202) 429-0823	
Health Management Systems, Inc. 401 Park Avenue South New York, NY 10016			
		BUYER/CA (517) 335-4804 Douglas Collier, CPPB	
Contract Compliance Inspector: Tanya Lowers (517) 335-8989 Insurance Information Exchange for Medicaid Recipients – Department of Community Health			
CONTRACT PERIOD: From: November 1, 2004 To: October 31, 2007			
TERMS		SHIPMENT	
N/A		N/A	
F.O.B.		SHIPPED FROM	
N/A		N/A	
MINIMUM DELIVERY REQUIREMENTS			
N/A			

NATURE OF CHANGE (S):

The following two initiatives are to be added to this contract.

- 1.) Public/Private Status of Detroit Medical Center.
- 2.) Creating Disproportionate Share Hospital (DSH) Room.

Both initiatives are to be priced at current contract Rates.

All other terms, conditions, specifications and pricing remain the same. Please refer to DMB File for additional information on Initiative.

AUTHORITY/REASON:

Per agency request and letter from vendor dated 6/27/05.

TOTAL ESTIMATED CONTRACT VALUE REMAINS: \$7,008,532.00

STATE OF MICHIGAN
 DEPARTMENT OF MANAGEMENT AND BUDGET
 ACQUISITION SERVICES
 P.O. BOX 30026, LANSING, MI 48909
 OR
 530 W. ALLEGAN, LANSING, MI 48933

October 3, 2005

CHANGE NOTICE NO. 2
TO
CONTRACT NO. 071B4200405
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR Health Management Systems, Inc. 401 Park Avenue South New York, NY 10016	TELEPHONE William Lucia (212) 857-5000 Fax (202) 429-0823
	BUYER/CA (517) 335-4804 Douglas Collier, CPPB
Contract Compliance Inspector: Tanya Lowers (517) 335-8989 Insurance Information Exchange for Medicaid Recipients – Department of Community Health	
CONTRACT PERIOD: From: November 1, 2004 To: October 31, 2007	
TERMS <p style="text-align: center;">N/A</p>	SHIPMENT <p style="text-align: center;">N/A</p>
F.O.B. <p style="text-align: center;">N/A</p>	SHIPPED FROM <p style="text-align: center;">N/A</p>
MINIMUM DELIVERY REQUIREMENTS <p style="text-align: center;">N/A</p>	

NATURE OF CHANGE (S):

The following two initiatives are to be added to this contract.

- 1.) **Public/Private Status of Detroit Medical Center.**
 - 2.) **Creating Disproportionate Share Hospital (DSH) Room.**
- Both initiatives are to be priced at current contract Rates.**

All other terms, conditions, specifications and pricing remain the same. Please refer to DMB File for additional information on Initiative.

AUTHORITY/REASON:

Per agency request and letter from vendor dated 6/27/05.

TOTAL ESTIMATED CONTRACT VALUE REMAINS: \$7,008,532.00

**STATE OF MICHIGAN
 DEPARTMENT OF MANAGEMENT AND BUDGET
 ACQUISITION SERVICES
 P.O. BOX 30026, LANSING, MI 48909
 OR
 530 W. ALLEGAN, LANSING, MI 48933**

February 4, 2005

**CHANGE NOTICE #1
 TO
 CONTRACT NO. 071B4200405
 between
 THE STATE OF MICHIGAN
 and**

NAME & ADDRESS OF VENDOR Health Management Systems, Inc. 401 Park Avenue South New York, NY 10016	TELEPHONE William Lucia (212) 857-5000 Fax (202) 429-0823
	BUYER/CA (517) 335-4804 Douglas Collier, CPPB
Contract Compliance Inspector: Tanya Lowers (517) 335-8989 Insurance Information Exchange for Medicaid Recipients – Department of Community Health	
CONTRACT PERIOD: From: November 1, 2004 To: October 31, 2007	
TERMS <p style="text-align: center;">N/A</p>	SHIPMENT <p style="text-align: center;">N/A</p>
F.O.B. <p style="text-align: center;">N/A</p>	SHIPPED FROM <p style="text-align: center;">N/A</p>
MINIMUM DELIVERY REQUIREMENTS <p style="text-align: center;">N/A</p>	

NATURE OF CHANGE (S):

Effective immediately the Contract Compliance Inspector for this contract is changed to:

**Tanya Lowers
 (517) 335-8989**

All other terms, conditions, specifications and pricing remain unchanged.

AUTHORITY/REASON:

Per DMB/Acquisition Services, and Agency contact (Laura Dotson)

STATE OF MICHIGAN
DEPARTMENT OF MANAGEMENT AND BUDGET
ACQUISITION SERVICES
P.O. BOX 30026, LANSING, MI 48909
 OR
530 W. ALLEGAN, LANSING, MI 48933

December 28, 2004

NOTICE
TO
CONTRACT NO. 071B4200405
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR Health Management Systems, Inc. 401 Park Avenue South New York, NY 10016	TELEPHONE William Lucia (212) 857-5000 Fax (202) 429-0823 BUYER/CA (517) 335-4804 Douglas Collier, CPPB
Contract Compliance Inspector: John Gates (517) 335-9510 Insurance Information Exchange for Medicaid Recipients – Department of Community Health	
CONTRACT PERIOD: From: November 1, 2004 To: October 31, 2007	
TERMS <p style="text-align: center;">N/A</p>	SHIPMENT <p style="text-align: center;">N/A</p>
F.O.B. <p style="text-align: center;">N/A</p>	SHIPPED FROM <p style="text-align: center;">N/A</p>
MINIMUM DELIVERY REQUIREMENTS <p style="text-align: center;">N/A</p>	

The terms and conditions of this Contract are those of [REQ. #391R4001791](#), this Contract Agreement and the vendor's quote dated [09/24/2004](#). In the event of any conflicts between the specifications, terms and conditions indicated by the State and those indicated by the vendor, those of the State take precedence.

Estimated Contract Value: **\$7,008,532.00**

**STATE OF MICHIGAN
 DEPARTMENT OF MANAGEMENT AND BUDGET
 ACQUISITION SERVICES
 P.O. BOX 30026, LANSING, MI 48909
 OR
 530 W. ALLEGAN, LANSING, MI 48933**

**CONTRACT NO. 071B4200405
 between
 THE STATE OF MICHIGAN
 and**

NAME & ADDRESS OF VENDOR Health Management Systems, Inc. 401 Park Avenue South New York, NY 10016	TELEPHONE William Lucia (212) 857-5000 Fax (202) 429-0823 BUYER/CA (517) 335-4804 Douglas Collier, CPPB
Contract Compliance Inspector: John Gates (517) 335-9510 Insurance Information Exchange for Medicaid Recipients – Department of Community Health	
CONTRACT PERIOD: From: November 1, 2004 To: October 31, 2007	
TERMS <p style="text-align: center;">N/A</p>	SHIPMENT <p style="text-align: center;">N/A</p>
F.O.B. <p style="text-align: center;">N/A</p>	SHIPPED FROM <p style="text-align: center;">N/A</p>
MINIMUM DELIVERY REQUIREMENTS <p style="text-align: center;">N/A</p>	
MISCELLANEOUS INFORMATION: The terms and conditions of this Contract are those of REQ. #391R4001791, this Contract Agreement and the vendor's quote dated 09/24/2004. In the event of any conflicts between the specifications, terms and conditions indicated by the State and those indicated by the vendor, those of the State take precedence. Estimated Contract Value: \$7,008,532.00	

THIS IS NOT AN ORDER: This Contract Agreement is awarded on the basis of our inquiry bearing the [REQ No. 391R4001791](#). A Purchase Order Form will be issued only as the requirements of the Department of Community Health submitted to Acquisition Services. Orders for delivery may be issued directly by the [Department of Community Health](#) through the issuance of a Purchase Order Form.

All terms and conditions of the invitation to bid are made a part hereof.

FOR THE VENDOR:

FOR THE STATE:

Health Management Systems, Inc.

 Firm Name

 Authorized Agent Signature

 Authorized Agent (Print or Type)

 Date

 Signature
Sean L. Carlson

 Name
Director, Acquisition Services

 Title

 Date

ACQUISITION SERVICES
STATE OF MICHIGAN
CONTRACT # 071B4200405

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DEFINITION OF TERMS

TERMS	DEFINITIONS
Contract	A binding agreement entered into by the State of Michigan resulting from a bidder's proposal; see also "Blanket Purchase Order."
Contractor	The successful bidder who is awarded a Contract.
DMB	Michigan Department of Management and Budget
RFP	Request For Proposal - A term used by the State to solicit proposals for services such as consulting. Typically used when the requesting agency requires vendor assistance in identifying an acceptable manner of solving a problem.
ITB	Invitation to Bid - A generic form used by Acquisition Services to solicit quotations for services or commodities. The ITB serves as the document for transmitting the RFP to interested potential bidders.
Successful Bidder	The bidder(s) awarded a Contract as a result of a solicitation.
State	The State of Michigan For Purposes of Indemnification as set forth in section I-J, State means the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees and agents.
Blanket Purchase Order	Alternate term for "Contract" used in the State's Computer system (Michigan Automated Information Network [MAIN])
Expiration	Except where specifically provided for in the Contract, the ending and termination of the contractual duties and obligations of the parties to the Contract pursuant to a mutually agreed upon date.
Cancellation	Ending all rights and obligations of the State and Contractor, except for any rights and obligations that are due and owing.
Work Product	Work Product means any data compilations, reports, and any other media, materials, or other objects or works of authorship created or produced by the Contractor as a result of and in furtherance of performing the services required by this Contract.



**SECTION I
CONTRACTUAL SERVICES TERMS AND CONDITIONS**

I-A PURPOSE

The purpose of this contract is to provide the services for Medicaid third party liability recovery and to identify and/or locate insurance coverage and medical support enforcement services for children covered by child support orders (**no work shall start on the child support / or any optional portions of this contract and shall remain as an option until internal details for this portion are agreed upon by MFIA and MDCH, and such details are given to Acquisition Service and a change notice is issued.**)

Contract awarded from this solicitation will be the following type:

- X Unit price Contract
- X Other (specify) Contingency fee

I-B TERM OF CONTRACT

The State of Michigan is not liable for any cost incurred by any bidder prior to signing and start date of contract by all parties. The activities in the proposed Contract cover the period November 1, 2004 through September 30, 2007 with two one year options based on contractor performance. The State fiscal year is October 1st through September 30th. The prospective Contractor should realize that payments in any given fiscal year are contingent upon enactment of legislative appropriations.

I-C ISSUING OFFICE

This contract issued by the State of Michigan, Department of Management and Budget (DMB), Acquisition Services, hereafter known as Acquisition Services, for the State of Michigan, the Michigan Department of Community Health (MDCH) and the Michigan Family Independence Agency (MFIA). Where actions are a combination of those of Acquisition Services and the Michigan Department of Community Health (MDCH) and the Michigan Family Independence Agency (MFIA), the authority will be known as the State.

Acquisition Services is the sole point of contact in the State with regard to all procurement and contractual matters relating to the services described herein.

Acquisition Services is the only office authorized to change, modify, amend, alter, clarify, etc., the prices, specifications, terms, and conditions of this Request For Proposal and any Contract(s) awarded as a result of this Request. Acquisition Services will remain the SOLE POINT OF CONTACT throughout the procurement process, until such time as the Director of Acquisition Services shall direct otherwise in writing. See Paragraph II-C below. All communications concerning this procurement must be addressed to:

Douglas Collier

DMB, Acquisition Services

2nd Floor, Mason Building

P.O. Box 30026

Lansing, MI 48909

CollierD1@michigan.gov

(517) 335-4804

**I-D CONTRACT ADMINISTRATOR**

Upon receipt at Acquisition Services of the properly executed Contract Agreement, it is anticipated that the Director of Acquisition Services will direct that the person named below or any other person so designated be authorized to administer the Contract on a day-to-day basis during the term of the Contract. However, administration of any Contract resulting from this Request implies no authority to change, modify, clarify, amend, or otherwise alter the prices, terms, conditions, and specifications of such Contract. That authority is retained by Acquisition Services. The Contract Administrator for this project is:

John Gates, Director

Revenue and Reimbursement Division
Michigan Department of Community Health
3423 N. Martin Luther King, Jr., Boulevard, Room 308
Lansing, Michigan 48909

AND

Debra Lynn Walker, Contract Manager
Office of Child Support
Michigan Family Independence Agency
P.O. Box 30037
Lansing, Michigan 48909

I-E COST LIABILITY

The State of Michigan assumes no responsibility or liability for costs incurred by the Contractor prior to the signing of any Contract resulting from this Request. Total liability of the State is limited to the terms and conditions of any resulting Contract.

I-F CONTRACTOR RESPONSIBILITIES

The Contractor will be required to assume responsibility for all contractual activities offered in this proposal whether or not that Contractor performs them. Further, the State will consider the Prime Contractor to be the sole point of contact with regard to contractual matters, including but not limited to payment of any and all costs resulting from the anticipated Contract. If any part of the work is to be subcontracted, the contractor must notify the state and identify the subcontractor(s), including firm name and address, contact person, complete description of work to be subcontracted, and descriptive information concerning subcontractor's organizational abilities. The State reserves the right to approve subcontractors for this project and to require the Contractor to replace subcontractors found to be unacceptable. The Contractor is totally responsible for adherence by the subcontractor to all provisions of the Contract.

I-G NEWS RELEASES

News releases pertaining to this document or the services, study, data, or project to which it relates will not be made without prior written State approval, and then only in accordance with the explicit written instructions from the State. No results of the program are to be released without prior approval of the State and then only to persons designated.

**I-H DISCLOSURE**

All information in a bidder's proposal and this Contract are subject to the provisions of the Freedom of Information Act, 1976 Public Act No. 442, as amended, MCL 15.231, *et seq.*

I-I ACCOUNTING RECORDS

The Contractor will be required to maintain all pertinent financial and accounting records and evidence pertaining to the Contract in accordance with generally accepted principles of accounting and other procedures specified by the State of Michigan. Financial and accounting records shall be made available, upon request, to the State of Michigan, its designees, or the Michigan Auditor General at any time during the Contract period and any extension thereof, and for six (6) years from the expiration date and final payment on the Contract or extension thereof.

I-J INDEMNIFICATION**A. General Indemnification**

To the fullest extent permitted by law, the Contractor shall indemnify, defend and hold harmless the State, its departments, divisions, agencies, sections, commissions, officers, employees and agents, from and against all losses, liabilities, penalties, fines, damages and claims (including taxes), and all related costs and expenses (including reasonable attorneys' fees and disbursements and costs of investigation, litigation, settlement, judgments, interest and penalties), arising from or in connection with any of the following:

1. any claim, demand, action, citation or legal proceeding against the State, its employees and agents arising out of or resulting from (1) the product provided or (2) performance of the work, duties, responsibilities, actions or omissions of the Contractor or any of its subcontractors under this Contract.
2. any claim, demand, action, citation or legal proceeding against the State, its employees and agents arising out of or resulting from a breach by the Contractor of any representation or warranty made by the Contractor in the Contract;
3. any claim, demand, action, citation or legal proceeding against the State, its employees and agents arising out of or related to occurrences that the Contractor is required to insure against as provided for in this Contract;
4. any claim, demand, action, citation or legal proceeding against the State, its employees and agents arising out of or resulting from the death or bodily injury of any person, or the damage, loss or destruction of any real or tangible personal property, in connection with the performance of services by the Contractor, by any of its subcontractors, by anyone directly or indirectly employed by any of them, or by anyone for whose acts any of them may be liable; provided, however, that this indemnification obligation shall not apply to the extent, if any, that such death, bodily injury or property damage is caused solely by the negligence or reckless or intentional wrongful conduct of the State;



5. any claim, demand, action, citation or legal proceeding against the State, its employees and agents which results from an act or omission of the Contractor or any of its subcontractors in its or their capacity as an employer of a person.

B. Patent/Copyright Infringement Indemnification

To the fullest extent permitted by law, the Contractor shall indemnify, defend and hold harmless the State, its employees and agents from and against all losses, liabilities, damages (including taxes), and all related costs and expenses (including reasonable attorneys' fees and disbursements and costs of investigation, litigation, settlement, judgments, interest and penalties) incurred in connection with any action or proceeding threatened or brought against the State to the extent that such action or proceeding is based on a claim that any piece of equipment, software, commodity or service supplied by the Contractor or its subcontractors, or the operation of such equipment, software, commodity or service, or the use or reproduction of any documentation provided with such equipment, software, commodity or service infringes any United States or foreign patent, copyright, trade secret or other proprietary right of any person or entity, which right is enforceable under the laws of the United States. In addition, should the equipment, software, commodity, or service, or the operation thereof, become or in the Contractor's opinion be likely to become the subject of a claim of infringement, the Contractor shall at the Contractor's sole expense (i) procure for the State the right to continue using the equipment, software, commodity or service or, if such option is not reasonably available to the Contractor, (ii) replace or modify the same with equipment, software, commodity or service of equivalent function and performance so that it becomes non-infringing, or, if such option is not reasonably available to Contractor, (iii) accept its return by the State with appropriate credits to the State against the Contractor's charges and reimburse the State for any losses or costs incurred as a consequence of the State ceasing its use and returning it.

C. Indemnification Obligation Not Limited

In any and all claims against the State of Michigan, or any of its agents or employees, by any employee of the Contractor or any of its subcontractors, the indemnification obligation under the Contract shall not be limited in any way by the amount or type of damages, compensation or benefits payable by or for the Contractor or any of its subcontractors under worker's disability compensation acts, disability benefits acts, or other employee benefits acts. This indemnification clause is intended to be comprehensive. Any overlap in subclauses, or the fact that greater specificity is provided as to some categories of risk, is not intended to limit the scope of indemnification under any other subclause.

D. Continuation of Indemnification Obligation

The duty to indemnify will continue in full force and affect notwithstanding the expiration or early termination of the Contract with respect to any claims based on facts or conditions, which occurred prior to termination.



Except as set forth herein, neither the Contractor nor the State shall be liable to the other party for indirect or consequential damages, even if such party has been advised of the possibility of such damages, and either party's maximum aggregate liability shall be limited to the maximum amount of the executed Contract. Such limitation as to in direct or consequential damages, and as to a party's maximum liability shall not be applicable for claims arising out of gross negligence, willful misconduct, or the Contractor's indemnification responsibilities to the State as set forth in Section I-J with respect to third party claims, actions and proceeding brought against the State.

I-L NON INFRINGEMENT/COMPLIANCE WITH LAWS

The Contractor warrants that in performing the services called for by this Contract it will not violate any applicable law, rule, or regulation, any contracts with third parties, or any intellectual rights of any third party, including but not limited to, any United States patent, trademark, copyright, or trade secret.

I-M WARRANTIES AND REPRESENTATIONS

The Contract will contain customary representations and warranties by the Contractor, including, without limitation, the following:

1. The Contractor will perform all services in accordance with high professional standards in the industry;
2. The Contractor will use adequate numbers of qualified individuals with suitable training, education, experience and skill to perform the services;
3. The Contractor will use its best efforts to use efficiently any resources or services necessary to provide the services that are separately chargeable to the State;
4. The Contractor will use its best efforts to perform the services in the most cost effective manner consistent with the required level of quality and performance;
5. The Contractor will perform the services in a manner that does not infringe the proprietary rights of any third party;
6. The Contractor will perform the services in a manner that complies with all applicable laws and regulations;
7. The Contractor has duly authorized the execution, delivery and performance of the Contract;
8. The Contractor has not provided any gifts, payments or other inducements to any officer, employee or agent of the State;

I-N TIME IS OF THE ESSENCE

The Contractor agrees that time is of the essence in the performance of the Contractor's obligations under this Contract.

**I-O STAFFING OBLIGATIONS**

The State reserves the right to approve the Contractor's assignment of Key Personnel to this project and to recommend reassignment of personnel deemed unsatisfactory by the State.

The Contractor shall not remove or reassign, without the State's prior written approval any of the Key Personnel until such time as the Key Personnel have completed all of their planned and assigned responsibilities in connection with performance of the Contractor's obligations under this Contract. The Contractor agrees that the continuity of Key Personnel is critical and agrees to the continuity of Key Personnel. Removal of Key Personnel without the written consent of the State may be considered by the State to be a material breach of this Contract. The prohibition against removal or reassignment shall not apply where Key Personnel must be replaced for reasons beyond the reasonable control of the Contractor including but not limited to illness, disability, resignation or termination of the Key Personnel's employment.

The State and the Contractor agree that the personnel listed in contractor's proposal are Key Personnel for purposes of this Contract: See Attached

Project Management Team

William Lucia, FLMI, President (Key Personnel)

Project Position: Accountable Executive/Project Advisor

Mr. Lucia oversees all aspects of HMS's operations—including marketing, sales, and product development—required to support our TPL Program on behalf of MDCH/MFIA. Mr. Lucia also oversees development of new technologies that support our third party revenue recovery processes.

Mr. Lucia has more than 20 years of experience in healthcare reimbursement, information systems, and large-scale insurance administration. In addition, Mr. Lucia has nine years of experience managing revenue recovery projects for healthcare providers and payors. Mr. Lucia has been instrumental in expanding HMS's products, launching our federal revenue enhancement and strategic sourcing offerings. Mr. Lucia was responsible for HMS's west coast operations and provider business office outsourcing before joining the company's Payor Services Division (now known as Health Management Systems). Before joining HMS, he served in multiple positions in the life and health insurance and managed care industries, including Senior Vice President, Operations and Information Systems, at Celtic Insurance Company and Senior Vice President, Insurance Operations, at North American Company for Life and Health Insurance.



Donna Price, HIA, Senior Vice President of Client Relations (Key Personnel)

Project Position: Senior Contract Manager

As the former TPL Director for the State of South Carolina, Ms. Price understands the value of a strong partnership with a TPL vendor. Ms. Price will provide guidance and oversight to the Department's project management team. Immediately prior to her present position, Ms. Price was an HMS Senior Program Director, in which capacity she managed HMS healthcare coverage identification and verification and revenue recovery engagements in the States of Indiana, Louisiana, Missouri, Oklahoma, and New York.

Ms. Price has more than 17 years of project management experience, Medicaid program and revenue enhancement experience and knowledge, and familiarity with Medicaid and other agency operations. Before joining HMS, Ms. Price was Director of Third Party Liability for Anthem, Inc./Acordia Healthcare Solutions. Responsible for managing and directing all of Acordia's third party liability contract business, she gained experience with various healthcare identification and verification and revenue recovery systems and program operations projects. In addition, she has worked within state government, including previous service as Third Party Liability Director for South Carolina's Medicaid program.

**Fran Coury, Program Director (Key Personnel)****Project Position: Project Manager**

Fran Coury will act as the Project Manager for this entire engagement, with focus on the Medicaid Third Party Liability Recovery and Insurance Locate projects. Along with Linda Lemonds of MAXIMUS, Mr. Coury will be available by telephone on a daily basis and available to attend on-site status meetings as MDCH/MFIA requests.

Mr. Coury has over 13 years of experience with Medicaid TPL and currently serves as Co-Chair of the NCPDP Governmental Workgroup. (NCPDP is the ANSI-accredited standards development organization whose standards are used billions of times annually to enable electronic pharmacy transmissions.) Mr. Coury has served as Project Manager for TPL recovery projects for a variety of state Medicaid TPL clients including: Arizona, Kentucky, Ohio, Pennsylvania, and South Carolina. Mr. Coury has established electronic billing submission protocols with national Pharmacy Benefits Managers (PBMs) and has implemented electronic billing/eligibility platforms with Medicare, Blue Cross/Blue Shield and numerous Commercial plans nationwide.

Keith Reinold, Senior Program Director/Manager (Key Personnel)**Project Position: Senior Project Manager**

Mr. Reinold, who has over 5 years experience serving as the day-to-day Project Manager to MDCH, will serve as Senior Project Manager for this contract. In this capacity, he will have responsibility for all aspects of contract performance, data submission, reporting and management liaison, and general customer service. He will be available by telephone on a daily basis and available to attend on-site status meetings as MDCH/MFIA requests.

Mr. Reinold, who has been with HMS for eight years, has 18 years of project management experience. He presently serves as Project Manager for HMS's Medicaid revenue enhancement projects in Connecticut ([\\$2.0 million recoveries to date](#)) and Massachusetts ([\\$3.3 million recoveries to date](#)). Mr. Reinold has experience in virtually every aspect of revenue enhancement operations for Medicaid and state healthcare programs—including TPL identification and recovery, revenue maximization, and cost savings project management. Well-versed regarding medical support requirements at the national and state levels, Mr. Reinold presently serves as a project leader for designing and implementing HMS's medical support services. Before coming to HMS, Mr. Reinold developed his project analysis and task leadership skills at KPMG Peat Marwick.

Mr. Reinold's career is distinguished by Medical Support Enforcement Program experience gained through implementing and overseeing our:

- Absent Parent Identification initiative for the State of Connecticut, Department of Social Services
- Medical Support Enforcement Pilot Project for the State of Maryland, Department of Health and Mental Hygiene



Cynthia Jones, Program Director (Key Personnel)

Project Position: Implementation Manager

To ensure continuity under the new contract, Ms. Jones will bring her expertise to the state as Project Implementation Manager. Ms. Jones, who is HMS's current Project Manager for Michigan, joined HMS in October 2002. She has more than eight years of operational and consulting experience in the healthcare, managed care, and insurance fields—and has led and participated in all aspects of project implementation, development, and management activities within a wide array of healthcare environments and initiatives (both government and private sector). She has extensive knowledge of the Michigan TPL project, has a thorough understanding of managed care concepts and principles, and has worked closely with John Gates, MDCH's administrator for this contract. In addition to currently serving as Project Manager for HMS's revenue recovery engagement in Michigan ([\\$48.67 million recoveries to date](#)), Ms. Jones also manages our project in Iowa ([\\$100 million recoveries to date](#)).

Revenue Recovery Operations

Steven Vaccaro, Senior Vice President, Operations (Key Personnel)

Project Position: Project Operations Director

Mr. Vaccaro maintains oversight responsibility for all key development and operations teams including business development, carrier operations, contract development, project management, provider relations, and yield management. He develops new opportunities for HMS and our clients by developing and implementing dynamic ideas and ideologies for increasing client recoveries and results. Mr. Vaccaro also ensures quality and effectiveness of HMS's recovery and cost avoidance results as well as supports HMS Program Directors in service of HMS clients. Mr. Vaccaro also coordinates service expansion and development by identifying additional market opportunities that will benefit all types of healthcare providers nationwide.

With the HMS family for more than 13 years, Mr. Vaccaro has extensive experience in managing healthcare revenue recovery operations, including: overseeing timely coordination of complex billing cycles, coordinating development and implementation of project enhancements, managing staff and allocating resources, and developing operational strategies for clients. Mr. Vaccaro's effective management and technical skills have resulted in significant benefits for HMS clients: he doubled claim payment rates and increased client recoveries by 20% by identifying and using additional data files and applying improved data match techniques.

Carl Borgatti, PMP, Vice President of Contract Operations (Key Personnel)

Project Position: Technical Operations Director

Mr. Borgatti leads the implementation of technical process improvements to meet client objectives and contract requirements. He is the architect of a new suite of Web-based applications within HMS's e-Center, through which clients will have secure access to data associated with their HMS revenue recovery projects.

Mr. Borgatti has 11 years of operational and information technology (IT) experience with HMS. He is a certified Project Management Professional (PMP) through the Project Management Institute. The PMP designation is a broadly recognized and respected credential for professionals in the project management field.

**Chuck Anderson, Vice President, Commercial Insurance (Key Personnel)****Project Position: Commercial Insurance and Pharmacy Development**

Mr. Anderson leads the Third Party Liability Commercial Insurance services for HMS. In this capacity, he is responsible for marketing, operations, and product development for HMS' CI TPL effort. Prior to this, Mr. Anderson lead HMS' product development efforts where he assessed current core competencies, developed and validated product concepts, and guided product development within HMS.

Mr. Anderson has over 20 years experience in pharmacy information technology and operations. While Vice President of Operations at First Data Bank, Mr. Anderson led the development of several new pharmacy products, including rebate analysis, formulary design, and pricing. Mr. Anderson also held executive positions at Medical Economics Data (Redbook), He has also worked with three PBMs (National Prescription Administrators, National Medical Health Card Systems, and CVS' s PharmaCare. Mr. Anderson has also been an independent consultant working with XCare.net, MediSpan, and The Pharmacy Fund.

Renee Gundersen, Manager of EDI Development**Project Position: Project Operations Team Leader**

Ms. Gundersen's responsibilities for this engagement are to: (i) manage the data match and billing processing of source files to generate hits and subsequent billings, (ii) ensure that HMS produces high-quality billings and that carriers adjudicate these billings in a timely and accurate manner, (iii) schedule billing cycles, (iv) process client-requested enhancements, (v) implement process improvements, (vi) develop technical interfaces with carriers and PBMs, (vii) develop and implement recommendations to re-engineer processing for revenue recovery tasks, (viii) work closely with HMS's Project Manager to ensure that project objectives are met.

Ms. Gundersen is a skilled information technology professional (10 years of experience) with detailed knowledge of current requirements in healthcare information systems, electronic billing, and third party payor regulations. Ms. Gundersen also regularly attends ANSI X12 quarterly meetings, actively participating with X12N (insurance) Work Group 2 (healthcare).

Information Systems**Joseph Joy, Vice President and Chief Information Officer (Key Personnel)****Project Position: Information Technology Project Advisor**

As HMS's most senior information technology executive, Mr. Joy will provide guidance and oversight to the MDCH/MFIA project management team. He will apply his extensive experience in healthcare information systems and a senior level background in claims adjudication systems, healthcare data management, software design, business development and resource management. As Vice President and CIO, Mr. Joy manages multiple information systems and projects, including legacy mainframe applications, data warehouse/datamarts, document imaging and workflow, web-deployed applications, and other office automation systems. He also develops and executes strategic plans to optimize the use of information technology in support of business objectives, primarily those of HMS clients.



Mr. Joy has more than 18 years of experience in the healthcare information systems arena. He started at HMS in 1985 as a Programmer/Analyst in our Managed Care Systems Division (also known as HSA Managed Care Systems). Mr. Joy also served as Managing Director/Senior Project Management Consultant at The Prevision Group, LLC, a healthcare IT consulting organization he helped found. In addition to performing HIPAA-related consulting, he implemented the business model and grew the organization to over \$1M in revenue in its first year of operation.

Pat Mohrfield, Manager, Programming

Project Position: Programmer Team Lead

Ms. Mohrfield will develop specifications for HMS's processing of Medicaid and other health plan data files and will act as HMS's liaison with MMIS staff.

Ms. Mohrfield has seven years of experience as a data processing professional, including experience in design, development, implementation, testing, and support of various business applications and systems development. She has highly developed technical skills and experience with both the mainframe and PC environments. Ms. Mohrfield manages the programming team's work on HMS's revenue recovery agenda. She is responsible for managing programmer support for production jobs to ensure successful completion.

Operations Support

Joanne Pennecke, PMP, Director, Process Improvement (Key Personnel)

Project Position: Accounts Receivable/Deliverables Manager

Ms. Pennecke will: (i) oversee all accounts receivable functions for this project, including invoicing and providing posting and cost avoidance data for timely MMIS updates, and (ii) prepare recoupment tapes, gross adjustment forms, refund notices, and other reports/documents that relate to provider disallowances.

Ms. Pennecke has eight years of experience providing client deliverables for HMS's revenue recovery projects. In addition, Ms. Pennecke is a certified Project Management Professional (PMP) through the Project Management Institute. The PMP designation is a broadly recognized and respected credential for professionals in the project management field.

Noreen Miller, Manager, New York Service Center

Project Position: Operations Support

Ms. Miller oversees timely posting and reconciliation of remittances from third party payors. Her team: (i) processes remittances, reconciles remittance postings, and updates the A/R, and (ii) coordinates all keypunching of remittance denials to the A/R.

Ms. Miller has nine years of experience reviewing and reconciling lockbox receipts, posting payments to the A/R, reconciling discrepancies, and preparing invoices and back-up documentation.



Carrier Relations

Robert Dickerson, Director of Commercial Insurance (Key Personnel)

Project Position: Carrier Relations Director

For this engagement, Mr. Dickerson will: (i) establish and maintain relationships with carriers, pharmaceutical benefit managers (PBM), and third party administrators (TPA), (ii) create channels of communication with carriers through routine contact and periodic site visits to obtain eligibility data and to resolve claims adjudication issues promptly, (iii) perform research analysis for carrier adjudication issues related to TPL billings, (iv) represent HMS at National Council for Prescription Drug Programs (NCPDP) conferences.

Mr. Dickerson has more than eight years of experience: (i) analyzing unpaid claim populations and working with commercial carriers successfully to resolve low payment rates on billings, (ii) enhancing the quality of HMS billings, (iii) creating an automated rebilling mechanism for claims with high recovery potential in unpaid status, (iv) billing pharmacy claims.

Mr. Dickerson's efforts have generated over \$100 million in recoveries through a project targeting pharmacy claims billed to PBMs and have enabled HMS to bill approximately 65% of pharmacy claims in electronic format.

In addition, Mr. Dickerson actively participates in NCPDP—the ANSI-accredited standards development organization whose standards are used billions of times annually to enable electronic pharmacy transmissions. Beginning in 2000, Mr. Dickerson helped establish a standard billing layout for TPL claims—currently used with commercial insurers and PBMs. This new claim layout has produced high adjudication rates and optimal recovery results.

Brian Voelkel, Carrier Relations Manager

Project Position: Carrier Relations Support

Mr. Voelkel establishes and maintains relationships with carriers and managed care organizations (MCOs). He creates channels of communication with carriers through routine contact and periodic site visits to obtain eligibility data and for prompt resolution of claims adjudication issues.

Mr. Voelkel has 21 years of experience working with commercial carriers, including eight years of experience with third party recovery. His present position focuses on: (i) acting as HMS's CMS liaison for Medicare adjudicated claims data and the Enrollment Database (EDB), (ii) introducing new commercial carriers to Medicaid reclamation claim billings—more than 15 new carriers in the past two years, (iii) performing carrier market penetration analysis for each state to ensure that HMS recruits all potential sources of third party coverage for data matching, (iv) working with each carrier's information technology contact to exchange layouts and eligibility files in the most efficient manner possible, (v) reviewing all reformatted eligibility files to ensure that the counters are consistent with the companies' covered lives, and (vi) encouraging carriers to use EDI for exchanging data related to eligibility, claims, and remittances.



Project Design and Development

Michael Hostetler, Vice President, New Product Development (Key Personnel)

Project Position: Project Design and Development Director

Mr. Hostetler oversees HMS's product design and development efforts. He focuses on identifying and analyzing revenue enhancement opportunities and developing the systems and processes necessary to implement those opportunities.

Mr. Hostetler has developed HMS's retroactive, fee-for-service family planning projects for Medicaid agencies in Florida, Missouri, Virginia, and other states. These projects have recovered approximately \$15 million in additional federal funds for these states by calculating and claiming the appropriate federal matching rate (90%) for Medicaid-eligible family planning services. Several new and exciting initiatives are currently in the early stages of development.

Mr. Hostetler—who specializes in enhanced Medicare coordination of benefits projects—has more than 17 years of systems development experience, including more than 12 years devoted to revenue recovery processes and systems. Leading up to his present role, Mr. Hostetler performed in other capacities within HMS operations, including Director of TPL Operations and Director of Business Development. Before joining HMS, Mr. Hostetler was a Programmer for Drexel Burnham Lambert and Coopers & Lybrand (now PricewaterhouseCoopers).

David Riave, Director of Business Development

Project Position: Project Design and Development Lead

For this engagement, Mr. Riave will: (i) lead development of HMS's payment integrity/erroneous payment recovery product, (ii) work with the Project Manager and clients to identify specific project requirements, (iii) oversee programming, testing, and implementation following the design phase, (iv) implement system enhancements, as needed.

Mr. Riave is one of HMS's senior technical development staff members. He brings to this project 22 years of experience in the revenue recovery and healthcare information management industry. Mr. Riave has an extensive background developing applications for identifying and validating third party resources and aberrant billing patterns. He is thoroughly familiar with Medicaid MMIS Paid Claims, Recipient, and State Provider Master files for most jurisdictions. In addition, he is familiar with many other files that are critical to third party recovery efforts, including: TRICARE, Medicare BENDEX, and various state Department of Labor files. Mr. Riave also has in-depth familiarity with state Medicaid plans and their reimbursement requirements. He developed and implemented the Connecticut Medical Support Identification Project, which has—to date—identified several thousand non-custodial parents (NCPs) with access to health insurance.



Thomas A. Baggett, Jr., CPA, Vice President, Overpayment Recovery Services
Project Position: Vice President, Overpayment Recovery Services

Mr. Baggett has almost 20 years of experience as a professional services engagement manager specializing in healthcare payor operations. Immediately before joining HMS, he was the Chief Financial Officer of City Enterprises, LLC, where he excelled at reducing expenses while improving employee and client satisfaction. Mr. Baggett is a member of the American Institute of Certified Public Accountants: Information Technology Practice Division and Management Consulting Practice Division. Mr. Baggett will oversee identification of billing irregularities for this engagement.

Gracie Farias, Director, Dallas Service Center
Project Position: Director, Service Center Support

Ms. Farias oversees HMS's National Service Center in Dallas, Texas, which houses client service units for provider relations, third party coverage verification, claim follow-up/collections, and medical support. In this capacity, Ms. Farias manages the consolidation of client services from multiple locations into the Service Center, which is expected to increase recoveries for clients by more than \$1.4 million in its first full year of operation. Ms. Farias also supervises implementation of new advanced technology call-processing, document imaging, and workflow systems to increase yield and reduce recovery time for claims.

Ms. Farias over has eight years of healthcare-related administration experience. Her expertise includes managed care, PPO & Medicare + Choice, information systems development, provider and employer relations, research and product development, claims processing, appeal and grievance processing, strategic planning, and provider contracting and compliance. She has managed provider relations operations, including the creation and implementation of policies and procedures to ensure client satisfaction. Her years of experience in customer relations have established an unmatched insight into healthcare client concerns, particularly in the area of claims resolution. Ms. Farias earned an M.B.A. in Healthcare Administration from Our Lady of the Lake University in San Antonio.

Compliance and Quality Control

Helene Garrick, HIA, Director of Compliance and Quality Assurance (Key Staff)
Project Position: Compliance and Quality Manager

Ms. Garrick, who has 10 years of operational experience with HMS, monitors and ensures the company's regulatory and contract compliance. She develops and implements quality assurance controls within operations units to help ensure that business results comply with requirements and goals.

Ms. Garrick has strong expertise in Medicare and commercial insurance payment methodologies and benefits as well as with revenue recovery projects. Her data mining efforts have enabled HMS to recover millions of dollars for Medicaid clients.

I-P WORK PRODUCT AND OWNERSHIP

1. Work Products shall be considered works made by the Contractor for hire by the State and shall belong exclusively to the State and its designees, unless specifically provided otherwise by mutual agreement of the Contractor and the State.



If by operation of law any of the Work Product, including all related intellectual property rights, is not owned in its entirety by the State automatically upon creation thereof, the Contractor agrees to assign, and hereby assigns to the State and its designees the ownership of such Work Product, including all related intellectual property rights. The Contractor agrees to provide, at no additional charge, any assistance and to execute any action reasonably required for the State to perfect its intellectual property rights with respect to the aforementioned Work Product.

2. Notwithstanding any provision of this Contract to the contrary, any preexisting work or materials including, but not limited to, any routines, libraries, tools, methodologies, processes or technologies (collectively, the "Development Tools") created, adapted or used by the Contractor in its business generally, including any and all associated intellectual property rights, shall be and remain the sole property of the Contractor, and the State shall have no interest in or claim to such preexisting work, materials or Development Tools, except as necessary to exercise its rights in the Work Product. Such rights belonging to the State shall include, but not be limited to, the right to use, execute, reproduce, display, perform and distribute copies of and prepare derivative works based upon the Work Product, and the right to authorize others to do any of the foregoing, irrespective of the existence therein of preexisting work, materials and Development Tools, except as specifically limited herein.
3. The Contractor and its subcontractors shall be free to use and employ their general skills, knowledge and expertise, and to use, disclose, and employ any generalized ideas, concepts, knowledge, methods, techniques or skills gained or learned during the course of performing the services under this Contract, so long as the Contractor or its subcontractors acquire and apply such information without disclosure of any confidential or proprietary information of the State, and without any unauthorized use or disclosure of any Work Product resulting from this Contract.

I-Q CONFIDENTIALITY OF DATA AND INFORMATION

1. All financial, statistical, personnel, technical and other data and information relating to the State's operation which are designated confidential by the State and made available to the Contractor in order to carry out this Contract, or which become available to the Contractor in carrying out this Contract, shall be protected by the Contractor from unauthorized use and disclosure through the observance of the same or more effective procedural requirements as are applicable to the State. The identification of all such confidential data and information as well as the State's procedural requirements for protection of such data and information from unauthorized use and disclosure shall be provided by the State in writing to the Contractor. If the methods and procedures employed by the Contractor for the protection of the Contractor's data and information are deemed by the State to be adequate for the protection of the State's confidential information, such methods and procedures may be used, with the written consent of the State, to carry out the intent of this section.
2. The Contractor shall not be required under the provisions of this section to keep confidential, (1) information generally available to the public, (2) information released by the State generally, or to the Contractor without restriction, (3) information independently developed or acquired by the Contractor or its personnel without reliance in any way on otherwise protected information of the State.



Notwithstanding the foregoing restrictions, the Contractor and its personnel may use and disclose any information which it is otherwise required by law to disclose, but in each case only after the State has been so notified, and has had the opportunity, if possible, to obtain reasonable protection for such information in connection with such disclosure.

I-R REMEDIES FOR BREACH OF CONFIDENTIALITY

The Contractor acknowledges that a breach of its confidentiality obligations as set forth in section I-Q of this Contract shall be considered a material breach of the Contract. Furthermore the Contractor acknowledges that in the event of such a breach the State shall be irreparably harmed. Accordingly, if a court should find that the Contractor has breached or attempted to breach any such obligations, the Contractor will not oppose the entry of an appropriate order restraining it from any further breaches or attempted or threatened breaches. This remedy shall be in addition to and not in limitation of any other remedy or damages provided by law.

I-S CONTRACTOR'S LIABILITY INSURANCE

The Contractor is required to provide proof of the minimum levels of insurance coverage as indicated below. The purpose of this coverage shall be to protect the State from claims which may arise out of or result from the Contractor's performance of services under the terms of this Contract, whether such services are performed by the Contractor, or by any subcontractor, or by anyone directly or indirectly employed by any of them, or by anyone for whose acts they may be liable.

The Contractor waives all rights against the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees and agents for recovery of damages to the extent these damages are covered by the insurance policies the Contractor is required to maintain pursuant to this Contract. The Contractor also agrees to provide evidence that all applicable insurance policies contain a waiver of subrogation by the insurance company.

All insurance coverages provided relative to this Contract/Purchase Order is PRIMARY and NON-CONTRIBUTING to any comparable liability insurance (including self-insurances) carried by the State.

The Insurance shall be written for not less than any minimum coverage herein specified or required by law, whichever is greater. All deductible amounts for any of the required policies are subject to approval by the State.

The State reserves the right to reject insurance written by an insurer the State deems unacceptable.

BEFORE THE CONTRACT IS SIGNED BY BOTH PARTIES OR BEFORE THE PURCHASE ORDER IS ISSUED BY THE STATE, THE CONTRACTOR MUST FURNISH TO THE DIRECTOR OF Acquisition Services, CERTIFICATE(S) OF INSURANCE VERIFYING INSURANCE COVERAGE. THE CERTIFICATE MUST BE ON THE STANDARD "ACCORD" FORM. THE CONTRACT OR PURCHASE ORDER NO. MUST BE SHOWN ON THE CERTIFICATE OF INSURANCE TO ASSURE CORRECT FILING. All such Certificate(s) are to be prepared and submitted by the Insurance Provider and not by the Contractor.

All such Certificate(s) shall contain a provision indicating that coverages afforded under the policies WILL NOT BE CANCELLED, MATERIALLY CHANGED, OR NOT RENEWED



without THIRTY (30) days prior written notice, except for 10 days for non-payment of premium, having been given to the Director of Acquisition Services, Department of Management and Budget. Such NOTICE must include the CONTRACT NUMBER affected and be mailed to: Director, Acquisition Services, Department of Management and Budget, P.O. Box 30026, Lansing, Michigan 48909.

The Contractor is required to provide the type and amount of insurance checked (☑) below:

- ☑ 1. Commercial General Liability with the following minimum coverages:
 - \$2,000,000 General Aggregate Limit other than Products/Completed Operations
 - \$2,000,000 Products/Completed Operations Aggregate Limit
 - \$1,000,000 Personal & Advertising Injury Limit
 - \$1,000,000 Each Occurrence Limit
 - \$500,000 Fire Damage Limit (any one fire)

The Contractor must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees and agents as ADDITIONAL INSUREDS on the Commercial General Liability policy.

- ☑ 2. If a motor vehicle is used to provide services or products under this Contract, the Contractor must have vehicle liability insurance on any auto including owned, hired and non-owned vehicles used in Contractor's business for bodily injury and property damage as required by law.

The Contractor must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees and agents as ADDITIONAL INSUREDS on the vehicle liability policy.

- ☑ 3. Worker's disability compensation, disability benefit or other similar employee benefit act with minimum statutory limits. NOTE: (1) If coverage is provided by a State fund or if Contractor has qualified as a self-insurer, separate certification must be furnished that coverage is in the state fund or that Contractor has approval to be a self-insurer; (2) Any citing of a policy of insurance must include a listing of the States where that policy's coverage is applicable; and (3) Any policy of insurance must contain a provision or endorsement providing that the insurers' rights of subrogation are waived. This provision shall not be applicable where prohibited or limited by the laws of the jurisdiction in which the work is to be performed.

- ☐ 4. For contracts providing temporary staff personnel to the State, the Contractor shall provide an Alternate Employer Endorsement with minimum coverage of \$1,000,000.

- ☑ 5. Employers liability insurance with the following minimum limits:
 - \$100,000 each accident
 - \$100,000 each employee by disease
 - \$500,000 aggregate disease

- ☑ 6. Professional Liability Insurance (Errors and Omissions coverage) with the following minimum coverage:
 - ☑ \$1,000,000 each occurrence and \$3,000,000 annual aggregate



- \$3,000,000 each occurrence and \$5,000,000 annual aggregate
- \$5,000,000 each occurrence and \$10,000,000 annual aggregate

- 7. Medical Professional Liability, minimum coverage:
 - \$100,000 each occurrence and \$300,000 annual aggregate
 - \$200,000 each occurrence and \$600,000 annual aggregate
 - \$1,000,000 each occurrence and \$5,000,000 annual aggregate

I-T NOTICE AND RIGHT TO CURE

In the event of a curable breach by the Contractor, the State shall provide the Contractor written notice of the breach and a time period to cure said breach described in the notice. This section requiring notice and an opportunity to cure shall not be applicable in the event of successive or repeated breaches of the same nature or if the State determines in its sole discretion that the breach poses a serious and imminent threat to the health or safety of any person or the imminent loss, damage or destruction of any real or tangible personal property.

I-U CANCELLATION

The State may cancel this Contract without further liability or penalty to the State, its departments, divisions, agencies, offices, commissions, officers, agents and employees for any of the following reasons:

1. Material Breach by the Contractor. In the event that the Contractor breaches any of its material duties or obligations under the Contract, which are either not capable of or subject to being cured, or are not cured within the time period specified in the written notice of breach provided by the State, or pose a serious and imminent threat to the health and safety of any person, or the imminent loss, damage or destruction of any real or tangible personal property, the State may, having provided written notice of cancellation to the Contractor, cancel this Contract in whole or in part, for cause, as of the date specified in the notice of cancellation.

In the event that this Contract is cancelled for cause, in addition to any legal remedies otherwise available to the State by law or equity, the Contractor shall be responsible for all costs incurred by the State in canceling the Contract, including but not limited to, State administrative costs, attorneys fees and court costs, and any additional costs the State may incur to procure the services required by this Contract from other sources. All excess procurement costs and damages shall not be considered by the parties to be consequential, indirect or incidental, and shall not be excluded by any other terms otherwise included in the Contract.

In the event the State chooses to partially cancel this Contract for cause charges payable under this Contract will be equitably adjusted to reflect those services that are cancelled.

In the event this Contract is cancelled for cause pursuant to this section, and it is therefore determined, for any reason, that the Contractor was not in breach of contract pursuant to the provisions of this section, that cancellation for cause shall be deemed to have been a cancellation for convenience, effective as of the same date,



and the rights and obligations of the parties shall be limited to that otherwise provided in the Contract for a cancellation for convenience.

2. Cancellation For Convenience By the State. The State may cancel this Contract for it convenience, in whole or part, if the State determines that such a cancellation is in the State's best interest. Reasons for such cancellation shall be left to the sole discretion of the State and may include, but not limited to (a) the State no longer needs the services or products specified in the Contract, (b) relocation of office, program changes, changes in laws, rules, or regulations make implementation of the Contract services no longer practical or feasible, and (c) unacceptable prices for additional services requested by the State. The State may cancel the Contract for its convenience, in whole or in part, by giving the Contractor written notice 30 days prior to the date of cancellation. If the State chooses to cancel this Contract in part, the charges payable under this Contract shall be equitably adjusted to reflect those services that are cancelled.
3. Non-Appropriation. In the event that funds to enable the State to effect continued payment under this Contract are not appropriated or otherwise made available. The Contractor acknowledges that, if this Contract extends for several fiscal years, continuation of this Contract is subject to appropriation or availability of funds for this project. If funds are not appropriated or otherwise made available, the State shall have the right to cancel this Contract at the end of the last period for which funds have been appropriated or otherwise made available by giving written notice of cancellation to the Contractor. The State shall give the Contractor written notice of such non-appropriation or unavailability within 30 days after it receives notice of such non-appropriation or unavailability.
4. Criminal Conviction. In the event the Contractor, an officer of the Contractor, or an owner of a 25% or greater share of the Contractor, is convicted of a criminal offense incident to the application for or performance of a State, public or private Contract or subcontract; or convicted of a criminal offense including but not limited to any of the following: embezzlement, theft, forgery, bribery, falsification or destruction of records, receiving stolen property, attempting to influence a public employee to breach the ethical conduct standards for State of Michigan employees; convicted under State or federal antitrust statutes; or convicted of any other criminal offense which in the sole discretion of the State, reflects upon the Contractor's business integrity.
5. Approvals Rescinded. The State may terminate this Contract without further liability or penalty in the event any final administrative or judicial decision or adjudication disapproves a previously approved request for purchase of personal services pursuant to Constitution 1963, Article 11, section 5, and Civil Service Rule 7. Termination may be in whole or in part and may be immediate as of the date of the written notice to Contractor or may be effective as of the date stated in such written notice.

I-V RIGHTS AND OBLIGATIONS UPON CANCELLATION

1. If the Contract is canceled by the State for any reason, the Contractor shall, (a) stop all work as specified in the notice of cancellation, (b) take any action that may be necessary, or that the State may direct, for preservation and protection of Work Product or other property derived or resulting from the Contract that may be in the



- Contractor's possession, (c) return all materials and property provided directly or indirectly to the Contractor by any entity, agent or employee of the State, (d) transfer title and deliver to the State, unless otherwise directed by the Contract Administrator or his or her designee, all Work Product resulting from the Contract, and (e) take any action to mitigate and limit any potential damages, or requests for Contractor adjustment or cancellation settlement costs, to the maximum practical extent, including, but not limited to, canceling or limiting as otherwise applicable, those subcontracts, and outstanding orders for material and supplies resulting from the canceled Contract.
2. In the event the State cancels this Contract prior to its expiration for its own convenience, the State shall pay the Contractor for all charges due for services provided prior to the date of cancellation and if applicable as a separate item of payment pursuant to the Contract, for partially completed Work Product, on a percentage of completion basis. In the event of a cancellation for cause, or any other reason under the Contract, the State will pay, if applicable, as a separate item of payment pursuant to the Contract, for all partially completed Work Products, to the extent that the State requires the Contractor to submit to the State any such deliverables, and for all charges due under the Contract for any cancelled services provided by the Contractor prior to the cancellation date. All completed or partially completed Work Product prepared by the Contractor pursuant to this Contract shall, at the option of the State, become the State's property, and the Contractor shall be entitled to receive just and fair compensation for such Work Product. Regardless of the basis for the cancellation, the State shall not be obligated to pay, or otherwise compensate, the Contractor for any lost expected future profits, costs or expenses incurred with respect to Services not actually performed for the State.
 3. If any such cancellation by the State is for cause, the State shall have the right to set-off against any amounts due the Contractor, the amount of any damages for which the Contractor is liable to the State under this Contract or pursuant to law and equity.
 4. Upon a good faith cancellation, the State shall have the right to assume, at its option, any and all subcontracts and agreements for services and materials provided under this Contract, and may further pursue completion of the Work Product under this Contract by replacement contract or otherwise as the State may in its sole judgment deem expedient.

I-W EXCUSABLE FAILURE

1. Neither party shall be liable for any default or delay in the performance of its obligations under the Contract if and to the extent such default or delay is caused, directly or indirectly, by: fire, flood, earthquake, elements of nature or acts of God; riots, civil disorders, rebellions or revolutions in any country; the failure of the other party to perform its material responsibilities under the Contract (either itself or through another contractor); injunctions (provided the injunction was not issued as a result of any fault or negligence of the party seeking to have its default or delay excused); or any other cause beyond the reasonable control of such party; provided the non-performing party and its subcontractors are without fault in causing such default or delay, and such default or delay could not have been prevented by reasonable precautions and cannot reasonably be circumvented by the non-performing party through the use of alternate sources, workaround plans or other means, including disaster recovery plans. In such event, the non-performing party will be excused from any further performance or observance of the obligation(s) so



- affected for as long as such circumstances prevail and such party continues to use its best efforts to recommence performance or observance whenever and to whatever extent possible without delay provided such party promptly notifies the other party in writing of the inception of the excusable failure occurrence, and also of its abatement or cessation.
2. If any of the above enumerated circumstances substantially prevent, hinder, or delay performance of the services necessary for the performance of the State's functions for more than 14 consecutive days, and the State determines that performance is not likely to be resumed within a period of time that is satisfactory to the State in its reasonable discretion, then at the State's option: (a) the State may procure the affected services from an alternate source, and the State shall not be liable for payments for the unperformed services under the Contract for so long as the delay in performance shall continue; (b) the State may cancel any portions of the Contract so affected and the charges payable thereunder shall be equitably adjusted to reflect those services canceled; or (c) the Contract will be canceled without liability of the State to the Contractor as of the date specified by the State in a written notice of cancellation to the Contractor. The Contractor will not have the right to any additional payments from the State as a result of any excusable failure occurrence or to payments for services not rendered as a result of the excusable failure condition. Defaults or delays in performance by the Contractor which are caused by acts or omissions of its subcontractors will not relieve the Contractor of its obligations under the Contract except to the extent that a subcontractor is itself subject to any excusable failure condition described above and the Contractor cannot reasonably circumvent the effect of the subcontractor's default or delay in performance through the use of alternate sources, workaround plans or other means.

I-X ASSIGNMENT

The Contractor shall not have the right to assign this Contract or to assign or delegate any of its duties or obligations under this Contract to any other party (whether by operation of law or otherwise), without the prior written consent of the State. Any purported assignment in violation of this section shall be null and void. Further, the Contractor may not assign the right to receive money due under the Contract without the prior written consent of the Director of Acquisition Services.

I-Y DELEGATION

The Contractor shall not delegate any duties or obligations under this Contract to a subcontractor other than a subcontractor named in the bid unless the Director of Acquisition Services has given written consent to the delegation.

I-Z NON-DISCRIMINATION CLAUSE

In the performance of any Contract or purchase order resulting herefrom, the bidder agrees not to discriminate against any employee or applicant for employment, with respect to their hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical or mental disability unrelated to the individual's ability to perform the duties of the particular job or position. The bidder further agrees that every subcontract entered into for the performance of any



Contract or purchase order resulting herefrom will contain a provision requiring non-discrimination in employment, as herein specified, binding upon each subcontractor. This covenant is required pursuant to the Elliot Larsen Civil Rights Act, 1976 Public Act 453, as amended, MCL 37.2101, *et seq*, and the Persons with Disabilities Civil Rights Act, 1976 Public Act 220, as amended, MCL 37.1101, *et seq*, and any breach thereof may be regarded as a material breach of the Contract or purchase order.

I-AA WORKPLACE SAFETY AND DISCRIMINATORY HARASSMENT

In performing services for the State pursuant to this Contract, the Contractor shall comply with Department of Civil Service Rules 2-20 regarding Workplace Safety and 1-8.3 regarding Discriminatory Harassment. In addition, the Contractor shall comply with Civil Service Regulations governing workplace safety and discriminatory harassment and any applicable state agency rules on these matters that the agency provides to the Contractor. Department of Civil Service Rules and Regulations can be found on the Department of Civil Service website at www.michigan.gov/mdcs.

I-BB MODIFICATION OF SERVICE

The Director of Acquisition Services reserves the right to modify this service during the course of this Contract. Such modification may include adding or deleting tasks that this service shall encompass and/or any other modifications deemed necessary.

Any Contract resulting from this RFP may not be revised, modified, amended, extended, or augmented, except by a writing executed by the parties hereto, and any breach or default by a party shall not be waived or released other than in writing signed by the other party.

The State reserves the right to request from time to time, any changes to the requirements and specifications of the Contract and the work to be performed by the Contractor under the Contract. The Contractor shall provide a change order process and all requisite forms. The State reserves the right to negotiate the process during contract negotiation. At a minimum, the State would like the Contractor to provide a detailed outline of all work to be done, including tasks necessary to accomplish the deliverables, timeframes, listing of key personnel assigned, estimated hours for each individual per task, and a complete and detailed cost justification.

1. Within five (5) business days of receipt of a request by the State for any such change, or such other period of time as to which the parties may agree mutually in writing, the Contractor shall submit to the State a proposal describing any changes in products, services, timing of delivery, assignment of personnel, and the like, and any associated price adjustment.

The price adjustment shall be based on a good faith determination and calculation by the Contractor of the additional cost to the Contractor in implementing the change request less any savings realized by the Contractor as a result of implementing the change request. The Contractor's proposal shall describe in reasonable detail the basis for the Contractor's proposed price adjustment, including the estimated number of hours by task by labor category required to implement the change request.

2. If the State accepts the Contractor's proposal, it will issue a change notice and the Contractor will implement the change request described therein. The Contractor will not implement any change request until a change notice has been issued validly.



The Contractor shall not be entitled to any compensation for implementing any change request or change notice except as provided explicitly in an approved change notice.

- 3. If the State does not accept the Contractor's proposal, the State may:
 - a. withdraw its change request; or
 - b. modify its change request, in which case the procedures set forth above will apply to the modified change request.

If the State requests or directs the Contractor to perform any activities that are outside the scope of the Contractor's responsibilities under the Contract ("New Work"), the Contractor must notify the State promptly, and before commencing performance of the requested activities, that it believes the requested activities are New Work. If the Contractor fails to so notify the State prior to commencing performance of the requested activities, any such activities performed before notice is given by the Contractor shall be conclusively considered to be In-scope Services, not New Work. If the State requests or directs the Contractor to perform any services or functions that are consistent with and similar to the services being provided by the Contractor under the Contract, but which the Contractor reasonably and in good faith believes are not included within the scope of the Contractor's responsibilities and charges as set forth in the Contract, then prior to performing such services or function, the Contractor shall promptly notify the State in writing that it considers the services or function to be an "Additional Service" for which the Contractor should receive additional compensation. If the Contractor does not so notify the State, the Contractor shall have no right to claim thereafter that it is entitled to additional compensation for performing such services or functions. If the Contractor does so notify the State, then such a service or function shall be governed by the change request procedure set forth in the preceding paragraph.

IN THE EVENT PRICES ARE NOT ACCEPTABLE TO THE STATE, THE CONTRACT SHALL BE SUBJECT TO COMPETITIVE BIDDING BASED UPON THE NEW SPECIFICATIONS.

I-CC NOTICES

Any notice given to a party under this Contract must be written and shall be deemed effective, if addressed to such party as addressed below upon (i) delivery, if hand delivered; (ii) receipt of a confirmed transmission by facsimile if a copy of the notice is sent by another means specified in this section; (iii) the third (3rd) Business Day after being sent by U.S. mail, postage pre-paid, return receipt requested; or (iv) the next Business Day after being sent by a nationally recognized overnight express courier with a reliable tracking system.

For the Contractor: Health Management Systems, Inc
ATTN: William Lucia
401 Park Avenue South - 10th floor
New York, NY 10016

For the State: Douglas Collier, P.O. Box 30684, Lansing, MI 48909

Either party may change its address where notices are to be sent giving written notice in accordance with this section.

I-DD ENTIRE AGREEMENT



The contents of this document and the vendor's proposal will become contractual obligations, if a Contract ensues. Failure of the successful bidder to accept these obligations may result in cancellation of the award.

The Contract resulting from this RFP shall represent the entire agreement between the parties and supersedes all proposals or other prior agreements, oral or written, and all other communications between the parties relating to this subject.

I-EE NO WAIVER OF DEFAULT

The failure of a party to insist upon strict adherence to any term of a Contract resulting from this RFP shall not be considered a waiver or deprive the party of the right thereafter to insist upon strict adherence to that term, or any other term, of the Contract.

I-FF SEVERABILITY

Each provision of the Contract shall be deemed to be severable from all other provisions of the Contract and, if one or more of the provisions of the Contract shall be declared invalid, the remaining provisions of the Contract shall remain in full force and effect.

I-GG HEADINGS

Captions and headings used in the Contract are for information and organization purposes. Captions and headings, including inaccurate references, do not, in any way, define or limit the requirements or terms and conditions of this Contract.

I-HH RELATIONSHIP OF THE PARTIES

The relationship between the State and the Contractor is that of client and independent Contractor. No agent, employee, or servant of the Contractor or any of its subcontractors shall be or shall be deemed to be an employee, agent, or servant of the State for any reason. The Contractor will be solely and entirely responsible for its acts and the acts of its agents, employees, servants and subcontractors during the performance of this Contract.

I-II UNFAIR LABOR PRACTICES

Pursuant to 1980 Public Act 278, as amended, MCL 423.231, et seq, the State shall not award a Contract or subcontract to an employer whose name appears in the current register of employers failing to correct an unfair labor practice compiled pursuant to section 2 of the Act. This information is compiled by the United States National Labor Relations Board.

A Contractor of the State, in relation to the Contract, shall not enter into a Contract with a subcontractor, manufacturer, or supplier whose name appears in this register. Pursuant to section 4 of 1980 Public Act 278, MCL 423.324, the State may void any Contract if, subsequent to award of the Contract, the name of the Contractor as an employer, or the



name of the subcontractor, manufacturer or supplier of the Contractor appears in the register.

I-JJ SURVIVOR

Any provisions of the Contract that impose continuing obligations on the parties including, but not limited to the Contractor's indemnity and other obligations shall survive the expiration or cancellation of this Contract for any reason.

I-KK GOVERNING LAW

This Contract shall in all respects be governed by, and construed in accordance with, the laws of the State of Michigan. Any dispute arising herein shall be resolved in the State of Michigan.

I-LL YEAR 2000 SOFTWARE COMPLIANCE

The Contractor warrants that services provided under this Contract including but not limited to the production of all Work Products, shall be provided in an accurate and timely manner without interruption, failure or error due the inaccuracy of Contractor's business operations in processing date/time data (including, but not limited to, calculating, comparing, and sequencing) from, into, and between the twentieth and twenty-first centuries, and the years 1999 and 2000, including leap year calculations. The Contractor shall be responsible for damages resulting from any delays, errors or untimely performance resulting therefrom.

I-MM CONTRACT DISTRIBUTION

Acquisition Services shall retain the sole right of Contract distribution to all State agencies and local units of government unless other arrangements are authorized by Acquisition Services.

I-NN STATEWIDE CONTRACTS

If the contract is for the use of more than one agency and if the goods or services provided under the contract do not meet the form, function and utility required by an agency, that agency may, subject to state purchasing policies, procure the goods or services from another source.

I-OO ADHERANCE TO PM METHODOLOGY STANDARD

The State has adopted a standard, documented Project Management Methodology (PMM) for use on all Information Technology (IT) based projects. This policy is referenced in the document titled "Project Management Methodology" – DMB Administrative Guide Procedure 1380.02 issued June 2000. Vendors may obtain a copy of this procedure by contacting the DMB Office of Information Technology Solutions. The State of Michigan Project Management Methodology can be obtained from the DMB Office of Project Management's website at <http://www.state.mi.us/cio/opm>.

The contractor shall use the State's PMM to manage State of Michigan Information Technology (IT) based projects. The requesting agency will provide the applicable



documentation and internal agency processes for the methodology. If the vendor requires training on the methodology, those costs shall be the responsibility of the vendor, unless otherwise stated.

I-PP ELECTRONIC FUNDS TRANSFER

Electronic transfer of funds is available to State contractors. Vendors are encouraged to register with the State of Michigan Office of Financial Management so the State can make payments related to this Contract electronically at www.cpexpress.state.mi.us.

I-QQ TRANSITION ASSISTANCE

If this Contract is not renewed at the end of this term, or is canceled prior to its expiration, for any reason, the Contractor must provide for up to 90 days after the expiration or cancellation of this Contract, all reasonable transition assistance requested by the State, to allow for the expired or canceled portion of the Services to continue without interruption or adverse effect, and to facilitate the orderly transfer of such services to the State or its designees. Such transition assistance will be deemed by the parties to be governed by the terms and conditions of this Contract, (notwithstanding this expiration or cancellation) except for those Contract terms or conditions that do not reasonably apply to such transition assistance. The State shall pay the Contractor for any resources utilized in performing such transition assistance at the most current rates provided by the Contract for Contract performance. If the State cancels this Contract for cause, then the State will be entitled to off set the cost of paying the Contractor for the additional resources the Contractor utilized in providing transition assistance with any damages the State may have otherwise accrued as a result of said cancellation.

I-RR DISCLOSURE OF LITIGATION

1. The Contractor shall notify the State in its bid proposal, if it, or any of its subcontractors, or their officers, directors, or key personnel under this Contract, have ever been convicted of a felony, or any crime involving moral turpitude, including, but not limited to fraud, misappropriation or deception. Contractor shall promptly notify the State of any criminal litigation, investigations or proceeding which may have arisen or may arise involving the Contractor or any of the Contractor's subcontractor, or any of the foregoing entities' then current officers or directors during the term of this Contract and three years thereafter.
2. The Contractor shall notify the State in its bid proposal, and promptly thereafter as otherwise applicable, of any civil litigation, arbitration, proceeding, or judgments that may have arisen against it or its subcontractors during the five years preceding its bid proposal, or which may occur during the term of this Contract or three years thereafter, which involve (1) products or services similar to those provided to the State under this Contract and which either involve a claim in excess of \$250,000 or which otherwise may affect the viability or financial stability of the Contractor, or (2) a claim or written allegation of fraud by the Contractor or any subcontractor hereunder, arising out of their business activities, or (3) a claim or written allegation that the Contractor or any subcontractor hereunder violated any federal, state or local statute, regulation or ordinance. Multiple lawsuits and or judgments against the Contractor or subcontractor, in any an amount less than \$250,000 shall be disclosed to the State to the extent they affect the financial solvency and integrity of the Contractor or subcontractor.



3. All notices under subsection 1 and 2 herein shall be provided in writing to the State within fifteen business days after the Contractor learns about any such criminal or civil investigations and within fifteen days after the commencement of any proceeding, litigation, or arbitration, as otherwise applicable. Details of settlements which are prevented from disclosure by the terms of the settlement shall be annotated as such. Semi-annually, during the term of the Contract, and thereafter for three years, Contractor shall certify that it is in compliance with this Section. Contractor may rely on similar good faith certifications of its subcontractors, which certifications shall be available for inspection at the option of the State.
4. Assurances - In the event that such investigation, litigation, arbitration or other proceedings disclosed to the State pursuant to this Section, or of which the State otherwise becomes aware, during the term of this Contract, causes the State to be reasonably concerned about:
 - a) the ability of the Contractor or its subcontractor to continue to perform this Contract in accordance with its terms and conditions, or
 - b) whether the Contractor or its subcontractor in performing services is engaged in conduct which is similar in nature to conduct alleged in such investigation, litigation, arbitration or other proceedings, which conduct would constitute a breach of this Contract or violation of Michigan or Federal law, regulation or public policy, then

The Contractor shall be required to provide the State all reasonable assurances requested by the State to demonstrate that: (a) the Contractor or its subcontractors hereunder will be able to continue to perform this Contract in accordance with its terms and conditions, (b) the Contractor or its subcontractors will not engage in conduct in performing services under this Contract which is similar in nature to the conduct alleged in any such litigation, arbitration or other proceedings.

5. The Contractor's failure to fully and timely comply with the terms of this section, including providing reasonable assurances satisfactory to the State, may constitute a material breach of this Contract.

I-SS STOP WORK

1. The State may, at any time, by written stop work order to the Contractor, require that the Contractor stop all, or any part, of the work called for by this Contract for a period of up to 90 days after the stop work order is delivered to the Contractor, and for any further period to which the parties may agree. The stop work order shall be specifically identified as such and shall indicate that it is issued under this section. Upon receipt of the stop work order, the Contractor shall immediately comply with its terms and take all reasonable steps to minimize the incurrence of costs allocable to the work covered by the stop work order during the period of work stoppage. Within the period of the stop work order, the State shall either:
 - a) Cancel the stop work order; or
 - b) Cancel the work covered by the stop work order as provided in the cancellation section of this Contract.



2. If a stop work order issued under this section is canceled or the period of the stop work order or any extension thereof expires, the Contractor shall resume work. The State shall make an equitable adjustment in the delivery schedule, the contract price, or both, and the Contract shall be modified, in writing, accordingly, if:
 - a) The stop work order results in an increase in the time required for, or in the Contractor's costs properly allocable to the performance of any part of this Contract; and
 - b) The Contractor asserts its right to an equitable adjustment within 30 days after the end of the period of work stoppage; provided, that if the State decides the facts justify the action, the State may receive and act upon a proposal submitted at any time before final payment under this Contract.
3. If the stop work order is not canceled and the work covered by the stop work order is canceled for reasons other than material breach, the State shall allow reasonable costs resulting from the stop work order in arriving at the cancellation settlement.
4. If a stop work order is not canceled and the work covered by the stop work order is canceled for material breach, the State shall not allow, by equitable adjustment or otherwise, reasonable costs resulting from the stop work order.
5. An appropriate equitable adjustment may be made in any related contract of the Contractor that provides for adjustment and is affected by any stop work order under this section. The State shall not be liable to the Contractor for loss of profits because of a stop work order issued under this section.

I-TT LIQUIDATED DAMAGES

- A. The State and the Contractor hereby agree to the specific standards set forth in this Contract. It is agreed between the Contractor and the State that the actual damages to the State as a result of Contractor's failure to provide promised services would be difficult or impossible to determine with accuracy. The State and the Contractor therefore agree that liquidated damages as set out herein shall be a reasonable approximation of the damages that shall be suffered by the State as a result thereof. Accordingly, in the event of such damages, at the written direction of the State, the Contractor shall pay the State the indicated amount as liquidated damages, and not as a penalty.

Amounts due the State as liquidated damages, if not paid by the Contractor within fifteen (15) days of notification of assessment, may be deducted by the State from any money payable to the Contractor pursuant to this Contract. The State will notify the Contractor in writing of any claim for liquidated damages pursuant to this paragraph on or before the date the State deducts such sums from money payable to the Contractor. No delay by the State in assessing or collecting liquidated damages shall be construed as a waiver of such rights.

- B. The Contractor shall not be liable for liquidated damages when, in the opinion of the State, incidents or delays result directly from causes beyond the control and without the fault or negligence of the Contractor. Such causes may include, but are not restricted to, acts of God, fires, floods, epidemics, and labor unrest; but in every case the delays must be beyond the control and without the fault or negligence of the Contractor.



C. Liquidated damages will be assessed as follows:

1. Monthly eligibility reporting and/or enrollment that is not accurate or timely.
2. Backlogged National Medical Support Notice (NMSN) not processed timely or accurately.

LIQUIDATED DAMAGES

1. 10% reduction in unit price or 1% in monthly contingency fee whichever is applicable for every month out of compliance.
2. 10% reduction in unit price for every month out of compliance.

I-UU RECOVERY EFFORTS

The MDCH is interested in identifying the recovery potential for the State of Michigan Medicaid Program and contracting with a contractor to identify specific recovery or cost avoidance areas and/or perform the actual recovery from the health insurance carrier or other liable party. The contractor will be encouraged to perform feasibility studies to identify potential areas of enhanced revenues or reduced expenditures for the State Medicaid Program. The State of Michigan may issue an additional RFP to encompass the revenue or cost saving sources identified as a result of the feasibility studies.



SECTION II WORK STATEMENT

II-A BACKGROUND/PROBLEM STATEMENT

This is a joint initiative with two distinct projects administered by two state agencies. Project #1 Medicaid Third Party Liability Recovery is managed by the Michigan Department of Community Health. Project #2 **Optional** Locate Commercial Health Insurance and Medicaid Support Enforcement is managed by Michigan Family Independence Agency.

PROJECT #1 Medicaid Third Party Liability Recovery

The Michigan Department of Community Health (MDCH) administers the Medical Assistance (Medicaid) and Children's Special Health Care Services (CSHCS) programs for the State of Michigan. In Fiscal Year 2002-2003, expenditures for medical services provided to Medicaid and CSHCS program beneficiaries in the State of Michigan totaled approximately \$7.15 billion. In Fiscal Year 2002-2003, there were approximately 1.3 million Medicaid eligible beneficiaries in Michigan. Of these, approximately 850,000 were enrolled in Medicaid Health Plans (Medicaid managed care plans). The remaining beneficiaries were in the fee-for-service program. Of the total Medicaid eligible population, on average, approximately 200,000 beneficiaries have other third party resources (excluding Medicare) available to pay for medical services. For Fiscal Year 2002-2003, approximately \$18.9 million in Medicaid Program expenditures were recovered as a result of the MDCH Medicaid third party liability recovery efforts. In addition, excluding Medicare, approximately \$181.1 million in Medicaid cost avoidance was achieved.

Within the MDCH, the Medical Services Administration, Bureau of Financial Management, Revenue and Reimbursement Division, has responsibility for performing the Medicaid Program Third Party Liability function. That function involves the responsibility for identifying and maximizing reimbursement from the Medicare Program, insurance carriers and other third party resources for expenditures made on behalf of Medicaid beneficiaries. The MDCH is seeking to supplement its Medicaid Program cost avoidance and recovery efforts by entering into a contract with a contractor that is able to assist it in identify additional coverage sources and recover payments made by the Medicaid and CSHCS Programs from the liable third parties. In contracting for assistance in performing its Medicaid Third Party Liability function, the MDCH is seeking proposals from possible contractors indicating the contractor's capability to perform services that are considered to be "core services" for the third party recovery function and services that the DCH considers "optional", but having potential for generating additional revenues for the Medicaid Program. Depending on the proposals received from possible contractors related to the "optional" services and available funding, the MDCH will decide on pursuing these opportunities.



PROJECT #2 Optional Locate Commercial Health Insurance and Medical Support Enforcement

The Michigan Family Independence Agency Office of Child Support (OCS) and the Friends of the Courts within the County Circuit Courts (FOCs) administer the IV-D Medical Support Enforcement Program in the State of Michigan. The IV-D Medical Support Enforcement Program enforces child support court order requirements that where medical insurance is available at a reasonable cost to the payer the dependents of the child support payer must be enrolled on the insurance. There are approximately 500,000 cases that will generate a National Medical Support Notice (NMSN) each year.

The OCS is seeking to supplement the current process used to enforce the medical support requirements of the court orders by entering into a contract with a contractor that is able to identify/locate insurance coverage and medical support enforcement: insurance, enrollment, insurance maintenance, processing existing backlog of National Medical Support Notice (NMSN).

II-B OBJECTIVES

PROJECT #1 Medicaid Third Party Liability Recovery

CORE SERVICES

ELIGIBILITY MATCHING

General:

The contractor will perform a “look-behind” of the MDCH Third Party Liability (TPL) coverage file. The “look-behind” will be performed by matching the Medicaid Management Information System (MMIS) Eligibility file with the beneficiary files of commercial health insurance carriers doing business in the State of Michigan and identifying coverage unknown to the MDCH. The eligibility file match will include those individuals who were Medicaid-eligible within the previous eighteen (18) month period. The eligibility match will include the Tricare/CHAMPUS program. The contractor will not perform the eligibility match with Blue Cross Blue Shield of Michigan. The MDCH has a process for matching eligibility files directly with Blue Cross Blue Shield of Michigan. It is expected that contractors responding to this request for proposals will demonstrate their ability to perform eligibility matches with the top twenty commercial health insurance carriers in the State of Michigan.

The eligibility matches with commercial health insurance carriers will be performed every two months to coincide with the MDCH’s scheduled Post Payment Billing (PPB) process. The match with Tricare/CHAMPUS will be performed on an annual basis according to the schedule established by the Department of Defense. The MDCH will run the contractor’s coverage update file resulting from the eligibility file matches against the Medicaid Paid Claims File (PCF) to identify medical expenses paid for clients having the newly identified coverages. A Medicaid paid claims file extract will then be sent to the contractor. For CHAMPUS identified coverage, the contractor’s coverage update file extract will also update the master TPL Coverage File for immediate cost avoidance of Medicaid claims.

Specific:

The MDCH will provide the contractor with the MMIS Eligibility File that identifies all Medicaid and CSHCS beneficiaries; and the TPL Coverage File that identifies all Medicaid and CSHCS beneficiaries that the MDCH has identified with insurance coverage. The MDCH will also provide the contractor with the TPL Carrier File that identifies all active insurance carriers that the State has interacted with; and the Provider Extract File that identifies all Medicaid providers and their addresses. The contractor will perform a match of the beneficiaries on the MMIS Eligibility File with the files of commercial health insurance carriers (including the Department of Defense Eligibility Enrollment Reporting System (DEERS) for CHAMPUS enrollees). As noted previously, the match process will exclude Blue Cross Blue Shield of Michigan. The contractor will then match the resulting file against the TPL Coverage File to produce the contractor's Newly Identified Coverage (NIC) File. The NIC file will contain only those beneficiaries and their coverages that are unknown to the MDCH. The contractor shall provide the MDCH with the NIC file in electronic format. The contractor shall also maintain complete files that sufficiently identify the NIC and their source. The contractor shall perform the match with commercial insurance carriers every two months in conjunction with the MDCH PPB process. The match to identify Tricare/CHAMPUS enrollees will be performed annually according to the schedule specified by the Department of Defense. The MDCH will run the NIC file against the Medicaid PCF. The MDCH will then run identified Claims against the Billed CRN File, which lists the Claim Reference Numbers (CRN) of those claims that have already been billed to a carrier. The resulting PCF extract will be sent to the contractor. For Tricare/CHAMPUS identified coverage, the contractor's Coverage Update File extract will also update the TPL Coverage File for immediate cost avoidance of Medicaid claims.

COMMERCIAL HEALTH INSURANCE RECOVERY

General:

The contractor will bill the newly identified insurance carriers and reconcile all payments and rejections. The contractor must produce a TPL coverage file update record listing beneficiaries having newly identified coverages for which the contractor has received payment from a carrier. The coverage file update record will be sent to the MDCH on a monthly basis and include health insurance carrier and coverage information specified by the MDCH. The MDCH will update the master TPL Coverage File used to cost avoid future Medicaid claims.

Under the current contract, the contractor is paid a contingency fee based on the actual amounts recovered. For the Fiscal Year 2002-2003, the current contractor recovered approximately \$4.9 million from commercial health insurance carriers and CHAMPUS.

Specific:

The contractor shall review the PCF extract to determine which claims will be billed to the insurance carriers. The contractor shall bill the insurance carriers. The contractor shall produce a Billed CRN File extract of the claims sent to the insurance carriers and send the file in electronic format to the MDCH within one month after billing the insurance carriers.

The contractor shall reconcile all carrier payments and claim rejections. Payments from carriers shall be made payable to the "State of Michigan" and deposited in a Lock-Box provided by the State of Michigan Department of Treasury.



If a State Lock-Box is not used, payments/deposits shall be forwarded to the MDCH Accounting Division on a weekly basis. The contractor shall reconcile all deposits with the MDCH Accounting Division. The contractor shall invoice the MDCH on a monthly basis for 100% of all deposits forwarded to the State of Michigan. If an insurance carrier subsequently identifies any claim errors, the contractor must research and reconcile the claims involved. The contractor shall request the MDCH to refund carrier payments processed in error and provide documentation supporting the refund. If the errors reduce recoveries deposited previously, the contractor shall reflect a corresponding reduction in its subsequent billing to the MDCH. If a reduction in billing is not possible, the contractor shall return, within 60 days of notification, the portion of the contract payment associated with the contested claims.

The contractor shall produce a Coverage Update File (CUF) listing those beneficiaries that have newly identified coverages (considered verified coverage) for which payment has been received from a carrier. The CUF shall be sent to the MDCH on a monthly basis and include carrier and coverage information. MDCH will use the CUF to update the master TPL Coverage File to cost avoid future Medicaid claims.

MEDICARE RECOVERY

General:

The contractor will perform follow-up Medicare Part A and Part B eligibility matches and provide the MDCH with a record of newly identified Medicare eligible individuals. The MDCH will match the record of newly identified eligible individuals against the Medicaid PCF. Medicare Part A services will be claim adjusted against providers' accounts payable. The contractor will submit claims for Medicare Part B services to the Medicare Part B intermediary and reconcile payments received. Under the current contract, the contractor is paid a contingency fee based on actual amounts recovered for the Medicare covered services. The contractor's bid should include a price proposal by:

Medicare Part A recoveries



Medicare Part B recoveries

The contractor's Medicare coverage period is the MDCH's previous fiscal year (i.e., the Fall, 2003 run for newly identified coverages includes Medicaid Program paid services provided between October 1, 2001 and September 30, 2002.). For FY 2002-2003, the current contractor identified new Medicare coverages totaling approximately \$187,000.

Specific

The MDCH will provide the contractor with information files that will enable the contractor to identify all Medicaid and CSHS beneficiaries and all Medicaid and CSHCS beneficiaries that the MDCH has identified with Medicare coverage. The files include the MMIS Eligibility File, BENDEX File, Medicare Buy-in File, and Medicare Eligibles File (MPR File).

The contractor shall use the files provided by the MDCH and any other Medicare related files available to the contractor. The contractor shall perform an eligibility match from the Medicare related data files to identify additional Medicare eligible beneficiaries and eligibility periods for both Medicare Part A and Part B. The contractor shall provide the MDCH with an electronic file of the newly identified Medicare eligible beneficiaries and their eligibility periods. The contractor shall maintain files that sufficiently identify the additional coverages and their source. The contractor shall perform the Medicare eligibility matches once each year to coincide with the MDCH's Fall Medicare run (currently scheduled in September).

The MDCH will run the contractor's file of newly identified Medicare eligible beneficiaries against the Medicaid PCF.

Medicare Part A Claims:

The MDCH will produce a report identifying all Medicaid paid claims for the newly identified Medicare eligible beneficiaries. The MDCH will send the report to providers, who will be given 45 days to identify errors on the report. MDCH staff will resolve errors identified by providers. The remaining valid Medicaid paid claims will be automatically claim adjusted against the providers accounts payable.

The contractor shall not invoice the MDCH for Medicare amounts recovered until 30 days has elapsed from the date the automated claim adjustment appeared on the provider's remittance advice. The contractor may then invoice the MDCH for 90% of the contract fee. The remaining 10% will be retained by the MDCH for twelve months for claim reconciliation purposes. If providers identify errors in excess of the 10% amount retained by the MDCH, the contractor shall return, within 60 days of notification, the portion of the contract payment associated with the contested claims. The contractor shall have an opportunity to review and refute the contested claims.

Medicare Part B Claims:

The MDCH will produce a file of Medicaid paid claims for the newly identified Medicare eligible beneficiaries. The file will be sent to the contractor. The contractor shall submit claims to the Medicare Part B intermediary for the newly identified Medicare eligible beneficiaries. The contractor shall also reconcile all payments and rejections received on these claims.



Payments from the Medicare Part B intermediary are to be made payable to the "State of Michigan" and deposited in a Lock-Box provided by the State of Michigan Department of Treasury. If a State Lock-Box is not used, payments/deposits shall be forwarded to the MDCH Accounting Division on a weekly basis. The contractor shall reconcile all deposits with the MDCH Accounting Division. The contractor shall invoice the MDCH on a monthly basis for 100% of all deposits forwarded to the State of Michigan. If the Medicare Part B intermediary identifies errors that reduce the recoveries deposited with the State of Michigan, the contractor shall reflect a corresponding reduction on its subsequent billing to the MDCH. If such a reduction in billing is not possible, the contractor shall return, within 60 days of notification, the portion of the contract payment associated with the contested claims.

PROJECT #1 –ADDITIONAL OPTIONAL SERVICES

HOSPITAL AND LONG TERM CARE PROVIDER AUDITS

General

The MDCH is requesting the contractors to perform, either directly or under a sub-contractor arrangement, on going, on-site audits of Medicaid participating hospital and long term care providers for the purpose of identifying and recovering potential Medicaid overpayments. Potential overpayments to be identified include those resulting from duplicate payments, coordination of benefit issues, and payments received by providers in excess of contractual arrangements with health insurance carriers. Currently the MDCH does not perform on-site audits for the purpose described above. Various reviews and audits performed in other states have identified significant amounts of Medicaid overpayments/credit balances at hospitals and long term care facilities.

The MDCH is requesting proposals from contractors interested in performing the audits. At a minimum, the contractor's proposal should include the following:

- a. The approach to performing the audits.
- b. The criteria for prioritizing the audits to be performed.
- c. The areas to be included in the audits.
- d. The estimated time for completing a provider audit.
- e. The specific tasks included in performing the audits.
- f. The estimated revenue to be recovered as a result of the audits.
- g. The products/reports to be delivered to MDCH upon completion of the audits.
- h. The qualifications/experience of staff performing the audits.
- i. The contractor's price proposal for performing the audits.



MEDICARE CLAIMS APPEALS AND ELIGIBILITY AUDITS

General

The MDCH is requesting proposals from interested contractors to perform on-going reviews/audits of cases where Medicaid beneficiaries that are potentially eligible for Medicare have been denied Medicare eligibility. In addition, the MDCH is requesting proposals from interested contractors to perform the service of appealing Medicare claims that are determined to have been inappropriately denied for Medicaid beneficiaries with dual (Medicare/Medicaid) eligibility. Due to errors by the Social Security Administration in determining Medicare eligibility for individuals, a number of Medicaid beneficiaries are inappropriately denied Medicare coverage for which they are entitled. In these cases, if Medicare eligibility can be obtained on a retroactive basis, the Medicaid program can recover payments made for beneficiaries from the Medicare Program. Also, Medicare claims for health services provided to dually eligible beneficiaries are inappropriately denied payment. Both of these situations increase costs to the Medicaid Program. With current staffing levels, the MDCH is unable to review Medicare eligibility determinations or appeal Medicare claims which may have been incorrectly denied for payment. The MDCH is evaluating the feasibility of contracting for these services.

The MDCH is requesting proposals from contractors to perform Medicare eligibility audits/reviews and Medicare claims appeals. At a minimum, the contractor's proposal should include the following:

- a. The approach to reviewing/auditing the Medicare eligibility denials and appealing Medicare claim denials.
 - b. The information and/or data necessary to perform the project, listed according to that required from the MDCH and from other sources.
 - c. The frequency for reviewing the eligibility determinations and for appealing claim denials.
 - d. The specific tasks involved in performing the reviews and appeals.
 - e. The estimated revenue to be recovered as a result of the projects.
 - f. The related products/reports to be delivered to the MDCH, and the schedule for providing the products/reports.
 - g. The qualifications/experience of staff to be assigned to the projects.
 - h. The contractor's price proposal for performing the audits.
-

**PROJECT #2 Locate Commercial Health Insurance and Medical Support Enforcement**

Commercial Health Insurance Locate

General:

The contractor will perform a match against a medical support enforcement file. The match will be performed by comparing an insurance inquiry file, provided by OCS, of cases where parents (potential or actual subscribers) are not providing the court-ordered health insurance for their dependent children with the beneficiary files of commercial health insurance carriers doing business in the State of Michigan and identifying coverage unknown to the FOC/OCS. The insurance inquiry file, provided by OCS, will be in a consistent format to the MMIS Eligibility file provided by DCH. It is expected that contractors responding to this request for proposals will demonstrate their ability to perform *electronic* eligibility matches with the top twenty commercial health insurance carriers in the State of Michigan.

The match will be performed on a monthly basis. The insurance inquiry file will be sent to the contractor for electronic insurance eligibility checks with health insurers. The contractor will respond with an insurance response file that details what insurance coverage was located, or not located, for each possible subscriber in the insurance inquiry file. The insurance response files that are returned by the contractor will be processed electronically through the current Michigan Child Support Enforcement System (MiCSES) interface.

Specific:

On a monthly basis the OCS will provide the contractor with the insurance inquiry file that identifies all cases where parents (subscribers) are not providing the court-ordered health insurance for their dependent children. The insurance inquiry file will contain a list of possible subscribers (parents) and possible members (dependents/beneficiaries).

There will be five record types in the insurance inquiry file, organized by likely insurance subscribers and members:

- 1 - Header: includes the inquiry date
- 2 - Sender: identifies Friend of the Court as the file sender
- 3 - Subscriber: identifies the intended insurance subscriber
- 4 - Member: identifies the intended member under subscriber.
- 11 – Trailer: identifies end of file.

Contractor will translate the insurance inquiry file into formats required by the various health insurers. Six specific benefits for the subscribers and members under each subscriber will be inquired on:

- General medical
- Major medical
- Pharmacy
- Dental care
- Vision
- Psychiatric



The contractor will perform a match of the subscribers and members on the OCS insurance inquiry file with the files of commercial health insurance carriers. The match will produce the contractor's insurance response file. The insurance response file will contain a listing of subscribers and any members that are covered. The insurance response file will also contain a listing of the type(s) of coverage. The contractor shall provide the insurance response file in electronic format.

Insurance Response File

There will be eight record types in the insurance response file, ordered by subscriber:

1 – Header

2 – Sender

3 –Subscriber: identifies subscriber's address as reported by the carrier, indicator if no insurance is found for subscriber

4 - Member

5 - Carrier: identifies the insurance carrier, carrier FEIN, address, contact information, group number

6 - Employer: identifies the employer or other source of the insurance, including FEIN and address

7 - Benefit: identifies policy number (or subscriber's SSN), effective date, expiration date, insurance type (commercial, Medicaid, Medicare, other state program), and benefit type (of the six requested benefits). The benefit record is repeated once for each benefit on the policy. The benefit record(s) are also repeated under each member the benefit(s) apply to.

11 – Trailer.

This service may be purchased alone or in conjunction with the Insurance Enrollment and or the Insurance Maintenance services.

Insurance Enrollment

General:

OCS will select child support cases where parents (subscribers) are not providing the court-ordered health insurance for their specifically identified dependent children (members/beneficiaries) and sufficient information, that indicates the parents may have insurance available to them, exists to initiate enforcement enrollment activities. Enrollment is initiated by generating and mailing the National Medical Support Notice (NMSN) to the employers of the parents (subscribers) that have been selected as identified above. The NMSN will be generated by MiCSES. OCS will create an electronic file of the NMSN that have been generated and mailed. On a daily basis, an insurance enrollment request file, containing the NMSNs generated and mailed by MiCSES, will be sent to the contractor.

The contractor will receive the NMSNs from the employers on a continuous basis and process the hardcopy and/or electronic communications with employers and benefit administrators and electronically report the results to OCS. The contractor will work with the employers and benefit administrators as needed to either affect health insurance enrollment for the dependents (members/beneficiaries) or identify why enrollment cannot be affected. The contractor will generate a daily electronic insurance enrollment response file and send the file to OCS. The insurance enrollment response file will contain insurance enrollment information created from processing the NMSN and working with the employers. The insurance enrollment response file will contain:



- insurance enrollment information
- explanation of why dependents (members/beneficiaries) cannot be enrolled,
- status updates per defined timeframes on insurance enrollment requests to employers that have not been resolved.

The contractor will also monitor the aging of NMSN requests per federal, state, and contractual requirements.

Specific:

OCS will select child support cases where parents (subscribers) are not providing the court-ordered health insurance for their specifically identified dependent children (members/beneficiaries) and sufficient information, that indicates the parents may have insurance available to them, exists to initiate enforcement enrollment activities.

Enforcement enrollment activities are initiated by generating and mailing the National Medical Support Notice (NMSN) to the employers of the parents (subscribers) that have been selected as identified above. The NMSN will be generated by MiCSES. The NMSN will be generated continuously. OCS will create an electronic file of the NMSN that have been generated and mailed. OCS will create an electronic file of the NMSN that have been generated and mailed. The on a daily basis, an insurance enrollment request file, containing the NMSNs generated and mailed by MiCSES, will be sent to the contractor.

The insurance enrollment request file will contain the following records (Note: The insurance enrollment service is not currently implemented. The files to be exchanged and record types are provided for illustrative purposes only as a means of meeting the needs of the service):

Insurance Enrollment Request File

There are eight record types planned for the insurance enrollment request file, ordered by case:

1 – Header

2 – Sender

8 – Case: identifies circuit court, county number, docket number, and insurance benefit(s) ordered

6 – Employer: identifies employer NMSN will be (was) sent to

3 – Subscriber / employee: identifies the employee being enforced on and their address

9 – Custodial parent: identifies name and address of custodial parent to be included on the NMSN. Address may be flagged as confidential which indicates that the address to be printed on the NMSN will be Vendor's address. When Vendor receives the insurance packet from the benefits administrator, Vendor will forward the information to the custodial parent.

4 – Member / dependent: identifies dependent to be enrolled on insurance, SSN, and DOB

11 – Trailer.

The NMSNs will list the contractor as the return address for the completed NMSN forms and whom to call with questions. The employers and benefit administrators will complete the NMSN and return them to the contractor. Contractor will provide the following services:

- Process the information returned on the NMSNs from the employers and benefits administrators. Contractors will work with the employers as needed to affect health insurance enrollment for the dependents/members or identify why enrollment cannot be affected.
- Coordinate with OCS and large employers to implement an electronic NMSN to replace the printing, mailing, and handling of paper NMSNs.

Monitor the aging of NMSN requests per federal, state, and contractual requirements.



The contractor will create an insurance enrollment response file based upon the results of processing of the NMSNs, including the interactions with the employers and benefit administrators. The contractor will generate a daily insurance enrollment response file and send the file to OCS. This response file will include insurance enrollment information, explanation of why dependents cannot be enrolled, and status updates per defined timeframes on unresolved enrollment requests.

The insurance enrollment response file will contain the following records Note: The insurance enrollment service is not currently implemented. The files to be exchanged and record types are provided for illustrative purposes only as a means of meeting the needs of the service:

Insurance Enrollment Response File

There are ten record types planned for the insurance enrollment response file, ordered by case:

- 1 – Header
- 2 – Sender
- 8 – Case
- 3 – Subscriber
- 5 - Carrier
- 6 – Employer
- 4 – Member / dependent
- 7 – Benefit
- 10 – Enrollment status
- 11 – Trailer.

Process Backlogged NMSNsGeneral:

OCS will transfer the existing backlog of hardcopy NMSNs that have accumulated in FOC offices to the contractor. The contractor will process each as a normal insurance enrollment task as described the Insurance Enrollment service. The contractor will implement application software to allow the contractor's staff to enter information from hardcopy NMSNs and create an file similar/same as the insurance enrollment response file described under the Insurance Enrollment service. The contractor will send the file to OCS. The file specifications to submit NMSN data from the contractor to OCS is to be determined but will likely be similar/same as the insurance enrollment response file.

Insurance Enrollment Response File

There are ten record types planned for the insurance enrollment response file, ordered by case:

- 1 – Header
- 2 – Sender
- 8 – Case
- 3 – Subscriber
- 5 - Carrier
- 6 – Employer
- 4 – Member / dependent
- 7 – Benefit
- 10 – Enrollment status
- 11 – Trailer.

Specific



The existing backlog approximately is 30,000 to 40,000 unprocessed NMSM.

II-C TASKS

PROJECT #1 Medicaid Third Party Liability Recovery

The following are the major tasks involved for developing the end product the “core services” included in this project. The Contractor is not constrained from supplementing this listing with additional steps, sub tasks or elements deemed necessary to permit maximum recovery possible.

ELIGIBILITY MATCHING

1. The MDCH shall:
 - a. Provide the contractor with the following files at the frequency indicated:
 - MMIS Eligibility File – quarterly
 - TPL Coverage File – quarterly
 - TPL Carrier File – monthly
 - Provider Extract File – monthly
 - b. Where needed, provide a letter of authorization requesting insurance carrier cooperation with the contractor.
 - c. Run the NIC File against the PCF.
 - d. Run the file produced in “1.c.” above against the Billed CRN File to produce the PCF Extract. Also, run the file produced in “1.c.” to update the TPL Coverage File for CHAMPUS identified coverages only.
 - e. Send the PCF Extract to the contractor.
 - f. Update the TPL Coverage File with the CUF for cost avoidance purposes.
 - g. Reimburse the contractor within 30 days of receipt of an approved invoice.
2. The contractor shall:
 - a. Provide the MDCH with a list of health insurance carriers it has agreements with to allow beneficiary file matches. (As noted previously, the MDCH expects that potential contractors responding to this project will demonstrate their ability to perform beneficiary file matches with the top twenty health insurance carriers in Michigan). The contractor shall update the list as new agreements are finalized.
 - b. Provide the MDCH, within two weeks of the contract award date, with a list of those health insurance carriers that it does not have agreements



with, but with which it has been negotiating for an agreement to allow beneficiary file matches.

- c. Perform a match, quarterly for insurance carriers and annually for CHAMPUS, of beneficiaries on the MMIS Eligibility File against the carriers' eligibility files.
- d. Produce, in electronic format, a NIC File by matching the file produced in "1.d." above with the TPL Coverage File.

COMMERCIAL HEALTH INSURANCE RECOVERY

- 1 The MDCH shall:
 - a. Reimburse the contractor within 30 days of receipt of an approved invoice.
- 2 The contractor shall:
 - a. Determine the claims from the PCF Extract that are to billed to the health insurance carriers.
 - b. Submit the claims identified in Eligibility Matching "1.f." above to the health insurance carriers.
 - c. Produce and send a Billed CRN File extract to the MDCH within one month of billing the carrier.
 - d. Reconcile carrier claim payments and rejections.
 - e. Establish a Lock-Box process for payments from carriers that is agreeable to the MDCH.
 - f. Ensure that all checks from carriers are made payable to the "State of Michigan" and that all deposits are forwarded to the State's account within one week of deposit.
 - g. Reconcile all deposits with the MDCH Accounting Division.
 - h. Produce and send a CUF to the MDCH monthly.
 - i. Invoice the MDCH for recoveries received from carriers monthly.

MEDICARE RECOVERY



1. The MDCH shall:
 - a. Maintain current Data Use Agreements with the Center for Medicare and Medicaid Services to provide access to Medicare Program eligibility and adjudicated claims files. The agreements will designate the contractor as the “custodian” of data accessed on behalf of the MDCH.
 - b. Provide the following files to the contractor approximately one month before MDCH runs the Medicaid PCF match:
 - MMIS Eligibility File
 - BENDEX File
 - Medicare Buy-In File
 - MPR
 - c. Run the contractor’s MPR Extract File (2.a., below) against the Medicaid PCF to produce the report of paid claims for the newly identified Medicare eligible individuals (MW861 Report) for Medicare Part A services.
 - d. Mail the MW861 Report to providers, giving them 45 days to identify errors.
 - e. Send the Medicaid PCF Extract File to the contractor for Medicare Part B services.
 - f. Resolve errors on the MW861 Report that have been identified by providers.
 - g. Forward the provider contested claims to the contractor.
 - h. Run the Automated Claim Adjustment Program for Part A claims before the second Medicaid payroll in December (the Purge Payroll).
 - i. Update the master MPR file.
 - j. Reimburse the contractor within 30 days of receipt of an approved invoice.

2. The contractor shall:
 - a. Perform an eligibility match from Medicare related data files to identify additional Medicare eligible beneficiaries and eligibility periods for Medicare Part A and Part B services.
 - b. Produce an MPR Extract File of newly identified Medicare eligible beneficiaries and eligibility periods. The file shall be produced within three weeks of receiving the MDCH files identified in 1.b., above. The MDCH contract administrator shall approve the match criteria.
 - c. Submit claims for Medicare Part B services to the Medicare Part B intermediary within 30 days of receiving the PCF Extract File from the MDCH.



- d. Establish a Lock-Box process for Medicare Part B payments that is agreeable to the MDCH.
 - e. Review and reconcile Medicare Part B claims contested by the Medicare Part B intermediary.
 - f. Invoice the MDCH for Medicare recoveries:
 1. 30 days after the Automated Claim Adjustments are processed by the MDCH for Part A services.
 2. Monthly for Part B services.
-

PROJECT #2 Locate Commercial Health Insurance and Medical Support Enforcement

Following are the tasks involved for developing the end product for the Insurance Locate services included in this project. The contractor is not constrained from supplementing this list with additional steps, sub-tasks or elements deemed necessary to permit the maximum results.

The OCS shall:

1. Provide the contractor a monthly insurance inquiry file.
2. Reimburse the contractor within 30 days after receipt of an approved invoice.

The Contractor Shall:

- a. Provide the OCS with a list of health insurance carriers it has agreements with to allow beneficiary file matches. The OCS expects that potential contractors responding to this project will demonstrate their ability to perform beneficiary file matches with the top twenty health insurance carriers in Michigan. The contractor shall update the list as new agreements are finalized.
- b. Provide the OCS, within two weeks of the contract award date, with a list of those health insurance carriers that it does not have agreements with, but with which it has been negotiating for an agreement to allow beneficiary file matches.
- c. Perform a monthly match against insurance carrier files.
- d. Produce in electronic format an insurance response file by matching the information in the insurance inquiry file to the insurance carriers' files and send the file to OCS for processing into the MiCSES system.

Insurance Enrollment

Following are the tasks involved for developing the end product for the Insurance Enrollment services included in this project. The contractor is not constrained from supplementing this list with additional steps, sub-tasks or elements deemed necessary to permit the maximum results.



The OCS shall:

1. Generate and mail the NMSN to employers.
2. Provide the contractor a daily insurance enrollment request file .
3. Reimburse the contractor within 30 days after receipt of an approved invoice.

Tasks:

1. Process the information returned on the NMSNs from the employers and benefits administrators.
2. Work with the employers as needed to affect health insurance enrollment for the dependents (members) or identify why enrollment cannot be affected.
3. Coordinate with OCS and large employers to implement an electronic NMSN to replace the printing, mailing, and handling of paper NMSNs.
4. The contractor will create a daily insurance enrollment response file based upon the results of processing of the NMSNs and send the file to OCS.
5. Monitor the aging of NMSN requests per federal, state, and contractual requirements.

Process Backlogged NMSNs

Following are the tasks involved for developing the end product for the Processing of Backlogged NMSM service included in this project. The contractor is not constrained from supplementing this list with additional steps, sub-tasks or elements deemed necessary to permit the maximum results.

The OCS shall:

1. Identify and transfer to the contractor the backlogged NMSM forms that need to be processed.
2. Reimburse the contractor within 30 days after receipt of an approved invoice.

The Contractor shall:

1. Process each NMSM as an insurance enrollment as described under Insurance Enrollment.
2. Create a file similar/same as the insurance enrollment response file described under Insurance Enrollment and send it to OCS on a weekly basis until the project is completed.

II-D PROJECT CONTROL AND REPORTS

- #2
1. Project Control - Project #1 Medicaid Third Party Liability Recovery and Project Locate Commercial Health Insurance and Medical Support Enforcement



- a. The contractor will carry out the project under the direction and control of the MDCH and MFIA. The MDCH will manage Project #1 and the MFIA will manage Project #2.
- b. To assure continuous liaison with MDCH and MFIA staff, the contractor shall establish and maintain an office in Lansing, Michigan. Expenses related to the maintenance of that office shall be the responsibility of the contractor. The contractor will have to assign one full-time project manager to manage both Project #1 and #2.
- c. In addition to continuous liaison with the contractor's project team, the MDCH and MFIA contract managers will meet quarterly, as a minimum, with the contractor's project manager. The meetings will be for the purpose of reviewing progress and providing guidance and direction to the contractor in resolving problems and issues that arise.
- d. The contractor will provide the MDCH and MFIA contract managers with written monthly project reports. The reports will summarize progress accomplished during the reporting period, work efforts to be accomplished during the subsequent reporting period, and issues or problems that should be brought to the attention of the MDCH and MFIA contract managers. The reports will also provide notification to the MDCH and MFIA contract managers of any significant deviation from previously agreed-upon work plans.
- e. Within five (5) working days of the award of the contract, the contractor shall submit a work plan to the MDCH and MFIA contract managers for final approval. The final work plan must be in agreement with Section IV-C, subsection 2, as proposed by the contractor and accepted by the State of Michigan for contract. The final work plan shall include the following:
 - (1) The contractor's project organizational structure.
 - (2) The contractor's staffing table with the names and titles of personnel assigned to the project. The staffing table must be in agreement with the staffing presented in the contractor's accepted project proposal. Necessary substitutions due to changes in employment status and other unforeseen circumstances may only be made with prior approval of the State of Michigan.
 - (3) The project breakdown showing sub-projects, activities and tasks, and the resources required and allocated to each.
 - (4) The time-phased plan in the form of a graphic display showing each event, task and decision point in the work plan.



2. Reports

PROJECT #1 Medicaid Third Party Liability Recovery

In performing the core services defined under the contract, the contractor shall provide, at a minimum, quarterly reports to the MDCH contract manager that include the following information in the following format:

- a. The following information shall be reported by health insurance carrier and billing cycle (date):
 - (1) Total claims and dollars billed.
 - (2) Total claims and dollars paid (also cumulative amounts).
 - (3) Unduplicated number of beneficiaries paid for (also cumulative amounts).
 - (4) Total claims and dollars denied (by the top five reasons for denial).
 - (5) Total claims and dollars pending.

- b. The following information shall be reported by major claim type and billing cycle (date):
 - (1) Total claims and dollars billed.
 - (2) Total claims and dollars paid (also cumulative amounts).
 - (3) Total claims and dollars denied (by the top five reasons for denial).
 - (4) Total claims and dollars pending.

PROJECT #2 Locate Commercial Health Insurance and Medical Support Enforcement

In performing the core services defined under the contract, the contractor shall provide, at a minimum, quarterly reports to the OCS contract manager that include the following information in the following format:

- a. The following monthly breakdown shall be reported quarterly for the Insurance Locate Service.
 - (1) Summary of the insurance inquiry file records received from OCS.
 - (2) The number of those records that were attempted to be matched at each insurer, sorted by insurer.
 - (3) The number of records returned matched and unmatched.
 - (3) A reconciliation of the insurance inquiry file records to those records included in the insurance response file.

- b. The following monthly breakdown information shall be reported quarterly for the Insurance Enrollment Service.



- (1) Summary of the insurance enrollment request file records received from OCS identified by date.
 - (2) Summary of the balance of unprocessed NMSM at the beginning of the month , the number of NMSM received from employers and benefit administrators in the current month and the balance unprocessed at the end of the month..
 - (3) Summary of the insurance enrollment response records sent to the OCS including whether insurance was enrolled or not.
 - (4) A reconciliation of the insurance enrollment request file records to those records included in the insurance enrollment response file.
- c. The following information shall be reported monthly for the Process Backlogged NMSM Service.
- (1) Summary of the NMSM received from OCS, identified by source and date.
 - (2) Summary of the number of NMSM not yet processed at the beginning of the month,(identified by date,received from OCS) , NMSM processed during the month,(identified by date received from OCS), and those not yet processed (identified by date received).



II-E PRICE PROPOSAL

All prices/rates quoted in bidder's response to this RFP will be firm for the duration of the Contract. No price changes will be permitted.

PRICING CHART

Project #1: Medicaid Third Party Liability Recovery		
<u>Required Core Services</u>	<u>Required Pricing Model</u>	<u>HMS Pricing</u>
1. Eligibility Matching – New Identifications	Unit price	\$14.00
2. Eligibility Matching – Changes and Terminations	Unit price	\$9.00
3. Commercial Health Insurance Recovery	Contingency fee	5.5%
4. Medicare A Identification	Contingency fee	3.4%
5. Medicare B Recovery	Contingency fee	5.0%
<u>Optional Services</u>	<u>Pricing Model</u>	<u>HMS Pricing</u>
1. On-Site Hospital Audits	Contingency fee	8.00%
2. On-Site Long-Term Care Audits	Contingency fee	10.0%
3. Medicare Claims Appeals	Contingency fee	13.0%
4. Medicare Eligibility Audits	Contingency fee	9.0%
Project #2: Locate Commercial Health Insurance and Medical Support Enforcement		
<u>Required Services</u>	<u>Required Pricing Model</u>	<u>HMS Pricing</u>
1. Locate Commercial Health Insurance	Unit price	\$14.00
2. Insurance Enrollment	Unit Price	\$9.00
3. Process Backlogged National MS Notices	Unit Price	\$13.00
4. Input Enrollment Data into MiCSES	Per Case	\$0.75

**II-F CONTRACT PAYMENT**

All invoices should reflect actual work done. Specific details of invoices and payments will be agreed upon between the Contract Administrator and the Contractor after the proposed Contract Agreement has been signed and accepted by both the Contractor and the Director of Acquisition Services, Department of Management & Budget. This activity will occur only upon the specific written direction from Acquisition Services.

HMS has offer quick payment terms as follows: 2% discount off the HMS monthly invoice total due, if our invoice is paid in full within 10 days of **receipt** by the state. A purchase discount notation of "2/10, n/30" will appear on each invoice indicating, "2% discount if paid within 10 days, net amount due within 30 days."



SECTION III

CONTRACTOR INFORMATION

III-A **BUSINESS ORGANIZATION****PRIMARY CONTRACTOR:**

Health Management Systems, Inc
ATTN: William Lucia
401 Park Avenue South - 10th floor
New York, NY 10016

SUB-CONTRACTOR:

MAXIMUS, Inc.
11419 Sunset Hills Road
Reston, VA 20190

Contact Person***Primary Contact Person:***

David Hogan
MAXIMUS Child Support Division President
11419 Sunset Hills Road
Reston, VA 20190
Telephone: 703.251.8500
Facsimile: 703.251.8240
E-mail: davidhogan@maximus.com

Secondary Contact Person

Jeff Ball
MAXIMUS Child Support Division Vice President
311 Caprice Court
Loveland, OH 45140
Telephone: 513.697.6519
Facsimile: 513.697.0015
E-mail: jeffreyball@maximus.com

- MAXIMUS will work with HMS to perform insurance enrollment and NMSN backlog processing under the child medical support enforcement project. MAXIMUS professionals have been conducting successful child support projects for more than 27 years. More than 800 Child Support Division staff work on outsourcing aspects of the IV-D program from full-service operations to call centers, from medical support to review and adjustment, plus consulting, systems staffing, and receipt processing. MAXIMUS previously performed MiCSES certification work and user training in Michigan.

**CDR Associates, LLC**

9690 Deereco Road, Suite 300
Timonium, MD 21093

Contact Person

Jeffrey D. Dawson
Principal
CDR Associates, LLC
9690 Deereco Road, Suite 300
Timonium, MD 21093
Telephone: 410.560.6700 ext. 1109
Facsimile: 410.561.7070
E-mail: jdawson@cdrassociates.com

- CDR Associates, LLC—the premier provider credit balance firm—will work with HMS to conduct the optional on-site audits of hospitals and nursing homes in the State of Michigan to identify and recover credit balances and other overpayments made by the Michigan Medicaid program.

Elder Law of Michigan, Inc. (ELM)

221 N. Pine Street
Lansing, MI 48933

Contact Person

Katherine B. White
Executive Director
Elder Law of Michigan, Inc.
221 N. Pine Street
Lansing, MI 48933
Telephone: 517.485.9164, ext. 236
Toll-free: 1.800.347.5297
Facsimile: 517.372.0792
E-mail: kwhite@elderslaw.org

- Elder Law of Michigan (ELM) will assist HMS in performing the optional Medicare claims appeals and eligibility audits. ELM has a long-standing history in Michigan of working to protect and promote the rights of seniors with information, advocacy services, and legal advice—including assistance and guidance on Medicare and Medicaid.



III-B AUTHORIZED CONTRACTOR EXPEDITER:

William C. Lucia
President
Health Management Systems, Inc.
401 Park Avenue South
New York, NY 10016
Telephone: 212.857.5307
Facsimile: 212.857.5010

APPENDIX A

CONTRACTOR'S TECHNICAL PROPOSAL
(EXCERPTS)



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Tab C-2 of this proposal responds to RFP Section IV-C.2 and:

- Provides a technical plan (narrative, resource allocation table, and time-related MS Project schedule) for accomplishing the work
- Demonstrates HMS's ability to perform eligibility matches with the top 20 commercial health insurance carriers in Michigan
- Provides a list of HMS's active eligibility match agreements and a list of matches that are under negotiation (including the status of negotiations and the expected date of agreement execution)
- Provides evidence that HMS has achieved approval from Medicare to submit HIPAA-compliant electronic claims
- Provides evidence that HMS submits electronic claims to commercial health insurance carriers
- Provides evidence that HMS has the capability to interface with the MDCH and MFIA computer systems
- Provides evidence that HMS plans to establish a Lansing-area office upon contract award

C-2.1 Technical Plan: Narrative

Provide a technical plan for accomplishing the work.

This section of HMS's proposal describes our proposed approach to delivering all of the RFP-required and optional services:

- Project #1: Medicaid Third Party Liability Recovery, including eligibility matching, commercial health insurance recovery, and Medicare recovery (Proposal Section C-2.1.a)
- Project #1: Optional Services, including hospital and long-term care provider audits and Medicare claims appeals and eligibility audits (Proposal Section C-2.1.b)
- Additional HMS projects that would enhance results under Project #1 (Proposal Section C-2.1.c)
- Project #2: Locate Commercial Health Insurance and Medical Support Enforcement, including commercial health insurance locate services, insurance enrollment, and processing backlogged National Medical Support Notices (Proposal Section C-2.1.d)
- Description of HMS's approach to the required project control and reporting tasks (Proposal Section C-2.1.e)

To ensure a complete response, HMS has responded to the requirements of RFP section IV-C.2 (Technical Work Plans) **and** addressed each of the MDCH, OCS, and contractor requirements in RFP sections II-C (Tasks) and II-D (Project Control and Reports).

C-2.1.a Project #1: Medicaid Third Party Liability Recovery

HMS understands that MDCH’s goal for this solicitation is to obtain the services of a contractor that can supplement MDCH’s Medicaid cost avoidance and recovery efforts by identifying additional coverage sources and recovering payments made by the Medicaid and Children’s Special Health Care Services (CSHCS) programs from liable third parties.

HMS has served as MDCH’s Third Party Liability contractor since 1994, and in this capacity, has recovered more than **\$48.6 million** for the state. HMS already performs most of the RFP-required TPL services in Michigan—and has demonstrated the capability to perform all required services or capabilities through other existing state Medicaid TPL contracts. In summary, HMS can deliver seamless continuation of TPL services—with no disruption to third party identification and recovery—under the new contract term.

The following narrative addresses the major tasks—as identified in the RFP—for developing and delivering the “core services.” HMS has also supplemented the RFP requirements listing with additional tasks and elements that will enable us to produce the maximum recovery possible for MDCH (see Section C-2.1.c).

C-2.1.a.i Eligibility Matching

C-2.1.a.i.a Eligibility Matching: MDCH Responsibilities

a. Provide Data Files

Provide the contractor with the following files at the frequency indicated:

MMIS Eligibility File—quarterly

TPL Coverage File—quarterly

TPL Carrier File—monthly

Provider Extract File—monthly

HMS currently receives the above files from MDCH, and has data exchange protocols in place, which allows us to understand the meanings of the fields and their values. HMS acknowledges that we will continue to receive the above data files from MDCH, at the specified frequency. We understand that the purpose of these files is as follows:

- MMIS Eligibility File: identifies demographic information and coverage dates for all Medicaid and CSHCS recipients
- TPL Coverage File: identifies all Medicaid and CSHCS recipients that MDCH has previously identified as having third party coverage.
- TPL Carrier File: identifies active insurance carriers with which the state has interacted
- Provider Extract File: identifies all Medicaid providers and their addresses

Depending on the total scope of TPL projects that MDCH requests, HMS may request certain other data files. We will work closely with MDCH and other project stakeholders to obtain these additional files.

HMS performs all data extraction and reformatting at our Technology and Data Processing Center, and our processing will impose minimal burden on MDCH and other project stakeholders. We will require only a copy of the specified data files on magnetic tape. We will not require MDCH or any other sources from which we obtain data files to reformat or reprogram the files.

b. Request Insurance Carrier Cooperation

Where needed, provide a letter of authorization requesting insurance carrier cooperation with the contractor.

As Michigan's Medicaid TPL contractor since 1994, HMS has already developed an extensive carrier network in the state—including 75% of the state's commercial insurance universe (15 of the top 20 carriers). Historically, most carriers cooperate with HMS's TPL efforts. However, we will continue to work with the State Insurance Commissioner and MDCH, when necessary, to gain the carriers' confidence and cooperation.

HMS urges MDCH to consider taking the steps necessary to have the state legislature pass a data match statute—which other states have found beneficial but is presently is not in place in Michigan. If legislation is not possible, MDCH could potentially use its rule-making processes to ensure that it maximizes its ability to discover other third party coverage through electronic data matches with the eligibility files of all insuring entities. HMS would be pleased to assist Michigan—as we have helped various other client states—in establishing and maintaining strong data match requirements.

c-e. Produce PCF Extract

Run the NIC File against the PCF.

Run the file produced in “1.c.” above against the Billed CRN File to produce the PCF Extract. Also, run the file produced in “1.c.” to update the TPL Coverage File for CHAMPUS identified coverages only.

Send the PCF Extract to the contractor.

HMS acknowledges MDCH’s responsibility to produce the PCF extract by running the Newly Identified Coverage (NIC) File—as will be provided by HMS—against the Billed Claim Reference Numbers (CRN) File.

Currently, HMS receives the full Paid Claims File and does not duplicate the billing efforts of MDCH.

f. Update TPL Coverage File

Update the TPL Coverage File with the CUF for cost avoidance purposes.

HMS affirms that we will provide a Coverage Update File (CUF), which MDCH will use to update the TPL Coverage File for cost avoidance purposes.

g. Reimburse Contractor

Reimburse the contractor within 30 days of receipt of an approved invoice.

HMS will prepare invoices, with supporting documentation regarding the eligibility match, for MDCH.

HMS will customize each invoice to meet MDCH requirements. An example of an invoice that HMS submits to MDCH under our current contract appears under **Attachment 2** of this Proposal.

C-2.1.a.i.b Eligibility Matching: Contractor Responsibilities

a. Provide List of Health Insurance Carriers

Provide the MDCH with a list of health insurance carriers it has agreements with to allow beneficiary file matches. (As noted previously, the MDCH expects that potential contractors responding to this project will demonstrate their ability to perform beneficiary file matches with the top twenty health insurance carriers in Michigan.) The contractor shall update the list as new agreements are finalized.

HMS's successful, ongoing experience with data match-based TPL identification and recovery for MDCH and more than 25 other current clients—most of which are state Medicaid agencies—is evidence of our continued ability to perform these projects in Michigan within the federally required 60-day timeframe.

HMS has data match agreements in place with an established, broad-reaching network of carriers serving Michigan. HMS's Michigan data match network includes Aetna, Health Alliance Plan, CIGNA, United Health Care, and many other carriers operating in the state. This means that commercial insurance recoveries and cost avoidance data will continue, without interruption, into the next contract term.

HMS Has the Largest National Data Match Network

HMS has assembled the most comprehensive health insurance data exchange network that exists today for purposes of identifying other third party coverage (please see **Exhibit C2-1: HMS Crossmatch and Billing Agreements**). Our in-place carrier network and highly effective billing protocols far exceed the similar capabilities of any other vendor. HMS is the first revenue recovery contractor to have more than 100 carriers in our network nationwide, including the majority of commercial insurers in Michigan. Because of this network, HMS can ensure that Medicaid remains the payor of last resort and that MDCH complies with federal requirements to cost avoid claims when there is known third party liability.

Although the scope of the present solicitation excludes BC/BS of Michigan data matches, HMS is able to enhance BC/BS recoveries for MDCH by performing matches to other BC/BS plans—including some of the largest plans operating in the country, which insure Michigan residents living in-state and out-of-state. These plans include Anthem (Ohio), BC/BS Florida, BC California, BS California, and BC/BS Massachusetts.

HMS has generated cumulative recoveries of more than \$900 million from our commercial insurance identification and recovery projects—including \$28.8 million for Michigan.

HMS Has the Largest Michigan Carrier Network

HMS's national network is only part of the story. We realize that commercial insurance recoveries for MDCH depend directly on the scope of HMS's network in Michigan. Accordingly, we provide **Exhibit C2-2**, which lists HMS's existing and in-process data exchange agreements with the top 20 health insurance carriers in the state (see left side of this

exhibit). HMS's carrier network presently includes 15 of the top 20 carriers in Michigan, including Aetna, Health Alliance Plan, CIGNA, and United Health Care. This network represents 75% of the top 20 carriers (and 88% of eligibility records among the top 20 carriers) in Michigan.

Exhibit C2-2 (right side of exhibit) also lists the top 20 carriers in the state, as identified in the state's answers to vendor questions. With respect to the state's list, HMS notes that:

- The list does not appear to be “listed from largest to smallest”—as the state has indicated. For example, Aetna—which has nearly one million members in Michigan—is listed near the bottom of the list, below many smaller plans.

- Medicaid third party liability services requested under this RFP are not applicable for 20% (four) of the carriers on the state’s list. These carriers are Medicaid-only MCOs (i.e., Community Choice Michigan, Cape Medical, Midwest Health Plan, and McLaren Health Plan).
- The state’s list includes three additional plans (Delta Dental, Michigan Dental Plan, and Vision Service Plan Insurance Co.) that have limited service lines and, therefore, very limited opportunity for TPL—despite having large enrollments. The vast majority of TPL opportunity is in medical lines of business, not dental or vision.

In addition, HMS would like to draw MDCH’s attention to the fact that the lack of a data match statute in Michigan has enabled some large insurers to “opt out” of Medicaid third party eligibility matches. For example, M-Care—one of the state’s largest carriers, with 165,000 members—has previously declined HMS’s request to participate in data matches. Given the significant third party liability represented by this carrier’s large enrollment, HMS plans to appeal M-Care’s decision. Establishing a strong data match statute would compel all carriers to participate in eligibility data matches and enable maximum third party coverage identifications and recoveries for MDCH.

HMS’s ultimate goal is to expand our network to cover the entire Michigan health insurance universe.¹ Hence, our data matches with insurers will tap virtually the entire health insurer-based universe in the state—as well as insurers operating in states that border Michigan and that may provide employer group health insurance to Michigan residents. HMS currently receives eligibility data from carriers in two of the three states contiguous to Michigan—Ohio and Indiana—which allows us to cross-match border populations for coverage in those states.

As Michigan’s current TPL vendor, HMS continually works to increase TPA recruitment by researching Michigan’s state data match regulations that govern fully insured and self-funded plans.

HMS has recently completed our first Michigan eligibility match with Wal-Mart—one of the largest self-insured employers in the country. This match yielded 5,398 confirmed Medicaid/Wal-Mart dual-eligibles in Michigan. Based on results from HMS’s recently completed Wal-Mart data match for Missouri Medicaid, we expect that this process will identify a significant number of Medicaid-paid claims in Michigan for which Wal-Mart is liable—estimated between \$0.5 million and \$1.5 million.

¹ Inclusion of all Michigan carriers may not be feasible, as some carriers may not underwrite health coverage in the state.

Exhibit C2-1: HMS Crossmatch and Billing Agreements (as of 4/30/04)

Commercial Insurers/HMOs/TPAs	Commercial Insurers/HMOs/TPAs (cont.)	Blue Cross/Blue Shield
<p>Aetna (includes Aetna, Aetna/US Health Care, Aetna Pharmacy Management, Prudential Health Care) American Insurance Administrators (TPA) American Medical Security (United Wisconsin) (TPA) American Postal Workers Union (APWU) American Republic AmeriChoice of NJ AmeriHealth HMO (Independence BC) Anthem Benefits Administrator (TPA) Av-Med Health Plan Bankers Life Beacon Health Plan Benefit Management, Inc. (TPA) Benesight (TPA) Capital Administrators (TPA) CBCA (PBM) Celtic Life Insurance Co. Central Reserve Century Planners (TPA) Christiana Health Care Cigna (includes Cigna, Cigna/Equicor, and Cigna/Provident) CNA (LTC) Community Care Connecticare Cornerstone Benefits (TPA) Coventry (Health America, includes Group Health Plan of Missouri) Educators Mutual Fallon Community Health Plan Florida Health Care Plan Fortis Healthcare (Time) Gallagher Benefit Administrators (TPA) GEHA (FEP)* Geisinger Health* Golden Rule Great West (General American, One Health Plan) Guardian Life Harvard Pilgrim Health Plan Health Alliance Plan Health First Health of Florida Health Guard of Lancaster (TPA) Health Net (includes Physicians Health Services—MD Health Plan and First Option Health Plan) Health Plan Services (New England Life) (TPA) Health Plus of Michigan</p>	<p>Humana (includes Choice Care, Employers Health, and CUNA) John Alden Kanawha Insurance Co. (TPA) National Association of Letter Carriers (FEP)* Managed Care Health Plan MDNY MedcoHealth (PBM) Medical Mutual of Ohio Mega Life and Health Insurance Mutual of Omaha (United of Omaha) Neighborhood Health (FL) New Jersey Manufacturers (Comp) NYHART (TPA) Oxford Health Plans PacifiCare (includes PacifiCare of Colorado, PacifiCare of Colorado HMO, and PacifiCare of Nevada HMO) Pacific Life Insurance Co. Paramount (TPA) Pharmacy Service Group (PBM) Phoenix Home Life Mutual Insurance Co. Physician Mutual Preferred Health Systems Principal Mutual Priority Health Rocky Mountain Health Plan (agreement in place; awaiting receipt of files) RX Options (PBM) Sierra Nevada State Farm Summa Care Teamsters Benefit Trust (TPA) Trustmark Tufts Health Plan UlliCare UniCare (includes UniCare/John Hancock and UniCare/Mass Mutual) United Health Care (includes United Health Care/Travelers and United Health Care/Met Life) United Medical Resources (TPA) UPMC Health Plan Vista Health Plan (includes Health Plan Southeast of Florida, Foundation Health) WALMART Westport Benefits (TPA)</p>	<p>Arkansas (pending receipt of data) California Blue Cross California Blue Shield Colorado (Anthem) Connecticut (Anthem) Capital Blue Cross (PA) Empire Florida Blue Cross Highmark Blue Cross (PA) and affiliated HMOs (includes Keystone Health Plans Central and West, and Keystone HMO) Independence BC (PA) and affiliated Keystone HMOs (as listed above) Indiana (Anthem) Iowa (Wellmark) Kansas Kentucky (Anthem) Maryland (includes CareFirst and affiliated HMOs: Free State, Delmarva, Blue Choice, and Preferred Health Network of Maryland) Massachusetts Blue Cross Michigan Missouri (Wellpoint) Missouri (BC/BS Kansas City) Nevada (Anthem) New Jersey (Horizon) NorthEast Pennsylvania Ohio (Anthem) Pennsylvania Blue Shield Rhode Island Virginia (includes Anthem and Healthkeepers) Federal Employee Program (FEP) thru BC/BS Association NASCO (National Accounts, BC Plans)</p>

***Carrier has agreed to provide eligibility data; receipt of data pending.**

Top 20 Carriers (HMS Analysis)			Top 20 Carriers (State-Specific)		
Carrier	Enrolled Volume in Michigan (All Medical) ²	HMS Network Status	Carrier	Enrolled Volume in Michigan ³	
				Medical	Other
1. Aetna	969,100	Yes	1. Health Alliance Plan of Michigan	417,980	
2. Health Alliance Plan	417,980	Yes	2. M-Care, Inc. ⁵	164,931	
3. CIGNA	291,200	Yes	3. Priority Health	242,009	
4. United Health Care	258,386	Yes	4. HealthPlus of Michigan, Inc.	66,551	
5. Priority Health	242,009	Yes	5. Physicians Health Plan, Inc. (MI)	31,400	
6. United Health Care	190,860	Yes	6. Care Choices HMO (MI)	121,241	
7. M-Care, Inc. ⁶	164,931	Declined	7. Delta Dental Plan of Michigan, Inc.	N/A	1
8. FORTIS	142,221	Yes	8. Wellness Plan	17,521	
9. Care Choices HMO	121,241	Under consideration	9. SelectCare HMO, Inc.	69,337	
10. UNICARE	98,441	Yes	10. OmniCare Health Plan	27,592	

² Source for participating carrier enrollment numbers: HMS file counts of actual data received from these carriers. Source for non-participating carrier enrollment numbers: National Association of Insurance Commissioners, 2002

³ Source for participating carrier enrollment numbers: HMS file counts of actual data received from these carriers. Source for non-participating carrier enrollment numbers: National Association of Insurance Commissioners, 2002

⁴ Enrollment is either dental, vision, or Medicaid MCO (limited to no third party liability anticipated among this population)

⁵ M-Care has previously declined HMS's request to participate in data matches—a decision that HMS plans to appeal. Michigan presently does not have a statute requiring carriers to participate in eligibility matches, and carriers are free to decline participation requests.

⁶ M-Care has previously declined HMS's request to participate in data matches—a decision that HMS plans to appeal. Michigan presently does not have a statute requiring carriers to participate

Carrier	Enrolled Volume in Michigan (All Medical) ²	HMS Network Status	Carrier	Enrolled Volume in Michigan ³	
				Medical	O
11. Principal	81,092	Yes	11. Community Choice Michigan	N/A	
12. American Medical Security	80,982	Yes	12. Total Health Care, Inc.	9,194	
13. FEP	79,208	Yes	13. Cape Medical (d/b/a Cape Health Plan)	N/A	
14. CIGNA	78,599	Yes	14. Midwest Health Plan	N/A	
15. SelectCare HMO, Inc.	69,337	In negotiation	15. Grand Valley Health Plan, Inc.	20,224	
16. Health Plus of Michigan	66,551	Yes	16. Aetna Health Inc.	969,100	
17. Employers' Health, Inc.	58,000	Yes	17. McLaren Health Plan	N/A	
18. Physician Health Plan of Southern Michigan	31,400	In negotiation	18. Vision Service Plan Insurance Co.	N/A	
19. BENESIGHT	31,176	Yes	19. Paramount Care of Michigan	4,000	
20. OmniCare Health Plan	27,592	In negotiation	20. Michigan Dental Plan, Inc.	N/A	
Total Enrolled Volume:	Medical: 3,500,306	In HMS Network: 3,085,805 ⁷ (88%)	Total Enrolled Volume:	Medical: 2,161,080 Enrolled in HMS Network: 1,516,883	C 2,3

⁷ Based on HMS's Top 20 Analysis, HMS has already established eligibility matching agreements with 75% of the Top 20 carriers in Michigan (excluding BC/BS Michigan)

HMS pioneered the use of data matches with health plans and managed care organizations for Medicaid third party identification and recovery. HMS has played a key role in helping stakeholders accept the use of these data matches for Medicaid TPL purposes, including overcoming significant concerns about data privacy and confidentiality. To gain this acceptance, HMS has reached out to many healthcare organizations, including CMS’s central office, the National Association of Insurance Commissioners (NAIC), the Health Insurance Association of

HMS has data match agreements in place with an established, broad-reaching network of carriers serving Michigan residents—including Aetna, Health Alliance Plan, CIGNA, and United Health Care. This means that commercial insurance recoveries and cost avoidance data will continue, without interruption, into the next contract term.

America (HIAA), and the Blue Cross/Blue Shield Association.

The Benefit of Data Match Statutes

A strong data match statute is a crucial element for third party data matches to be successful. Michigan presently does not have a data match statute, and this creates a “loophole” that carriers can use to avoid the data match process. Some carriers, for example, provide eligibility files to HMS for our other client states that do have data match requirements, but decline to participate in data matches in states that do not have a statutory or regulatory requirement. Obviously, the fact that carriers can “opt out” of data matches reduces the effectiveness of Michigan’s data match process—and also results in decreased recoveries and cost avoidance.

HMS urges MDCH to consider taking the steps necessary to have the state legislature pass a data match statute. If legislation is not possible, MDCH could potentially use its rule-making processes to ensure that it maximizes its ability to discover other third party coverage through electronic data matches with the eligibility files of all insuring entities.

In developing legislation or regulations, Michigan should consider the following:

- The definition of “insurer” should be broad enough to include the wide variety of insuring entities that exist today.
- Language should specifically require ERISA and self-insured and/or administered plans to participate in data matches. Often, large national employers who are self-insured refuse to participate in data matches, asserting that they are not required to provide eligibility data under current state statutes. ERISA plans are not usually required to provide eligibility data unless the statute specifically includes them in the definition of insurer.
- TPAs and PBMs should be included as entities that must furnish their eligibility data to the Medicaid agency.
- Terms should be well-defined to avoid “loopholes” and clarify the obligation to provide eligibility data.

- The required frequency of matches should be adequate to maximize MDCH’s ability to maintain valid third party coverage information. If the insurer is required to match infrequently (e.g., annually), lapsed coverage information will interfere with—and may preclude—billing and cost avoidance activity.
- The state should consider establishing penalties for carrier noncompliance.

Statutory and regulatory text that may be referenced for examples include Texas, Missouri, and Florida’s recently amended statute. The Medicare as secondary payer definition of “primary payer” in the Social Security Act (42 U.S.C. §1395y(b)) also contains helpful information.

HMS would be pleased to assist Michigan—as we have helped various other client states—in establishing and maintaining strong data match requirements.

HMS Aggressively Builds our Network of Third Party Payors

HMS traditionally seeks to include in our data match network the major carriers that we know are operating in our client states. But we don’t stop there. HMS has already undertaken and will continue to undertake extensive and aggressive efforts to identify the maximum number of third party resources in Michigan and to include them in our network. HMS identifies these additional third party coverage resources by:

- Contacting the major municipalities, counties, and private self-insured employers and self-insurance pools in the state
- Working with the Department of Insurance
- Conducting research using industry data sources (e.g., the National Underwriters’ ERISA Database, National Association of Insurance Commissioners (NAIC) health insurer reports, the Judy Diamond Database, managed care directories)
- Reviewing MDCH’s TPL Coverage File
- Performing employer wage matches and conducting employer surveys
- Examining third party administrator (TPA) directories
- Analyzing the eligibility data files that our network carriers provide to identify liable subcontractors who may be working with primary payors (e.g., PBMs, behavioral health plans)

Using NAIC Data Sources

As part of our ongoing efforts to identify the broadest possible range of third party resources, HMS is now using the customized Health Insurance Reports from the NAIC. These reports will provide a variety of data specific to health insurers operating in Michigan, including:

- ◆ Balance sheet
- ◆ Statement of revenue and expenses
- ◆ Underwriting and investment exhibit
- ◆ Five-year historical information
- Exhibit of premiums, enrollment, and utilization

HMS will use these reports to enhance our Michigan network development efforts and to facilitate targeted recruitment by covering as broad a base as possible and ensuring that we focus on insurers that are likely to cover the largest number of state residents.

HMS Performs Interstate Data Matches to Augment Coverage Identification

HMS will continue to augment our intrastate health insurance data matches with interstate health insurance data we receive for the residents in more than 20 other states where HMS performs TPL services. These files provide additional third party coverage information for recipients who may have insurance coverage directly or through a responsible relative (e.g., noncustodial parent (NCP)) outside of the state. These specialized data matches will continue to help HMS identify more third party resources and recover more revenue for Michigan.

Dedicated Carrier Relations Staff Expand the Reach of HMS's Network

HMS has a dedicated unit that is responsible for obtaining, reviewing, analyzing, and assuring the quality of carrier subscriber files for data matches. This unit creates channels of communication with carriers through routine contact and periodic site visits, during which they obtain the carrier subscriber data and resolve claims adjudication issues.

b. Provide List of Agreements under Negotiation

Provide the MDCH, within two weeks of the contract award date, with a list of those health insurance carriers that it does not have agreements with, but with which it has been negotiating for an agreement to allow beneficiary file matches.

As required by RFP section IV-C.2 (Technical Work Plans), HMS's proposal includes a list of carrier eligibility matches that HMS is presently negotiating, including the status of negotiations and anticipated date of agreement execution (**Exhibit C2-3**).

Exhibit C2-3: HMS Data Match Agreements Under Negotiation as of 4/26/04

Carrier	Status of Negotiations	Anticipated Date of Agreement⁸
M-Care, Inc.	Carrier's declination is under appeal	Unknown
Care Choices	In negotiation	5/31/04
SelectCare HMO	In negotiation	8/31/04
Physician Health Plan of Southern Michigan	In negotiation	8/31/04
OmniCare Health Plan	In negotiation	8/31/04

⁸ Agreement dates are estimated—based on HMS's experience negotiating similar agreements with other network carriers—and are also contingent upon each carrier's willingness to participate in data matches. Michigan presently does not have a statute requiring carriers to participate in eligibility matches, and carriers are free to decline participation requests.

c. Perform Eligibility Matches

Perform a match, quarterly for insurance carriers and annually for CHAMPUS, of beneficiaries on the MMIS Eligibility File against the carriers' eligibility files.

HMS affirms that we will perform bimonthly eligibility matches with insurance carriers and annual data matches with TRICARE/CHAMPUS. This section of HMS's proposal identifies the various types of third party insurers that HMS's data matches will include and also describes the process we propose for performing MDCH eligibility matches.

Although the RFP requires the contractor to perform matches for individuals who were Medicaid-eligible within the previous 18-month period, HMS proposes to match for a 24-month retroactive period as several carriers permit this longer timely filing period. This more extensive approach to eligibility matching will result in a higher number of third party coverage identifications for MDCH—as well as correspondingly higher recovery and cost avoidance levels.

Overview of Data Match Resources

Specific third party resources from which we propose to obtain eligibility data for data matching are listed below. These third party resources have historically generated the most significant recoveries for the 30 TPL clients HMS has served, including MDCH.

Health Insurance Carriers, Self-Funded Plans, and TPAs. HMS's health insurance data match project significantly increases our clients' revenue recoveries and augments their cost avoidance from health insurance carriers. HMS has successfully billed and had claims adjudicated by more than 250 different health insurance carriers—including carriers that provide administrative services for self-funded plans. We use sources such as health insurance industry reports from the National Association of Insurance Commissioners, the "Judy Diamond Directory of Self-Funded Plans," the "Managed Care Information Center," and the "Medicode Insurance Directory," in conjunction with state resource data and other databases, to identify TPAs and self-funded plans. Furthermore, HMS is the **only** TPL vendor that has an in-place data match arrangement with Wal-Mart—one of the largest self-insured, self-administered health plans in the country.

HMS receives data approximately every three to six months from health insurers operating in the states we serve. HMS is striving to increase the frequency of the data feeds from health carriers and other entities to monthly. Thus far, various carriers have welcomed our efforts, and some now provide monthly data feeds to HMS.

HMS has also developed a proprietary, real-time eligibility verification Web-server that verifies several hundred policies per hour (as compared to an individual performing Web-based eligibility inquiries, who might be able to verify 20 policies an hour). HMS uses this system to identify eligibility for high-dollar Medicaid recipients for which we find no other eligibility within our carrier data match network.

Blue Cross/Blue Shield Plans. HMS acknowledges that eligibility matches with BC/BS Michigan are outside the scope of this solicitation.⁹ However, HMS's data match agreements with more than 25 other BC/BS plans nationwide, including Anthem BC/BS (Ohio) will result in increased third party coverage identifications for MDCH (see **Exhibit C2-1**). In addition—under a unique agreement with the BC/BS Association—HMS successfully receives BC/BS Federal Employee Plan (FEP) eligibility data for FEP members residing in all of our client states. Under this agreement, eligibility data are transmitted directly to HMS's mainframe. We are also negotiating data matches with the BC/BS National Accounts Service Company (NASCO). NASCO's national eligibility database includes eligibility from 1,200 national and regional accounts representing over 5.8 million members.

Managed Care Organizations. HMS will also increase health insurance recovery by identifying other health coverage for Medicaid recipients who are also enrolled in managed care organizations in Michigan (including HMOs and PPOs). Traditionally, these plans have taken the position that they will not pay Medicaid TPL claims, because they must grant prior approval for members to receive benefits "outside" the MCO provider community. However, HMS works with these MCOs to identify specific situations under which they will reimburse Medicaid (e.g., emergency care, drug services). As HMS identifies specific covered services that the MCOs will reimburse, we update our programs to bill claims of this type. Even though recovery limitations are associated with MCOs, HMS is still able to provide quality cost avoidance data to our clients through ongoing data match and coverage verification processes.

CHAMPUS/TRICARE. HMS has conducted highly successful TRICARE data match and billing projects for 23 state Medicaid agency clients during the past 18 years and, through this work, has developed the most effective DEERS matching and intermediary billing methodology for TRICARE identification and recovery. To perform the data match, HMS prepares a Medicaid eligibility input tape. We send this tape to DEERS for the scheduled annual match. (Michigan's next scheduled match date is July 20, 2004.) If a child support case file is available, HMS also includes this information in the DEERS data match process, per CMS regulations. Between annual data matches, HMS uses our direct access to the DEERS database to perform real-time, online eligibility verification lookups—a capability that enables us to perform coverage queries for newly eligible Medicaid recipients without waiting for the next annual data match. In addition, HMS uses GIQD system access to verify TRICARE leads received through non-data match sources. In addition, HMS ensures full compliance with state and federal (CMS) reconciliation and reporting requirements. HMS's enhanced TRICARE TPL capabilities will ensure increased eligibility matches for MDCH.

⁹ Although eligibility matches with BC/BS Michigan are outside the scope of the solicitation, the state's response to vendor questions (item 30) clarifies that a vendor may identify BC/BS Michigan coverage through processes other than a direct eligibility match. For example, after submitting a claim to another carrier, HMS may learn that the recipient actually has coverage through BC/BS Michigan. In these cases, HMS will report the newly identified BC/BS Michigan coverage to MDCH.

Through our close working relationship with the Tom Braun, Department Supervisor of Database and Cost Avoidance within MDCH, HMS was able to identify the need for supplemental information to the annual DEERS data match, which prompted the GIQD access on behalf of all of our contracted states. By working closely with Michigan to improve our processes, TRICARE recoveries have increase dramatically from \$293,000 in 2002 to \$435,000 in 2003.

Pharmaceutical Coverage Plans/Pharmacy Benefit Managers (PBM). Pharmaceutical claims are often difficult to bill and recover because of the specific billing formats and platforms that individual pharmaceutical coverage plans require. HMS has extensive experience identifying third party coverage and billing and recovering drug claims that Medicaid has paid. HMS is effective in this area not only because we have developed the appropriate software, systems, and electronic billing and remittance mechanisms—which we customize to each carrier's/PBM's detailed specifications—but because we have established close and cooperative working relationships with the nation's major PBMs.

HMS leads the industry in establishing effective PBM billing and recovery protocols, with over \$500 million recovered to date. HMS has implemented identification and electronic billing processes for third party pharmacy coverage with most of the largest PBMs operating in the country (AdvancePCS, Medco Health, ExpressScripts, MedImpact, Aetna Pharmacy Management, Argus). In fact, HMS was the first TPL vendor to test National Council for Prescription Drug Programs v5.1 transactions with a PBM.

HMS's pharmacy recovery capabilities are significant, given that pharmacy costs are among the fastest-growing Medicaid costs in Michigan—as in most states. HMS's pharmacy identification and recovery services will continue to complement the state's own cost containment efforts by ensuring that Medicaid pays only for pharmaceutical services for which it is liable.

Medicare Supplemental (Medi-gap) Plans. HMS has performed several billing and recovery projects using Medi-gap coverage information from commercial insurance carriers, BC/BS plans, and MCOs. We identify Medicaid payments for coinsurance and deductibles, pharmacy services, and other services where Medi-gap coverage was available. HMS regularly receives eligibility data from the large Medi-gap plans in Michigan and nationwide and has established, proven data match exchange agreements and data processing procedures, which we will continue to apply successfully under MDCH's TPL contract.

HMS's Strong Data Matching Expertise

To identify third party coverage leads, HMS performs a complex series of electronic data matches. These matches help HMS identify third party coverage that MDCH has not yet detected. We perform many different types of data matches and tailor each individual match to accommodate the characteristics of the source data we use.

HMS data matches are on a level of technical sophistication that exceeds the capabilities of data match operations of competing vendors. HMS is able to identify many cases of new third party coverage because we use specialized software that produces the highest possible number of accurate “hits” (i.e., identifications of eligibility for third party coverage). Using multiple, successively applied match keys, we obtain eligibility information despite data discrepancies that may exist in records for the same recipient on various files.

Examples of our specialized match criteria include:

- Social Security Number (SSN), full last name, and first three positions of first name, combined with:
- Percentage matches on the following fields: first name, sex, date of birth, and other demographic variables of the recipient

Although technically complex, multiple match keys are effective tools that help identify the maximum number of third party coverages, despite discrepancies in data that may appear on various files. For instance, a person's demographic information may vary between insurance carrier files and the Medicaid or Absent Parent/Child Support Case File—a different first or last name, possibly no SSN, or an SSN with a one-digit difference.

HMS’s approach overcomes these problems—and generates accurate third party coverage leads despite discrepancies in source data files. As a result, we can produce a significantly greater volume of eligibility match “hits.”

[Accurate On-Site Data Matches](#)

HMS will continue to perform most Michigan data matches at our data processing center in New York City. HMS owns this facility, and uses only HMS employees to perform all data processing operations. Hence, because we do not have to compete with other companies for data processing time, we can assure timely project performance for our clients.

HMS matches on-site for:

- ◆ Commercial insurance carrier files
- ◆ BC/BS Plans
- ◆ Medicare files
- Wage and earning files

[Effective Off-Site Data Matches](#)

On occasion, third party coverage resources (primarily DEERS and some BC/BS plans) perform eligibility matches on their systems. In these situations, we extract and reformat each appropriate Medicaid eligible record on our third party coverage database to the specifications of DEERS or the specific BC/BS plan and send them an input file to match against their own files. We then receive a file of match “hits” from DEERS or BC/BS, which we add to our third party coverage database.

Overview of Approach to Performing Eligibility Matches

This methodology applies to the following third party resources:

- ◆ Commercial health insurance carriers, self-funded plans, and TPAs
- ◆ BC/BS plans (other than BC/BS Michigan)
- ◆ Managed care organizations
- ◆ Medicare supplemental (Medi-gap) plans
- ◆ TRICARE
- ◆ PBMs

1. Receive and Prepare Data (ongoing)

- Obtain data files (e.g., MMIS Eligibility File, Provider Extract File, Medicaid Paid Claims File (PCF Extract), TRICARE File, health insurance eligibility files, Medicaid TPL Coverage File, BC/BS eligibility files (including FEP), Procedure Code File, and Absent Parent/Child Support Case File) from various sources.
- Convert files to the HMS format (no additional programming required on the part of the state), and load the files in our Third Party Coverage Database.

2. Perform Eligibility Matches for Medicaid and CSHCS Recipients (bimonthly for commercial insurance and annually for TRICARE)

- Perform matches between the MMIS Eligibility File, insurer eligibility files, BC/BS eligibility files, and Medicaid's TPL Coverage File to identify state Medicaid eligibles with other insurance coverage. Add this new coverage information to HMS's Third Party Coverage Database.
- Obtain copy of MDCH's PPB schedule and time matches to coincide with PPB billing cycles.
- Create and forward a Medicaid/CSHCS eligibility input tape to DEERS at least one week before the scheduled annual date for the state's TRICARE data match.
- When DEERS returns a tape of TRICARE eligibility matches, HMS processes the file and then checks these matches against the GIQD access database to insure that the coverages are valid. The verified coverage is updated in HMS's Third Party Coverage Database with newly identified coverage.
- Extract from MDCH's TPL Coverage File all recipients with TRICARE coverage, and add this information to HMS's Third Party Coverage Database.
- HMS augments eligibility matches by verifying leads through our work with PBMs. For example, HMS:
 - Verifies eligibility and PBM identification using claim and group level verification processes
 - ◆ Verifies eligibility using the [automated WebMD Real-time Access for Big Batches of Individual Transactions \(R.A.B.B.I.T.\) system](#) (ANSII 270/271 transaction)
 - Verifies pharmacy coverage using [other automated verification tools, such as PBM websites](#). For example, through the Medco Health website, we are able to perform thousands of eligibility verifications per day.

3. Maintain Group/PBM Information (ongoing)

- HMS requests and obtains group/PBM information from carriers, if possible. We request this information on eligibility files or reference files, if available.
- HMS proactively identifies and maintains group/PBM information in our eligibility system. HMS:
 - Places telephone calls to identify and maintain PBM/other benefit manager information for many thousands of groups annually
 - Maintains group information in our Group Capture System, which enables us to bill or rebill all eligible claims to the appropriate PBM as soon as we identify specific information related to a group carrier change

4. Continue to Receive and Prepare MMIS Files (ongoing)

- With the support of MDCH, continue to obtain copies of the following MMIS data files: (i) MMIS Eligibility File, (ii) TPL Coverage File, (iii) TPL Carrier File, (iv) Medicaid Provider Extract File, and (v) Medicaid Paid Claims File (or PCF Extract).
- Perform data extraction and reformat files to standard HMS file format. (Note: HMS's project team handles all reformatting. HMS is highly experienced in reading and processing these files for our present Michigan TPL engagement.)
- Add MDCH's MMIS Eligibility Files to HMS's Medicaid Client Master File.

Approach to Verifying Match Results

HMS has detailed and accurate processes for verifying third party insurance coverage leads identified through eligibility matches. This step is imperative, as the eligibility data provided by insurers and other third parties is often dated or inaccurate. Without a verification process that removes policies identified in the data matches that may no longer provide active coverage or that don't provide comprehensive coverage (i.e., medical and hospital), MDCH would receive eligibility match information that could be as high as 40% inaccurate. This inaccuracy rate would have a negative effect on MDCH's cost avoidance efforts and would also result in incorrect billings to third party resources—negatively impacting the recovery process.

Data Fields to Be Verified

When investigating coverage leads from our data matches, HMS will verify all required data fields for carrier- and benefit-related information and—as required—will report this verified information on the Newly Identified Coverage (NIC) File. HMS will report all coverage changes and terminations that we identify through the eligibility matching process. The NIC File we provide will include the following fields:

- ◆ Recipient identification number
- ◆ Date created
- ◆ Policy begin date
- ◆ Policyholder name
- ◆ Policy end date
- ◆ Carrier ID (from TPL Carrier File)
- ◆ Policy number
- Contract number (Social Security Number)

HMS will also report the following additional data, if available:

- ◆ Recipient relationship to insured
- ◆ Policyholder SSN
- ◆ Policyholder address
- Employer name and address

[Verifying Eligibility Online](#)

HMS verifies health insurance coverage eligibility online with a select group of carriers (see **Exhibit C2-4**). We access this functionality through WebMD Transaction Services or direct Internet connections. Online verification (by individual subscriber or batch) speeds the coverage identification process. Because of the efficiencies associated with online verification, HMS is actively developing verification interfaces with additional carriers.

Exhibit C2-4: Carriers for which HMS Verifies Eligibility Online

▪ Aetna/Prudential	▪ Horizon Blue Cross
▪ Americhoice	▪ Humana
▪ BC/BS Florida	▪ Medica
▪ BC/BS Louisiana	▪ MedcoHealth (PBM)
▪ BC/BS Massachusetts	▪ Methodist Health System
▪ Blue Cross California (Wellpoint)	▪ Nationwide
▪ TRICARE	▪ Oxford
▪ CIGNA	▪ Pacificare
▪ Coventry	▪ Principal
▪ Empire Blue Cross	▪ Tufts
▪ Family Health System	▪ United Healthcare/Met Life

HMS uses the website of United Healthcare (UHC, the largest commercial insurance plan in the United States) to check real-time eligibility from the most reliable eligibility source. Refreshed nightly, this source's benefit plan detail includes data for PBMs.

When carriers are able to support Web-based eligibility verification, HMS enhances our on-line verification processes by using automated software agents, or “data entry robots.” (See **Exhibit C2-5: Sample Web-based Eligibility Verification Screen.**) Whereas an individual performing Web-based eligibility inquiries might be able to verify 20 policies an hour, the “robots” can complete and document several hundred verifications an hour! Operating according to rules that HMS assigns, these automated agents follow an automated inquiry process to verify third party coverage—including coverage types, group numbers, and effective and termination dates. These automated agents can also create an output file that contains the requested information as well as a range of other data output files from the verification process. Because automated agents are faster and less expensive than human personnel, we can assure that we will perform coverage verification quickly and cost effectively for MDCH.

Exhibit C2-5: Sample Web-based Eligibility Verification Screen

ECARE: HMS's Proprietary Internet Verification Tracking System

When coverage cannot be verified online, HMS verifies policy information via phone contact with the carrier or employer.

To serve our clients proficiently, we have perfected the art of the verification phone call via our proprietary *Eligibility Verification System*, known as **ECARE**. **ECARE** is a work management tool used to verify and document commercial insurance coverage information for our clients. The **ECARE** system is initially loaded automatically with policies to be verified, and the system is worked in conjunction with sophisticated inbound/outbound call management technology for maximum efficiency. **ECARE**, when used in conjunction with a call script, allows HMS to:

- ◆ Verify current policy/coverage information
- ◆ Capture any missing information
- Change information that may have become outdated

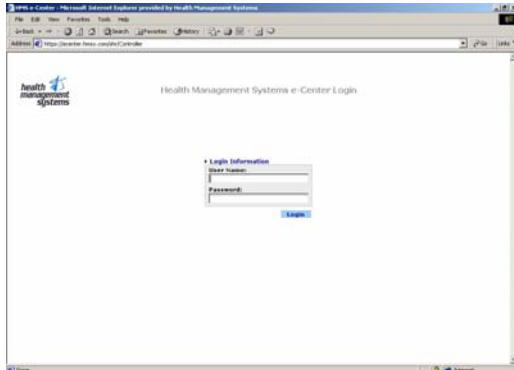
ECARE is a distributed, interactive work management system, which:

- Presents policies requiring verification in a structured way
- Allows for interactive updating of coverage information while on a call with a commercial insurance customer service representative
- Allows HMS to update policyholder status for further verification, or closure

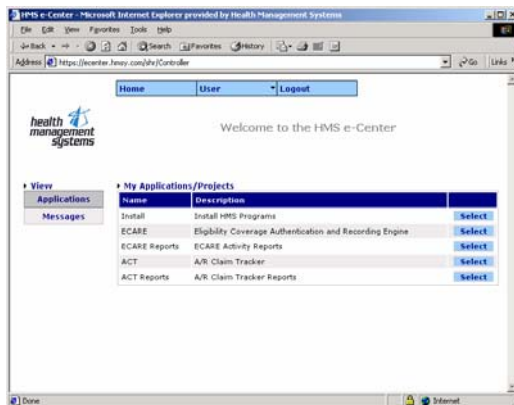
Because **ECARE** is a distributed system, clients may also access the system and analyze HMS's progress on verification of policies. The screen shots included here as **Exhibit C2-6** give an overview of functionality available to HMS expert staff performing verifications and a sample of reports available to clients. *All data depicted in these examples are dummy data.*

Exhibit C2-6: ECARE

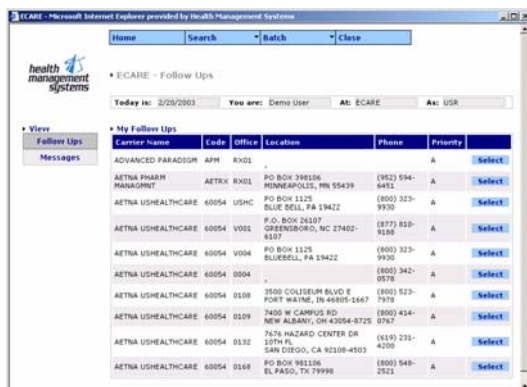
The **ECARE** System is accessed through a fully secured Web site, the HMS e-Center.



Each user has a unique login and password to the HMS e-Center. The login controls which applications and data are accessible to the user. All users must execute a Confidentiality Agreement in order to access the e-Center website.



There are many applications available on the e-Center. The ECARE (Eligibility Coverage Authentication and Recording Engine) application can be found here.



Insurance information that needs to be verified is sorted and prioritized as it is loaded into the application. HMS and the client work together to determine these priorities.

Within each priority level, policies are grouped and listed by carrier/office. By clicking on a “Select” button, an HMS verification representative loads a work queue with policies associated with a carrier/office group to be verified. In the first work step, the HMS verification representative verifies the carrier/office group information. The system is flexible and allows recording of information received by phone contact, fax, or mail. The HMS verification representative then moves to verifying individual policyholder information.

When verifying individual information, the verification representative works with a call script to ensure quality and follows a detailed set of screens verifying information, or recording new data if data are missing. HMS staff identify any dependents covered under a policy and/or if the health coverage plan allows for dependent coverage. If the plan shows minor dependents enrolled, staff are automatically directed to a “related individuals” screen within **ECARE** to verify dependent coverage and other information. When possible, employer data are also verified.

The screenshot shows a web browser window titled "ECARE - Microsoft Internet Explorer provided by Health Management Systems". The main content area contains a form with the following sections:

- Policy Info:** Start Date (01/01/2000), Termination Date, Policy Type (MCO, PPO, POS, Indemnity Plan, Other).
- Coverage:** Emergency Care, Hospitalization, Lab Services, Maternity Care, Physician Office Visits, Prescription Drugs, Mental Health, Death, Vision, Family Planning, Homecare, Skilled Nursing, Private Duty Nurse, Hospice.
- Emergency Care:** Yes/No
- Hospitalization:** Yes/No
- Lab Services:** Yes/No
- Maternity Care:** Yes/No
- Physician Office Visits:** Yes/No
- Prescription Drugs:** Yes/No
- Mental Health:** Yes/No
- Death:** Yes/No
- Vision:** Yes/No
- Family Planning:** Yes/No
- Homecare:** Yes/No
- Skilled Nursing:** Yes/No
- Private Duty Nurse:** Yes/No
- Hospice:** Yes/No

HMS is able to validate eligibility coverage to the level specified by the client. Certain fields within the eligibility verification screens are required, and work is not considered complete until those fields are populated.

The screenshot shows a web browser window titled "ECARE - Microsoft Internet Explorer provided by Health Management Systems". The main content area contains a table of verification records. The table has the following columns: Group, Policy, Last Name, First Name, SSN, DOB, Status, and a Select button. The data rows are as follows:

Group	Policy	Last Name	First Name	SSN	DOB	Status	Select
MCFF	888134B	BRITT	CLIFTON	731-21-2336	07/12/1957	ELGVER	Select
MCFF	88816XA	COLLIER	WILSON	880-22-0568	10/17/1952	UMPRCSD	Select
MCFF	88816XB	COLLIER	WILSON	880-27-0448	10/17/1952	UMPRCSD	Select
MCFF	88816XD	COLLIER	WILSON	955-21-9982	10/17/1952	UMPRCSD	Select
MCFF	88816XE	COLLIER	WILSON	800-21-3336	10/17/1952	UMPRCSD	Select

After a record has been processed, its status is updated to reflect work completed. Verification work can now be started again with a new policyholder record, presented automatically by the ECARE queue.

Summary reports from **ECARE** are also available to clients and HMS management via the HMS e-Center. These reports can be used to obtain a quick analytic view on work in progress; they also provide a summary-level audit trail.

ECARE Summary Report

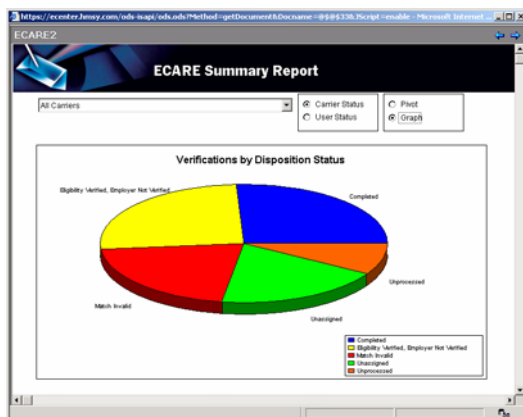
All Carriers

Carrier Status: Carrier Status User Status

	Completed	Eligibility Verified, Employer Not Verified	Match Invald	Unassigned	Unprocessed	Total
BC CALIFORNIA	143	104	116	97	39	543
AETNA PHARM MANAGEMNT	67	72	54	45	10	258
AETNA US HEALTHCARE	47	51	38	32	13	181
ADVANCED PARADIGM	36	10	29	39	24	139
COBA	31	33	25	20	9	118
UNITED HEALTHCARE	27	29	22	19	8	105
PMD PRESCRIPTIONS	19	20	15	13	5	72
WELLPOINT	18	20	15	12	5	70
PCS INC	15	16	12	10	4	67
ARGUS	5	2	5	6	4	22
GREAT WEST	5	6	4	4	2	21
CHAMPUS	5	6	4	4	2	21
HOME LIFE INSURANCE	4	4	3	3	1	15
HEALTHNET CA	4	4	3	3	1	15
BS CALIFORNIA	4	4	3	3	1	15
FORTIS	4	4	2	2	2	14
CHENMARK	3	3	3	2	2	13
	7	7	7	7	2	30

HMS Client - Center

Reports can be fully customized to a client's specification. These are examples of reports using results from ECARE. The data can be displayed in a number of formats, including graphs for clear, concise representation.



The HMS **ECARE** System is designed for maximum efficiency and automated audit trail support. In addition, it affords full visibility to a client on eligibility verification work in progress, from the detail policy level up through summary reports. The result of HMS's successful eligibility verification is current, updated information regarding benefits available under a policy for an identified individual.

Upon completion of insurance verification, HMS will format verified records according to MDCH's specifications for the NIC File. Policies that have not been verified (based on information received from carriers) are also available from **ECARE**, completing the audit trail of work performed.

HMS and the ANSI 270/271 Transactions

HMS is in the process of becoming certified in all HIPAA transactions through Claredi—and has already obtained Claredi certification for the 270 transaction (Eligibility Inquiry).

HMS is currently testing the ANSI 270/271 transaction with WebMD to submit eligibility status requests to Aetna US Healthcare. We will continue the same process for all of the other major carriers that participate with WebMD. We are also testing with TRICARE to obtain DEERS eligibility. We also plan to begin testing this transaction with Medunite to send requests to the

carriers that participate with this vendor. Additionally, some insurance carriers have approached HMS and asked us to use the 270 transaction to obtain eligibility information, and we are testing directly with the carriers.

HMS is currently working with United Healthcare (UHC) on using their B2B product. This product includes an ANSI 270/271 component that will allow HMS to send the ANSI 270 transaction directly to UHC as opposed to going through a clearinghouse such as WebMD. It will also allow for real time eligibility responses.

HMS has already made significant progress in using the 270/271 transactions and anticipates extensive future use of these transactions.

d. Produce NIC File

Produce, in electronic format, a NIC File by matching the file produced in “1.d.” above with the TPL Coverage File.

HMS will compare our data match results (commercial and TRICARE) against MDCH’s TPL Coverage File, remove matches where health coverage is known to MDCH, and include the remaining records on the Newly Identified Coverage (NIC) file.

We will provide the NIC file to MDCH in electronic format. HMS proposes to run this file against the GIQD system to ensure valid coverage before transmitting the final NIC file to MDCH, as MDCH and HMS have identified problems with the DEERS response record coverage inform. As specified in MDCH’s response to vendor questions (item 7), HMS proposes to report the following fields on the NIC File:

- ◆ Recipient identification number
- ◆ Date created
- ◆ Policy begin date
- ◆ Policyholder name
- ◆ Policy end date
- ◆ Carrier ID (from TPL Carrier File)
- ◆ Policy number
- Contract number (Social Security Number)

HMS will also report the following data, if available:

- ◆ Recipient relationship to insured
- ◆ Policyholder SSN
- ◆ Policyholder address
- Employer name and address

C-2.1.a.ii Commercial Health Insurance Recovery

HMS's insurer revenue recovery expertise has produced more than **\$900 million** in recoveries for our state Medicaid agency clients, including **\$28.8 million for Michigan**—far exceeding what any other vendor has achieved in this recovery category. In Michigan and other client states, HMS recovers from a broad range of health insurance carriers and plans, including self-funded plans, TPAs, HMOs/PPOs, pharmacy plans, dental plans, BC/BS plans based outside of Michigan, and TRICARE.

C-2.1.a.ii.a Commercial Health Insurance Recovery: MDCH Responsibilities

a. Reimburse Contractor

Reimburse the contractor within 30 days of receipt of an approved invoice.

HMS will prepare invoices—with supporting documentation regarding commercial insurance recoveries during the invoice period—for MDCH.

HMS will customize each invoice to meet MDCH requirements. A sample invoice appears under **Attachment 2** of this Proposal.

C-2.1.a.ii.b Commercial Health Insurance Recovery: Contractor Responsibilities

a. Identify Claims for Billing

Determine claims from the PCF Extract that are to be billed to the health insurance carriers.

HMS will use the PCF Extract, as provided by MDCH, to identify claims for billing to third party carriers. This extract will exclude data related to claims MDCH has already billed—helping to ensure that HMS does not inadvertently bill duplicate claims. In addition, HMS internal processes will remove claims that are not payable by third parties, claims that exceed timely filing limits, and claims missing fields required for adjudication.

b. Bill Claims

Submit the claims identified in Eligibility Matching “1.f.” above to the health insurance carriers.

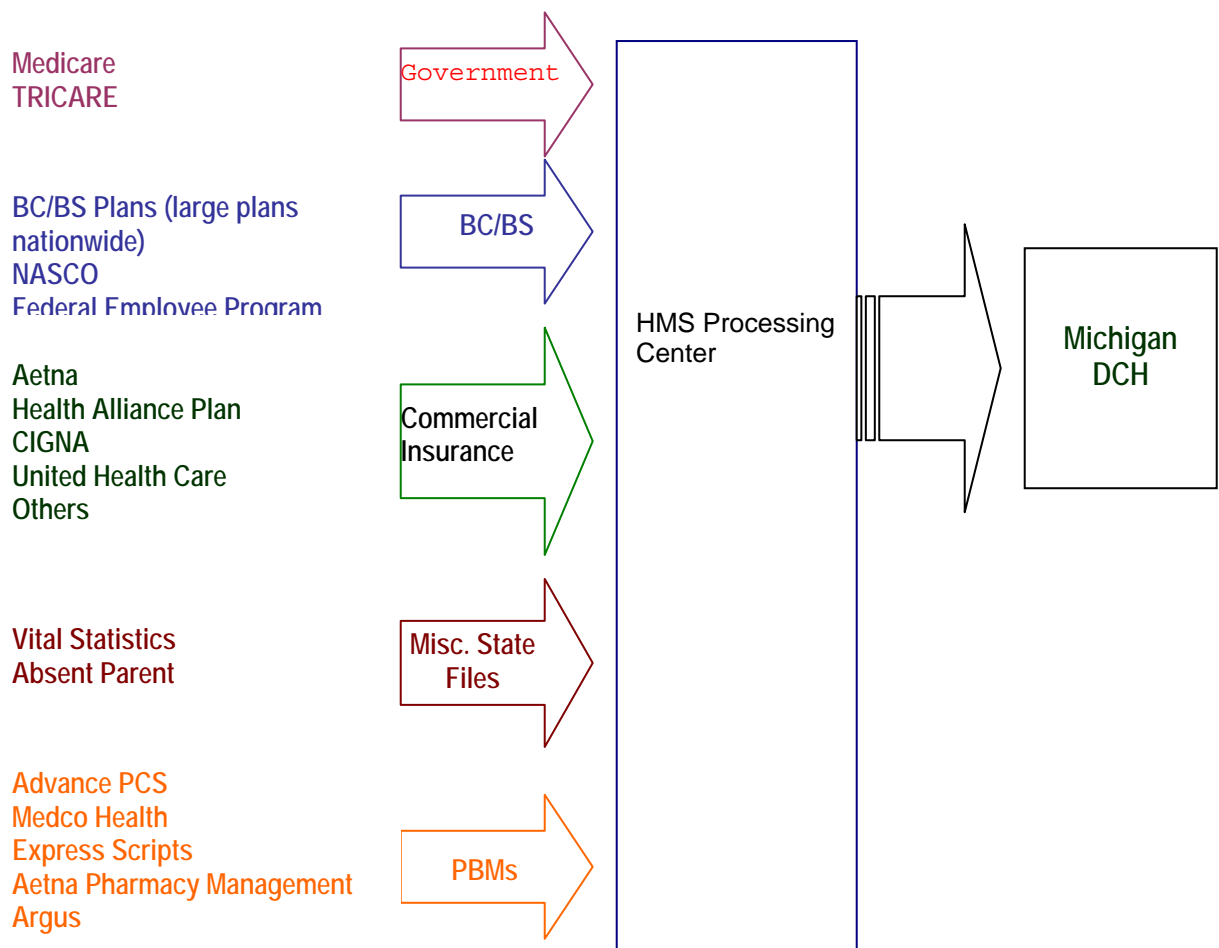
HMS is adept at billing claims to third party insurers and claims processors in the format they require. HMS has demonstrated the capability to perform these services for mandatory “pay and chase” claims and for claims that we identify through our data matching processes (i.e., through retrospective identification of primary insurance and Medicare).

HMS's sophisticated billing and recovery capabilities have helped us become the first TPL contractor to achieve \$2 billion in recoveries for our Medicaid agency clients—including more than \$48.6 million for the Michigan Department of Community Health.

HMS will continue to modify our billing media to comply with the claims filing requirements of a broad range of third party resources in Michigan, including: health insurers, BC/BS plans based outside of Michigan, plan administrators/TPAs, managed care plans (including HMOs and PPOs), TRICARE, various Federal Employee Plan (FEP) participating health insurance plans, and PBMs.

HMS submits claims to a broad range of third party resources and recovers on the broadest range of claim types, including: inpatient, outpatient, physician, long-term care, home health, pharmacy, emergency service, mental health, Medicare crossover, durable medical equipment (DME), and dental and managed care claims. **Exhibit C2-7: HMS's Extensive Data Matching and Billing Program** demonstrates the broad extent of HMS's third party billing program.

Exhibit C2-7: HMS's Extensive Billing and Collection Program for Michigan



Overview of Recovery Methodology

This methodology provides a high-level overview of the tasks involved in performing commercial insurance recoveries for MDCH. HMS applies this methodology under our current, successful Michigan TPL engagement and proposes to continue this approach under the new contract.

Our recovery methodology applies to the following commercial insurers:

- ◆ Health insurance carriers, self-funded plans, and TPAs
- ◆ BC/BS plans (large plans nationwide, excluding BC/BS Michigan)
- ◆ Managed care organizations
- ◆ Medicare supplemental (Medi-gap) plans
- ◆ TRICARE
- Pharmaceutical coverage plans/PBMs

More detailed information about HMS's specific billing protocols for insurers and PBMs appears following this methodology narrative. [These protocols are already in place under HMS's current contract and will ensure that Michigan does not experience the implementation and operational delays that it would with a new vendor.](#)

1. Identify MDCH-Paid Claims Billable to Commercial Insurers

- Based on the PCF Extract that MDCH provides, identify Medicaid and CSHCS claims that MDCH paid when other coverage was available.
- Match the results against the cumulative void file and HMS's A/R file to eliminate any claims that:
 - Either HMS or MDCH has already identified and has voided
 - HMS previously billed

2. Generate the Wide Spectrum of Billing Formats

- Prepare and submit electronic and paper billings to all payors. (HMS bills 80% of carriers electronically.)
- Instruct payors to send all checks— payable to the State of Michigan—and remittance data to the state-approved bank lock-box. [HMS already uses a lock-box arrangement maintained by the Michigan Treasury under our present TPL contract in Michigan and—unless MDCH elects to pursue a different approach—we propose to maintain this arrangement under the new contract. HMS has recently analyzed many banks' lock-box offerings on behalf of our clients nationwide, and can assist MDCH if a new lock-box is necessary.](#)

3. Remit Posting and Client Deliverables

- Receive copies of checks and remittance data sent to the Treasury, and update HMS's A/R system with the status of billed claims. When available, HMS receives and posts electronic remittances.
- Follow up on cases for which the insurance company has already reimbursed the insured or the healthcare provider. Seek reimbursement from the insured or the provider, as appropriate, via correspondence and protocols that MDCH approves.

4. Produce Client Deliverables

- Produce Coverage Update File (CUF) monthly.
- Produce recovery reports (according to MDCH specifications).
- Produce other management or financial reports as mutually agreed.

5. Carrier Refunds

- Carriers occasionally notify HMS regarding incorrectly paid reclamation claims. If this occurs, HMS will research the circumstances, and if valid, will submit a “Carrier Refund Request” form and supporting documentation to MDCH for processing.

6. Claims Follow-Up

- Monitor claims adjudication and follow-up on outstanding and denied claims—including investigation of non-payments—and post detail information to the HMS A/R system.
- Rebill claims as required.
- Periodically, follow up with carriers if claims remain outstanding.

Electronic Billings Enhance Recoveries

HMS’s billing protocols will ensure that we continue to prepare and submit Medicaid TPL claims to liable third parties, on behalf of MDCH, within federally mandated timeframes (Code of Federal Regulations, Title 42, Section 433.139).

This regulation requires state Medicaid agencies to seek recovery of third party reimbursement within 60 days after the end of the month in which the agency learns of the third party coverage.

HMS bills 80% of Medicaid TPL claims electronically.

HMS submits claims through various electronic paths—including directly to carriers (through custom platforms/interfaces that HMS develops with these carriers), and through WebMD Transaction Services. *Per RFP requirements, HMS has provided proof in this Proposal of our electronic claiming capabilities in the form of letters from several carriers* (see Section C-2.5).

HMS Submits Electronic Claims through WebMD to Facilitate Prompt Adjudication and Recovery

Insurance carriers process an extraordinary volume of claims. Accordingly, to facilitate efficient claims processing, they tend to prefer electronic claiming.

HMS submits approximately 80% of most Medicaid TPL claims through various electronic platforms, including WebMD Transaction Services. WebMD Transaction Services submits electronic claims to nearly 85% of group health reimbursement plans in the nation—which makes it a major “gateway” for electronic Medicaid TPL claims.

By using WebMD Transaction Services, HMS achieves faster turnaround on claims, automatic front-end pre-editing of claims, and a vehicle for tracking claims in the adjudication process. Processing similar claim volumes on paper would take months and would generate increased rejections and lower recovery levels.

HMS's Partnership with WebMD Transaction Services Shows our Commitment to Enhancing Revenue Recovery Technology

HMS's highly effective partnership with WebMD Transaction Services establishes HMS as a pioneer and innovator in the field of revenue collection. HMS is WebMD's top client in terms of the number of Medicaid TPL claims submitted. Furthermore, our billings to WebMD have an initial acceptance rate of 98%—a very high acceptance rate for Medicaid TPL claims.

As the following examples demonstrate, HMS's ongoing work with WebMD Transaction Services has improved Medicaid TPL claims processing nationwide.

Example 1

WebMD Transaction Services, with substantial input from HMS, designed an electronic claim record that has significantly increased claim acceptance rates. WebMD Transaction Services implemented a unique record type for Medicaid TPL that addresses two fields on Medicaid claims: (i) provider of services and (ii) amount to be paid. Together, these fields generated the majority of denials, pends, queries, and incorrect payments on Medicaid TPL claims. (Before implementation of the new record type, carriers rejected up to 50% of WebMD claims.)

WebMD has implemented this unique Medicaid TPL claim record type for all of its customers—an example of HMS's ability to effect sweeping change on behalf of our revenue recovery clients.

Example 2

HMS is proud to be one of two participants in a WebMD Transaction Services pilot project for prescription claim billing. This project may expand to other carriers in the future, thereby creating a vehicle for submitting electronic Medicaid TPL claims to carriers that offer a pharmacy component but are not “true” PBMs.

Example 3

HMS works directly with our WebMD account representative to expand WebMD Transaction Services' carrier network—and accordingly, the scope of possible Medicaid TPL billings. For example, Mutual of Omaha, Humana, BC/BS Maryland, and BC/BS Massachusetts recently joined the WebMD network. Other carriers presently in a testing mode with WebMD include HealthNet, BS California, and Oxford.

HMS Also Has Electronic Billing Platforms with non-WebMD Carriers

For non-WebMD Transaction Services carriers, HMS performs carrier-specific electronic billings (primarily with BC/BS plans and TRICARE) or paper facsimile billings, depending on the technical environment of the carrier.

HMS currently submits electronic claims for inpatient, outpatient, physician, pharmacy, home health, and long-term care services. Furthermore, we maintain a staff of systems specialists who continually work with insurers, PBMs, and other claims payors to develop and enhance electronic billing and remittance platforms.

Both MDCH and third party insurers “win” when HMS bills claims electronically. Specifically, insurers can adjudicate claims more accurately and remit payment more quickly than with paper claims, which insurers must enter manually into a processing system. This increased efficiency means earlier recoveries for MDCH and lower cost and staff burden for insurers.

[HMS and the ANSI 835/837 Transactions](#)

HMS has already been certified for both the professional and institutional-type 837 claim transactions (v4010 and v4010A) and is in the process of becoming certified in all HIPAA transactions, including the 835 transaction.

We believe that obtaining certification on the standard 837 transactions will facilitate testing and approval on the reclamation claim transaction, once it is finalized by the ASC X12N committee and made law. In addition, we have determined that we can use the standard 837 medical format to submit TPL claims to Medicare Part B.

HMS already receives and processes transactions that are ANSI-835 compliant for some Medicare B carriers, BC/BS plans, and for commercial insurers that we bill through WebMD.

HMS anticipates extensive use of the 835 and 837 transactions in the future.

Billing Third Party Health Insurance Resources

The following narrative provides detailed information about how HMS proposes to effect recoveries from specific third party resources.

[Health Insurance Carriers](#)

HMS’s successful, ongoing experience with TPL recovery in Michigan—and for more than 25 other clients, most of which are state Medicaid agencies—supports our ability to continue providing these services for MDCH within the federally required 60-day timeframe.

HMS will continue to bill the liable carriers, and provide third party coverage data that enables MDCH to cost avoid claims.

HMS’s eligibility network includes 109 carriers and is the largest network in the revenue recovery industry.

HMS has assembled the most comprehensive health insurance data exchange network that exists today—in Michigan and nationwide—for purposes of identifying other third party coverage (see **Exhibit C2-1: Crossmatch and Billing Agreements**). Our in-place, Michigan-specific carrier network and highly effective billing protocols far exceed the similar capabilities of any other vendor.

Because of this network, HMS can ensure that Medicaid remains the payor of last resort and that MDCH complies with federal requirements to cost avoid claims when there is known third party liability. HMS will use this proprietary health insurance network to identify past and present third party coverage eligibility periods that overlap with periods of Medicaid eligibility and to ensure a continuous flow of recoveries from primary sources of third party health insurance coverage in the state.

Blue Cross/Blue Shield

HMS acknowledges that eligibility matches with and recoveries from BC/BS Michigan are outside of the scope of this solicitation. However, HMS proposes to deliver maximum recoveries for MDCH by continuing to bill BC/BS plans based outside of Michigan that serve Michigan residents. Depending on the individual BC/BS plan, HMS produces recoveries through direct billings, provider recoupments, and negotiated settlements.

Data Match/Direct Billing. HMS has a highly successful track record of enlisting BC/BS plans to participate in third party data matches and related recovery activities. HMS has developed match and billing arrangements with many BC/BS plans (including Anthem BC/BS (Ohio)), the BC/BS Association (for Federal Employee Plan (FEP) enrollees), and is currently negotiating with BC/BS National Account Service Company (NASCO).

Through HMS's long-standing relationships with different BC/BS plans, we have developed highly specialized platforms to address the plans' unique requirements for billing Medicaid TPL claims. We submit billings to BC/BS plans electronically or on paper, according to individual plan requirements.

In addition, some BC/BS plans subcontract with pharmacy benefits managers (PBMs). HMS extends the reach of our BC/BS billing and recovery efforts by working with these PBMs.

As a result of HMS's proactive approach to working with BC/BS plans, HMS's recoveries from BC/BS plans have increased significantly with each successive billing.

Provider Recoupments. For some BC/BS recovery projects, HMS sends "Notices of Intent to Recover" letters to providers. These letters identify Medicaid payments that HMS has identified as erroneous and for which BC/BS appears to be the liable third party. These letters also express the Medicaid agency's intent to recover the erroneous payments from the providers. Providers then have a specified time period during which they may submit documentation disputing claim recoupment. As HMS receives documentation (i.e., BC/BS denials) from providers for the identified claims, we update our Accounts Receivable (A/R) system. At the end of the provider response period, HMS prepares and submits to the Medicaid agency a tape or listing of recoverable claims. The Medicaid agency/MMIS staff then processes these claims to recover erroneous payments from the providers.

Settlements. HMS has an unparalleled track record of successfully negotiating settlements or advance payment arrangements with BC/BS plans, resulting in large cash recoveries for our clients.

- On behalf of **Iowa**, HMS submitted over 225,000 claims to the BC/BS carrier and negotiated a **settlement amount of \$5.3 million**.
- In **New Jersey**, HMS partnered with the Department of Human Services to negotiate a **\$15 million settlement** on outstanding claims and continues to support the Department's ongoing efforts to forge settlement agreements and reimbursements.
- For **Massachusetts**, HMS submitted **\$29 million** over six billing cycles to BC/BS. Due to systems problems, the BC/BS plan had difficulty processing the claims. HMS then negotiated with BC/BS to make an initial payment of \$2.5 million, until the plan could overcome processing problems and adjudicate the claims that HMS submitted. BC/BS recoveries in Massachusetts alone now exceed **\$62 million**.

These results demonstrate:

- ◆ HMS's specific expertise in negotiating payment arrangements with BC/BS plans
- ◆ HMS's ability to obtain cooperation from BC/BS plans for Medicaid third party recovery
- HMS's commitment to pursue all claim types for our clients

BC/BS Federal Employee Plan Data Matches. HMS is the only vendor having an agreement with the BC/BS Association to obtain subscriber eligibility files for individuals enrolled in the BC/BS Federal Employee Plan (FEP). HMS uses these data to identify Medicaid recipients who also have healthcare coverage through the BC/BS FEP Plan and bill claims to the appropriate FEP processor. To date, HMS has recovered approximately **\$7.0 million** from our FEP projects: \$5.0 million through direct billings to affiliated carriers and approximately \$2.0 million in FEP-related recoupments to providers.

TRICARE

HMS's TRICARE recovery capabilities include:

- **Recoveries for 23 state Medicaid agencies.** HMS has conducted highly successful TRICARE data match and billing projects for its Medicaid agency clients for 18 years.
- **Strong relationships with TRICARE fiscal intermediaries (FI).** This includes Palmetto GBA, the FI that handles all claims processing for TRICARE enrollees in Region 5 (Heartland), which includes Michigan.
- **Electronic billing and remittance capabilities.** HMS bills all TRICARE claims and claim types electronically.
- **On-line eligibility access to the GIQD System.** This capability enables us to verify eligibility and coverage periods for TRICARE eligibles.

- **Ongoing enhancements to TRICARE processing.** HMS has performed detailed assessments for several aspects of our TRICARE processing. Specifically, we analyzed:
 - ◆ DEERS data match results
 - ◆ Eligibility categories (sponsor/dependent)
 - ◆ Billing amounts and recoveries by claim type
 - ◆ Adjudication rates
 - Denial categories

As a result of these analyses, HMS implemented several system modifications that have increased our TRICARE recovery yields by 10% - 15%.

- **State agency and federal reporting capabilities.** HMS ensures full compliance with state and federal (CMS) reconciliation and reporting requirements.

Billing Pharmacy Benefits Managers

HMS's eminent qualifications to perform pharmacy billing and recovery services are illustrated by our innovative billing approaches, electronic pharmacy claims expertise, and active participation in NCPDP workgroups.

HMS has recovered approximately \$500 million to date in pharmacy payments for our Medicaid agency clients.

Overview of HMS's Approach to Pharmacy Recovery

HMS's approach to maximizing pharmacy recoveries, which is already in place for MDCH, includes the following key components:

1. Identify and Bill the Appropriate Processor (Generally a PBM)

- HMS requests and obtains group/PBM information from carriers if possible. We request this information on eligibility files or reference files, if available.
- HMS proactively identifies and maintains group/PBM information in our eligibility system. HMS:
 - Places telephone calls to identify and maintain PBM/other benefit manager information for many thousands of groups annually
 - Maintains group information in our Group Capture System, which enables us to bill or rebill all eligible claims to the appropriate PBM as soon as we identify specific information related to a group carrier change

2. Present Clean and Accurate Claims to the PBM in an Electronic Format Compatible with the PBM's System

- HMS **bills electronically** to PBMs whenever they will accept electronic subrogation/COB claims.
- HMS proactively works with carriers through industry workgroups, such as NCPDP, and through other trading partners to advance the format/process by which we submit claims. HMS:

- Actively participated in the workgroup that developed the NCPDP Medicaid Subrogation v.5.1 format (an industry-adopted format that supports subrogation pharmacy claims)
 - Has tested the NCPDP v.5.1 format with Medco Health.
 - Is working with a major industry player to develop methodologies to bill subrogation claims in a state-of-the-art manner
- HMS maintains a National Association of Boards of Pharmacy number database for all providers in client states so that the pharmacy's NABP number can be added to each claim. This information is generally not on the claim but is sometimes required and always helps facilitate efficient claim adjudication.

3. Work Cooperatively with PBMs to Ensure Timely and Accurate Claims Processing

- After submitting claims, HMS follows up with PBMs to ensure that they received our transmissions and to ascertain claims processing schedules. (Although electronic submissions generally facilitate high claims processing volumes, PBMs still have limitations regarding the number of claims they can process each day.) HMS monitors claim adjudication and ensures the PBMs are processing according to schedule.

[HMS monitors remittances and billing results to identify issues and secure maximum recoveries for our clients.](#) Through monitoring, we ensure that HMS has submitted claims correctly and that PBMs process claims correctly. Monitoring has helped HMS identify many nuances involved in effective claims submission (e.g., one PBM requires that the relationship code appear at the end of the certificate number). We have also identified and helped PBMs resolve significant processing errors—substantially increasing recoveries for our clients. For example, recovery results from a recent large pharmacy claims submission were lower than we expected. Deciding to investigate, HMS asked the PBM to re-verify a number of the denials. Upon re-examining the claims, the PBM determined that it had, in fact, erroneously denied many of the claims due to an incorrect edit that was active during the processing. The PBM agreed to reprocess these claims—which doubled the original payment rate.

Innovative Billing Approaches

The HMS team applies creative approaches to develop extraordinary pharmacy recovery solutions for each of our clients, leading to a number of “firsts.” HMS is the [first](#) revenue recovery company to:

- Test [NCPDP 5.1](#) subrogation billings with PBMs
- Test [real-time](#) subrogation billings with PBMs
- Have a systematic process for claims follow-up and the only company with significant staff resources assigned to this process

Largest Pharmacy Benefit Management Payor Network

HMS makes it easy for every PBM to enter HMS's growing network of payors. We have consistently demonstrated to the industry that paper processing is obsolete. PBMs strive to reduce their workload and increase their productivity, both of which are inherent to our service offering. As a result, more and more payors are eager to join us since some claim processors require little more than a few changes on their end. Grateful to do away with piles of claims and the cumbersome management of batched files, PBMs find HMS's efficient electronic systems attractive. Of course, more payors mean more recoveries for our clients.

HMS leads the industry in establishing effective PBM billing and recovery protocols, with over \$500 million recovered to date. Our high adjudication rates and maximum recovery results are attributable to the fact that we work with each PBM to ensure that we submit a claim format that the PBM can process.

Many insurers and PBMs are changing their processing systems to accept electronic claims in National Council for Prescription Drug Programs (NCPDP) formats. These formats are based upon the standards used for point-of-sale systems. **HMS has more than 10 years of experience billing NCPDP claims and currently bills approximately 63% of our pharmacy claims in this format.**

HMS has established specialized billing processes with the PBMs listed in **Exhibit C2-8: HMS Billing and Remittance Formats for PBMs.**

Exhibit C2-8: HMS Billing and Remittance Formats for PBMs

PBM	Billing Format	Remittance Format
Advance PCS	NCPDP	Electronic
Medco Health	NCPDP	Electronic
Express Scripts/Diversified	NCPDP	Electronic
Aetna Pharmacy Management	NCPDP	Electronic
MedImpact	NCPDP	Electronic
Anthem Pharmacy Management	NCPDP	Electronic
Argus	NCPDP	Electronic
Rx Prime	NCPDP	Electronic
PharmaLink	Paper	Paper
Caremark	Paper	Paper
Value Rx	Paper	Paper
Wellpoint	Paper	Paper
NMHCRx	Paper	Paper

HMS is presently working with Caremark and Wellpoint to develop electronic billings. HMS is also seeking approval from several other insurers and PBMs (including Prescription Solutions, Pharmacy Services Group, and RxOptions) to perform electronic billings.

HMS Works Closely with NCPDP and Other Industry Committees

HMS is an active participant in industry committees and workgroups that address pharmacy recovery issues, including the committee that is developing the NCPDP Medicaid Subrogation v.5.1 claims layout. We believe strongly that this participation and information sharing creates synergies that benefit all stakeholders involved in pharmacy reclamation billing processes.

NCPDP Governmental Workgroup. Two HMS employees participate in the NCPDP Governmental Workgroup: Fran Coury, HMS's Project Manager for this procurement, serves as Co-Chair, and Robert Dickerson, HMS's PBM Relations Manager, participates as a member. In this capacity, they are helping develop the NCPDP Medicaid Subrogation v.5.1 claims layout. This claims layout is the subrogation corollary to the NCPDP Telecommunication Standard Format, Version 5.1. HIPAA final standards for electronic healthcare transactions and code sets have adopted this format and the NCPDP Batch Standard Version 1 Release 1 for pharmacy claims. Health plans, health clearinghouses, and healthcare providers who use electronic transactions were to comply with these standards as of October 2002. Although HIPAA does not yet mandate a subrogation/TPL format for pharmacy claims, HMS believes that this requirement will eventually exist, and accordingly, we are working closely with NCPDP to define the standard. HMS is actively testing this billing format with Medco Health, a PBM to which HMS submits approximately 10% of our total pharmacy claim volume. Chuck Anderson, HMS's Vice President of Commercial Insurance, is also actively involved in NCPDP. Over the course of more than 20 years in the industry, Mr. Anderson has led the development of various innovations in pharmacy information technology and operations.

CMS Pharmacy Reimbursement Team. In addition to our work with NCPDP, HMS has advised members of the CMS Pharmacy Reimbursement Team and provided solutions to issues regarding current and future Medicaid TPL claim submissions. The CMS Pharmacy Reimbursement Team includes representatives from CMS, state Medicaid agencies, and PBMs.

c. Produce Billed CRN File Extract

Produce and send a Billed CRN File extract to the MDCH within one month of billing the carrier.

HMS affirms that we will produce and send a Billed CRN File extract to MDCH within one month of billing the carrier. HMS prepares this file under our current contract with MDCH. The CRN is a file that contains information on the claims HMS bills to third parties and includes the following fields:

- ◆ Medicaid Beneficiary Identification Number
- ◆ MDCH Carrier Code
- Claim CRN

d. Reconcile Claim Payments/Rejections

Reconcile carrier claim payments and rejections.

HMS uses a sophisticated Accounts Receivable (A/R) system and employs thorough claims follow-up protocols. Together, these capabilities help HMS monitor carrier payments and denials to the individual claims level.

Accounts Receivable System

HMS will store every claim that we bill on behalf of MDCH in our automated, fully integrated Accounts Receivable (A/R) system. This proprietary system is the cornerstone of our claims status, financial, and management reporting system for all revenue recovery and financial reporting requirements. We update the A/R, manually or electronically, with all remittance data (payments and denials) that we receive from carriers, providers, and fiscal intermediaries. For claims submitted through WebMD Transaction Services, we receive electronic updates from WebMD Transaction Services Claim Status Check, providing the status of each claim adjudicated by the carriers.

The A/R system is sufficient to provide an audit trail for state and federal documentation requirements. In addition, HMS's A/R are compatible—and will continue to be compatible—with and capable of updating the TPL Billing File in the MMIS.

A/R System Features

HMS's A/R system:

- Maintains individual, claim-specific records on each claim that HMS bills for all revenue recovery projects (e.g., commercial insurance (including pharmacy), BC/BS, Medicare Parts A and B, TRICARE, and overpayment recovery). For every claim we submit to a third party, HMS can certify that we have received either payment or a valid denial of payment.
- ◆ Generates the following client deliverables:
 - ◆ Audit listings/tapes
 - ◆ Recoupment listings/tapes
 - ◆ Refund notices
 - ◆ Void listings/tapes
 - ◆ Financial adjustment listings/tapes
 - ◆ Cost avoidance reports/tapes for updating the MMIS
 - ◆ Invoice documentation
 - ◆ Recovery reports/follow-up reports
 - Daily, weekly, monthly, quarterly billing cycle reports
- ◆ Automatically updates the HMS Database and Group Capture System with remittance data to:
 - ◆ Eliminate non-covered groups, insurers, dependents, and claim types from future billings
 - Create new or updated carrier/group coverage information

- Generates key project statistics to complete client monthly project status reports and other ad hoc client reports
- Produces managerial reports that HMS uses to ensure quality control of all output
- Generates reports that HMS claims follow-up staff use to monitor adjudication rates, identify non-adjudicated claims populations, and rebill open and denied claims
- ◆ Provides data file link to MDCH—including update of billing, recoupment, and cost avoidance files directly to the MMIS and its subsystems.

[HMS Monitors Claims Adjudication through the A/R](#)

HMS monitors claims adjudication through the A/R system. We follow up on unprocessed claims to obtain the adjudication status of all billed claims. Our billing platform includes a sophisticated prioritization and calendaring function that our staff can use to identify the appropriate point to initiate telephone follow up with carriers and third parties. We analyze, correct, and resubmit rejected claims until we can determine that third parties have correctly paid or processed all claims.

[Identifying and Recording Denial of Claims](#)

HMS's sophisticated A/R system incorporates full tracking capabilities—to the claim level—for all HMS-billed claims (including those paid and denied by third party carriers).

The A/R system contains individual, claim-specific records on each claim that HMS bills for all revenue recovery projects (e.g., commercial insurance (including pharmacy), BC/BS, Medicare Parts A and B, TRICARE, and overpayment recovery). For every claim we submit to a third party, HMS can certify that we have received either payment or a valid denial of payment. In the event of a denial, the A/R system captures and records the reason for denial.

Furthermore, the A/R system generates reports that HMS uses to monitor adjudication rates, identify non-adjudicated claims populations, and rebill open and denied claims.

Denied claims are not necessarily unrecoverable claims. HMS analyzes, corrects, and resubmits rejected claims until we can determine that third parties have correctly paid or processed all claims: HMS's follow-up protocols include the following examples:

- HMS analyzes all denials when the carrier that HMS originally billed asks that HMS refile the claim to a new payor. For example, we often refile claims for specialty services—such as pharmacy and mental health/substance abuse services—when separate vendors provide those services under a given health insurance contract (e.g., a PBM or an MH/SA carve-out).
- HMS analyzes all denials for which the carrier needs additional claim field information. HMS requests additional data from providers—such as original itemized bills, which may contain more information than the Medicaid Paid Claims File (or PCF Extract).
- HMS analyzes denials where preauthorization was not obtained for a recipient's hospital stay. HMS will request medical records from the provider and appeal the denial, indicating that services were medically necessary and should be payable under the third party coverage.

In addition, an A/R system enhancement that HMS is now piloting includes payment and denial reports (i.e., explanation of benefits forms) that MDCH's contract management staff and auditors will be able to view on-line. HMS is now imaging all paper documents that reflect TPL payments and denials and storing these documents electronically. Documents will be accessible through a secure, password-protected Internet connection. If desired, MDCH contract management staff will be able to retrieve documents directly or by asking the HMS Project Manager to obtain reports through system queries. (Note: MDCH will be able to view only those documents that pertain to the Michigan TPL contract.)

The A/R System Provides an Audit Trail

The A/R system also provides a comprehensive audit trail for all transactions associated with Medicaid claims that HMS submits. The system records all activity on each claim, together with the identifying code of the employee who updates the record. All employees who have access to the A/R have authorization to post certain actions to the A/R. However, only the A/R Supervisor may post actions outside the norm. HMS will provide these audit trails to MDCH upon request.

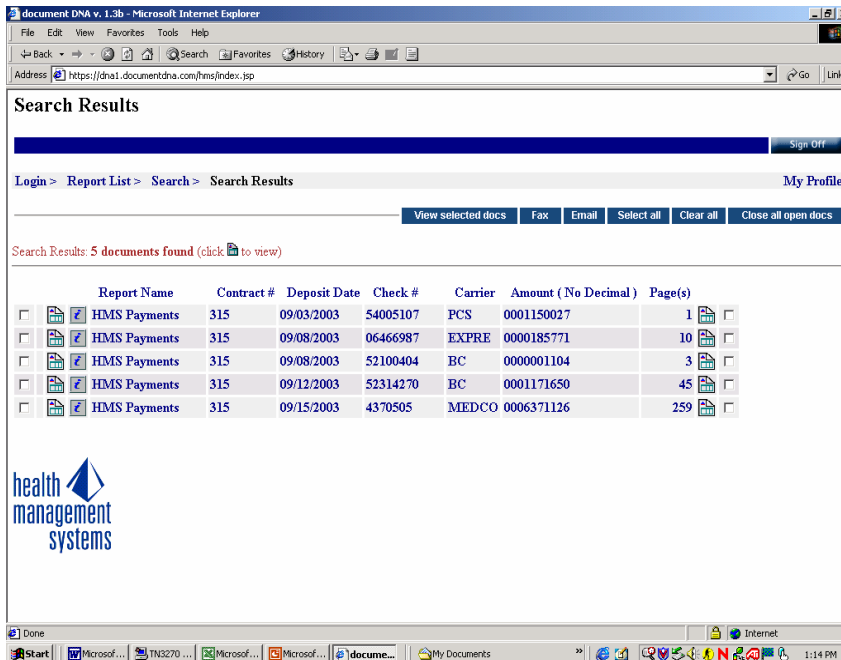
Client Access to Full TPL Payment Documentation

HMS is preparing to implement an A/R system enhancement that will facilitate both HMS and MDCH efforts to monitor recoveries. We have been piloting this enhancement with selected clients in recent months and—based on their positive response—will introduce it to additional clients in the near future.

HMS is now imaging all paper documents that reflect TPL payments and denials and storing these documents electronically. Documents are accessible through a secure, password-protected Internet connection. Clients can retrieve documents directly or by asking their HMS Project Manager to obtain reports through system queries. Clients may view only those documents that pertain to their respective TPL contracts.

The available documents—including payment and denial reports (i.e., explanation of benefits forms) and deposit slips—demonstrate the full extent of HMS's recovery efforts and will be extremely helpful to clients in a variety of contexts—for example, audits and routine project management. After identifying the type of report(s) they want to view, users focus their search by applying various criteria, including dates and text fields (e.g., carrier name). Users can view, store, and print retrieved documents, or transmit them by facsimile or e-mail. **Exhibit C2-9** is a sample search results screen view from this A/R system enhancement.

Exhibit C2-9: Search Results Screen View



Follow Up on Billed Claims

“Yield management” is HMS’s unique process through which we monitor and follow up on billed claims. HMS gathers more claim data than does any other revenue recovery vendor. We use these data to rebill an estimated \$5 million in claims each week, or approximately \$250 million each year—thereby increasing recovery yields by 25% - 30% for our clients.

HMS is the only revenue recovery contractor that has a staff unit dedicated to claims follow up.

HMS knows that many denied claims are actually eligible for recovery. We use data that we obtain through the yield management process to identify these unpaid claims and to pursue payment. To ensure that we recover all monies to which our clients are entitled, we actively and consistently communicate with third parties. For example, we provide the third parties with any additional information they may need to complete the recovery process (through either a payment or valid denial of a claim). **HMS is the only revenue recovery contractor that pursues billed claims to this extent.**

HMS’s yield management process comprises three phases:

Verify receipt of claims. HMS verifies that WebMD Transaction Services and carriers with which we have independent billing agreements have received and accepted our claims.

Monitor claim adjudication. Throughout the carrier’s claim adjudication process, HMS examines large pools of data—electronically—sorted according to “key indicators,” which we describe in more detail below. We use these data to identify potential adjudication and processing problems or anomalies.

Perform follow-up projects. HMS performs a broad range of follow up projects, depending on the type of adjudication issues that we identify through monitoring. We employ experienced healthcare recovery specialists (including staff members who have experience in the pharmacy benefit management industry).

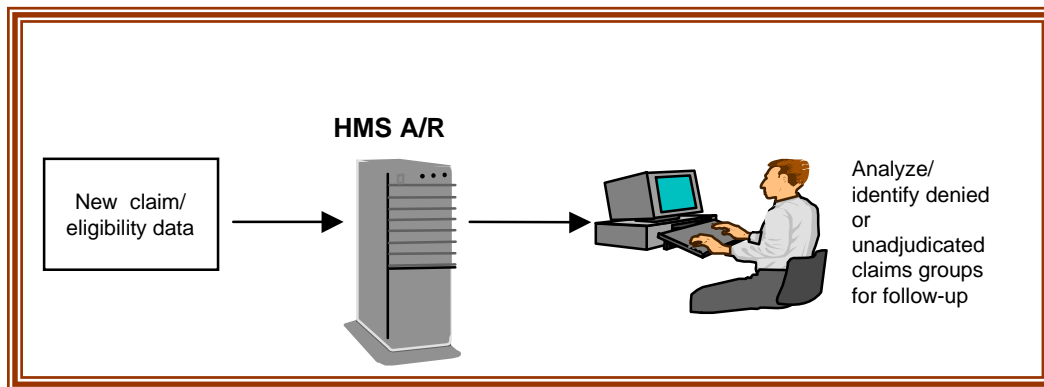
Step 1: Verify Receipt of Claims

Because we submit most claims electronically (approximately 80%), HMS can easily verify whether the third party resource has received them:

- **WebMD Transaction Services Claims.** Approximately 24 hours after we submit claims, HMS dials into WebMD and reviews a Front End Edit Report. This report identifies (by state) the claim dollars submitted, accepted, and rejected. HMS has established a highly effective working relationship with WebMD, and **our claim acceptance rate through WebMD exceeds 99%**. This is an extraordinary first pass rate—by any standard.
- **Non-WebMD Carriers.** HMS confirms receipt of claims directly with each carrier. Some carriers (e.g., Aetna) are able to confirm receipt within minutes after we transmit the data.
- **PBMs.** Each PBM that works with HMS has designated a liaison that confirms receipt of our transmissions/tapes and alerts us to any potential problems. HMS maintains ongoing communication with PBMs throughout claim adjudication.
- **TRICARE.** HMS submits claims electronically and receives a Front End Edit Report the next day. This report identifies (by state) the claim dollars submitted, accepted, and rejected.

Step 2: Monitor Claim Adjudication

Exhibit C2-10: HMS Actively Monitors Claims to Ensure Payment/Adjudication



As shown in **Exhibit C2-10**, HMS actively monitors the adjudication of commercial insurance claims.

On an ongoing basis, HMS updates our third party coverage database and our A/R system with all recovery and adjudication data that we receive. Our team of specialists then analyzes HMS's A/R data and produces reports that show claim status and adjudication results for more than 20 key indicators/perspectives. HMS has learned over time that these indicators/perspectives are most likely to help us identify claim populations that merit additional follow up. They include the following:

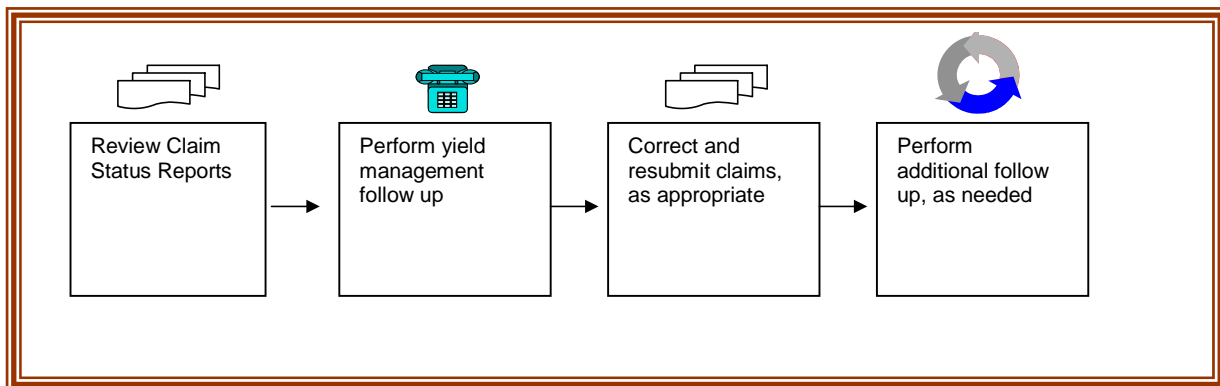
- ◆ Carrier
- ◆ Carrier and group
- ◆ Different carrier offices
- ◆ Billing transmission
- High-dollar recipient

In addition, HMS receives and reviews weekly Claim Status Update tapes from WebMD Transaction Services. These data identify every status change for every claim that HMS has submitted to WebMD. For example, whenever a carrier “touches” a claim (e.g., to acknowledge receipt, initiate claim processing), WebMD records the event. HMS transfers data from the Claim Status Update tapes to our A/R, where it is available for further analysis.

The benefits of HMS's monitoring activities appear throughout the claim life cycle. Such monitoring helps HMS identify the need for appropriate “interventions”—i.e., follow up projects (step 3)—that may result in higher payment rates.

Step 3: Perform Follow Up Projects

Exhibit C2-11: HMS Performs Follow Up Projects to Ensure Maximum Adjudication/Recovery



Based on the claim populations or issues that we identify through monitoring activities (step 2, above), HMS selects from a broad range of possible follow up activities to ensure maximum claim adjudication. These activities include:

- **Carrier follow up.** HMS establishes high-level carrier contacts and conducts in-person meetings (if necessary) to resolve processing issues. For example, we might suggest electronic claim processing if EDI protocols are not already in place with a specific carrier. HMS also has account managers assigned to each pharmacy benefit manager. These specialists are experts in working with each PBM's billing and remittance process.
- **Pharmacy group follow up.** HMS identifies and contacts employer groups with outstanding pharmacy claims that have low or no payment rates.
- **Confirmation of eligibility and benefits.** HMS uses websites such as Medco Health for the most accurate information.
- **Bill-type follow up.** HMS identifies and resolves electronic billings that a carrier did not process.
- **Office follow up.** HMS identifies and contacts specific carrier offices that are not processing claims according to an expected standard.
- **Denial analysis.** HMS reviews and identifies inappropriate carrier denials and queues specific denials for recovery and/or appeal.
- **Recipients with a payment history.** HMS follows up on unpaid claims for recipients who have prior recorded payments from the same third party payor.
- **Type of service follow up.** HMS reviews and attempts to resolve claim types that have lower than expected adjudication rates.

Claims Follow-Up Activities and Results in Michigan

HMS performs claims follow-up activities under our existing Michigan TPL contract, with the following results achieved for MDCH:

- Amounts rebilled in 2003 by regenerating and refiling claims: \$8.2 million
- Amounts rebilled to a new payor in 2003 through group/employer carrier changes: \$8.7 million

In addition, HMS has identified a commercial insurance policy that pays custodial long-term care claims for a group of General Motors retirees. To receive reimbursement on these claims, HMS provides CIGNA with information that allows the carrier to coordinate benefits with Medicare (the primary coverage) and BC/BS (the secondary coverage). Since 1997, HMS has recovered more than \$4.7 million—from this project alone—for MDCH.

Group Capture System: Another Unique Feature of HMS Yield Management

Another important element of HMS's yield management approach is our Group Capture System, which helps us produce higher recoveries and more accurate cost avoidance data for our clients. When HMS receives remittance data indicating that we should forward certain claims to another carrier, we triage these data to our Group Capture System follow-up unit. Unit staff members then update the HMS third party coverage database. This update automatically results in refiling of all applicable claims to the new carrier and ensures that future claims go to the correct payor. For example, if remittance information indicates that a group uses a PBM for pharmacy claims adjudication, HMS adds the name of the PBM to the group record and automatically rebills all outstanding pharmacy claims for that group to the appropriate PBM. HMS will also continue to bill the PBM directly for future claims.

The Group Capture System also extends the range of HMS's commercial insurance carrier network. If HMS discovers that a group has moved to a carrier that is not in our data match network, we bill the group's claims to the new carrier and then take steps to add this carrier to our network. HMS performs over 1,000 group updates each year and—as a result, through the Group Capture System alone—rebills more than \$30 million in claims to new carriers.

e. Establish Lock-Box Process

Establish a Lock-Box process for payments from carriers that is agreeable to the MDCH.

Under our existing contract with MDCH, insurance carriers and claims processors send checks and remittance documentation for HMS's billings to a post office box at the Michigan Treasury. Copies of the checks and documentation are forwarded by Treasury to MDCH Accounting and then sent to HMS. To avoid confusion with third party payors, HMS recommends maintaining this lock-box arrangement.

HMS proposes the following lock-box protocols:

- As suggested by the RFP, HMS will continue to use the current lock-box arrangement with the Department of Treasury.
- Alternatively, HMS will establish the lock-box, in MDCH's name, at an agency-approved institution. HMS will bear all costs of the lock-box throughout the duration of the contract. HMS is satisfied with its current relationship with the Michigan Treasury lock-box, and all HMS requested protocols are being followed. If MDCH would like to investigate alternatives under the new contract, HMS is presently analyzing lockbox product offerings on behalf of other clients, and can suggest banks for MDCH's consideration.
- HMS will specify that checks are to be made payable to the State of Michigan will identify the lock-box address within our correspondence. Placing this information on the bills reminds carriers to send remittance correspondence to the correct payee and address—thereby expediting recoveries. HMS will instruct carriers to include with the check either a remittance advice or third party documents identifying the recipient, the type and date of service, and the amount of payment.
- The Treasury will deposit all checks into the designated HMS TPL account and will forward a copy of the checks, remittance documentation, and deposit slips to MDCH Accounting.
- Daily, MDCH will send remittance correspondence to HMS's keypunch vendor in Troy, Michigan. HMS will post updates to our A/R system.
- Monthly, the Treasury will send a bank statement to HMS, showing all the activity in the lock-box account during that month.

HMS monitors claims adjudication and follows up on outstanding and denied claims through our claims follow-up process.

f. Establish Protocols for Handling Checks

Ensure that all checks from carriers are made payable to the “State of Michigan” and that all deposits are forwarded to the state’s account within one week of deposit.

HMS will inform carriers to make checks payable to the “State of Michigan.” Within one week after receipt of checks, the bank will deposit all checks from the lock-box into the state’s interest bearing lock-box account and will forward deposit slips to MDCH, which forwards these to HMS.

g. Reconcile Deposits

Reconcile all deposits with the MDCH Accounting Division.

HMS affirms that we will reconcile all deposits with the MDCH Accounting Division. MDCH receives lockbox receipts even before HMS, so the Department is able to carefully track HMS’s invoice deposit amounts against its own tallies. HMS prepares a reconciliation of daily deposits and includes it as part of the monthly invoice package to MDCH.

h. Produce Coverage Update File (CUF)

Produce and send a CUF to the MDCH monthly.

HMS understands the importance of providing accurate and timely third party coverage data to our clients. State agencies use this information for cost avoidance purposes. Medicaid and other state-sponsored health plans are payors of last resort—paying only after healthcare providers have exhausted available third party coverage resources. By denying a Medicaid claim when other healthcare coverage exists, a state agency can significantly reduce its administrative and benefits costs.

As the national leader in third party coverage verification and cost avoidance, HMS has generated over \$4 billion in cost avoidance savings for our Medicaid state agency clients through the identification and verification of over 1 million insurance policies.

To help MDCH ensure that its TPL Coverage File is accurate and current, HMS will provide verified cost avoidance data monthly (or according to another time interval that MDCH may request).

HMS is the national leader in providing accurate, verified cost avoidance data.

Depending upon MDCH requirements, HMS will transmit these data via tape (as we currently do), batch CPU-to-CPU transmission (NDM), or FTP from HMS directly to the MMIS system. At the request of MDCH, HMS will also provide hard copy listings of these updates.

Requirements for cost avoidance data vary from state to state. However, typical data fields that HMS provides to other clients include:

- ◆ Name of recipient who is the named insured and/or a dependent of an insured recipient or non-recipient (i.e., spouse, parent, or noncustodial parent)
- ◆ Recipient's Medicaid identification number
- ◆ Policy holder's name and relationship to the program-eligible person, if different
- ◆ Name(s) and state-assigned codes of all liable third parties, including PBMs
- ◆ Addresses for billing Medicaid claims
- ◆ Policy and group number(s)
- ◆ Begin and end dates of insurance coverage
- ◆ Employer information, if available
- Scope of coverage (e.g., basic major medical, managed care plans, pharmacy)

HMS currently provides the following field on its CUF file, which we can expand at MDCH's request:

- ◆ Record type
- ◆ Recipient identification
- ◆ Create date
- ◆ Begin date
- ◆ Control number
- ◆ Policyholder name
- ◆ End date
- ◆ Carrier ID
- ◆ Policy number
- ◆ Relationship to insured
- ◆ Other insurance code
- ◆ Contract number
- ◆ Policyholder Social Security Number
- ◆ Employer name
- ◆ Employer address
- ◆ Employer street
- ◆ Employer city
- ◆ Employer state
- ◆ Employer ZIP Code
- ◆ Source county
- ◆ Health scope
- ◆ Policyholder address
- ◆ Policyholder street
- ◆ Policyholder city
- ◆ Policyholder state
- ◆ Policyholder ZIP Code
- ◆ Sponsor branch of service
- ◆ Sponsor status

- ◆ Verified health code
- ◆ Recording date
- Comments line 1

HMS will transfer to the MMIS all details of verified third party coverage information and will promptly resolve any missing details. For example, if HMS provides MDCH with an invalid carrier code, we will identify the proper code and update the MMIS.

i. Produce Invoice

Invoice the MDCH for recoveries received from carriers monthly.

HMS will prepare invoices—with supporting documentation regarding commercial insurance recoveries during the invoice period—for MDCH.

HMS will customize each invoice to meet MDCH requirements. A sample invoice appears under **Attachment 2** of this Proposal.

Refunds Related to Erroneous Recoveries

Third party carriers occasionally determine that they have incorrectly paid a reclamation claim from HMS. We typically receive these refund requests through the project lock-box. First, we look up the related claims on our Accounts Receivable system to verify that we received payment and that the carrier has specified a valid reason for the refund. Next, we forward the carrier notice and a refund memo to the state agency and ask the agency to reimburse the carrier. Finally, on our next invoice, we credit the agency for fees associated with the inaccurate recovery.

Enhanced Recoveries from Commercial Insurance and TRICARE

HMS proposes to perform the following, additional project enhancements to increase commercial insurance and TRICARE cost avoidance and recoveries for MDCH:

Exclusive Provider Organization (EPO) Recovery/Appeals

HMS actively pursues claims, through our appeals process, where third party coverage exists but has a rendering provider restriction that prevents the claims from being paid in the commercial carrier's normal process. An example would be a claim denied for "no prior authorization" or "provider not in network." HMS would obtain written approval from the Bureau prior to engaging in any action that could be construed as a legal action for collections.

Commercial Contractual Discount Coordinated Disallowance

Through our disallowance process, HMS will recover claims paid to providers who have billed a commercial carrier and received payment in full under their contractual arrangement and have billed Medicaid for the balance. An example would be a surgical procedure for which Medicaid allows \$700, while a Blue Cross plan may pay the provider a contracted rate of \$400 for the same procedure with no deductible or share of cost. The provider then bills Medicaid for the \$300 difference. The \$300 would be recovered from the provider in a disallowance.

Commercial Usual, Customary, and Reasonable Recovery

HMS will recover from commercial carriers where subrogation reimbursement to Medicaid was not complete. An example would be a claim where Medicaid paid \$1,500 for a hospital stay, although a commercial plan was the primary insurer. The UCR charges are \$1,700, and the commercial plan paid \$1,250. HMS would pursue recovery from the commercial plan for \$250 (\$1,500 – \$1,250).

Maximize Eligibility via Wage Match Process

Although HMS will develop data match agreements with the vast majority of large carriers in the state, a significant amount of employer group third party coverage is not processed through commercial health insurance carriers. To ensure full identification of TPL eligibility, HMS will perform a match between the state employee wage file and the Medicaid eligibility database. HMS will use the results of this match (after enhancing it with a match to our national employer databases) to generate regular mailings to employers to gather recipient and group eligibility data, which we will then enter into our Group Capture and Eligibility System. This process will enable us to identify third party liability more completely, and will significantly enhance our ability to bill the coverage to the appropriate carrier, TPA, benefit manager, or employer, and to provide enhanced cost avoidance information to the state. 42 CFR 433.138(d)(1) contains the match requirement: States must exchange data "from the State wage income information collection agency (SWICA) and from the SSA wage and earnings files," and as a result of the match, "use the information that identifies Medicaid recipients that are employed and their employer(s)." Then, per 42 CFR 433.138 (g)(1), "within 45 days, the agency must follow up on such information in order to identify legally liable third party resources and incorporate such information into the eligibility case file and into its third party data base.... so the agency may process claims under the TPL payment procedures."

Proactive Reservist Eligibility Identification

Traditionally, TRICARE eligibility is identified by states through the annual DEERS eligibility cross match process. While this match can be effective for active and retired personnel, the process does not result in effective eligibility dates for reserve personnel and personnel whose benefit periods are more dynamic in nature. With the trend toward increased use of reservists, this is an important sector. This eligibility is available through the TRICARE online system, and HMS has developed technology that, with the state's permission, will enable us to perform automatic queries of the TRICARE online system to verify suspected/potential eligibility for reservists and others on a frequent basis. This will significantly enhance recoveries and cost avoidance information to the state.

TRICARE for Life Billing and Recovery

Military personnel who have served for 20 years or more, retire as disabled, or receive the Congressional Medal of Honor and are age 65 or older and enrolled in Medicare Part B, are eligible for TRICARE-for-Life, which is TRICARE's Medicare Supplemental Benefit. These claims must be billed in a specific way (they cannot be billed using the normal TRICARE electronic billing process), and eligibility is not always apparent from the DEERS match process. HMS has developed procedures for identifying and billing these claims to ensure that the state is fully able to use this third party resource.

TRICARE Senior Pharmacy Billing and Recovery

Military personnel who have served for 20 years or more, retire as disabled, or receive a Medal of Honor and are age 65 or older are eligible for the TRICARE Senior Pharmacy Program, which covers prescription drugs. These claims must be billed in a particular way (they cannot be billed using the normal TRICARE pharmacy electronic billing process), and eligibility is not always apparent from the DEERS match process. HMS has developed procedures for identifying and billing these claims to ensure that the state is fully able to use this third party resource.

C-2.1.a.iii Medicare Recovery

HMS has recovered more than **\$630 million** through our Medicare identification and recovery services for 26 states. In Michigan, HMS identifies Medicare Part A eligibility for MDCH, and MDCH then recovers payments made for these service from the providers. HMS does submit Medicare Part B claims directly to the carrier on behalf of MDCH. HMS has identified a cumulative total of **\$16 million in Medicare A claims for Michigan and has identified and recovered \$0.73 million in Part B claims**. HMS's in-place Medicare recovery capabilities—which are already proven in Michigan—will continue to ensure ongoing recoveries for the state:

- HMS maximizes Medicare eligibility identification and Medicare Part B identification and recoveries through the use of Medicare Adjudicated Claims File and the Medicare Enrollment Database.
- HMS has experience recovering for a broad range of Medicare-covered services, including: inpatient (including ancillary and psychiatric), outpatient (including mental health), skilled nursing facility, physician/professional, end-stage renal disease, ambulance, durable medical equipment, and pharmacy.
- HMS has a superior Medicare Part B billing methodology.

HMS's Medicare identification, billing, and recovery program will continue to reduce MDCH's liability by identifying and recovering MDCH payments associated with Medicaid and CSHCS recipients who are also eligible for Medicare.

By examining MMIS and Medicare enrollment files, payments, adjustments, voids, and MDCH's initiated claims, HMS will continue to:

- Construct the population of Medicaid/CSHCS recipients who are also eligible for Medicare
- Identify MDCH payments associated with periods of Medicare benefits
- Recover payments on the agency's behalf
- Provide verified cost avoidance information

HMS's Medicare recovery process is ongoing and provides a continuous flow of timely cost avoidance information after every cycle. HMS has demonstrated the ability to identify and process claims for Medicare recovery before they expire under timely filing limitations.

C-2.a.iii.a Medicare Recovery: MDCH Responsibilities

a. Maintain Data Use Agreements with CMS

Maintain current Data Use Agreements with the Center for Medicare and Medicaid Services to provide access to Medicare Program eligibility and adjudicated claims files. The agreements will designate the contractor as the “custodian” of data accessed on behalf of the MDCH.

HMS is currently working with MDCH and CMS to extend the existing Data Use Agreement for two years to obtain the Medicare EDB. (HMS currently receives and processes this file as custodian for 18 of our state Medicaid agency clients.) The EDB Data Use Agreement has been submitted to CMS, and HMS will continue to follow up to ensure timely receipt of data. The EDB data, an extract from CMS’s Health

HMS uses the Medicare Enrollment Database and Adjudicated Claims Files to increase Medicare coverage identifications and recoveries.

Insurance Master Record, include eligibility data for Medicare beneficiaries enrolled in both traditional Medicare and Medicare contracted managed care organizations. HMS uses EDB data, once available, in all of our contracts where we perform Medicare TPL.

The Medicare Adjudicated Claims File (ACF), also obtained through a data use agreement with CMS, contains data on Medicare payments for Medicare beneficiaries in Michigan. HMS will use the ACF to coordinate benefits between Medicare and Medicaid and will use EDB and ACF data to identify dually eligible recipients for whom Medicaid has secondary payor liability. HMS will integrate the data into our Medicare data match process to enhance our Medicare Part A identification and recoupment project, Part B identification and billing project, and special recovery projects.

b. Provide Data Files to Contractor

Provide the following files to the contractor approximately one month before MDCH runs the Medicaid PCF match:

MMIS Eligibility File

BENDEX File

Medicare Buy-In File

MPR

With MDCH support, HMS will continue to obtain copies of the following state/MMIS and Medicare-related data files:

State MMIS Files	Medicare-Related Files
MMIS Eligibility File	BENDEX File
Medicaid Paid Claims File (or PCF Extract)	Buy-In (Parts A and B)
MPR File	COLA
Provider Extract File	Medicare Adjudicated Claims
	Medicare Enrollment Database

c-d. Coordinate Provider Recoupments (Part A Services)

- c. Run the contractor's MPR Extract File (2.a., below) against the Medicaid PCF to produce the report of paid claims for the newly identified Medicare eligible individuals (MW861 Report) for Medicare Part A services.
- d. Mail the MW861 Report to providers, giving them 45 days to identify errors.

HMS acknowledges that MDCH will continue to use the MPR Extract File, which HMS produces, to:

- Identify MDCH-paid claims that were eligible for reimbursement under Medicare Part A; and
- Send recoupment notices (MW861) to providers

e. Provide Medicaid PCF Extract File

Send the Medicaid PCF Extract File to the contractor for Medicare Part B services.

HMS will continue to use MDCH's Medicaid PCF Extract File to prepare billings for Medicare B services.

f. Resolve Errors on MW861 Report

Resolve errors on the MW861 Report that have been identified by providers.

HMS acknowledges that MDCH is responsible for resolving errors on the MW861 Report that providers identify. The errors result mostly from inaccurate Medicare eligibility start and end dates.

g. Forward Provider Contested Claims

Forward the provider contested claims to the contractor.

HMS will receive provider-contested claims from MDCH and will review these claims—and associated Part A provider refunds—to determine if enhancements need to be made to HMS’s data match process.

h. Run Automated Claim Adjustment Program

Run the Automated Claim Adjustment Program for Part A claims before the second Medicaid payroll in December (the purge payroll).

HMS acknowledges that MDCH is responsible for running the Automated Claim Adjustment Program for Part A claims.

i. Update Master MPR

Update the Master MPR file.

HMS acknowledges that MDCH is responsible for updating the Master MPR file.

j. Reimburse Contractor

Reimburse the contractor within 30 days of receipt of an approved invoice.

HMS understands that MDCH will provide reimbursement within 30 days after receiving an approved invoice. HMS’s proposed invoice protocols are described in this Tab under Section C-2.a.iii.c (Medicare Recovery: Contractor Responsibilities), item (f) (Produce Invoice).

C-2.a.iii.b HMS’s Medicare Recovery Expertise

Identifying Medicare enrollment/coverage involves some unique challenges. Although numerous sources of Medicare data are available (most available through CMS or SSA), no single source contains comprehensive enrollment and coverage information on all Medicare enrollees. HMS overcomes the limitations of the various Medicare files by aggregating the data into a single comprehensive database of Medicare enrollment/coverage information. Through data matches and data extracts with numerous Medicare files and databases, HMS identifies Medicare enrollment/coverage unknown to MDCH for Medicaid recipients and recovers claim payments.

Through our revenue recovery projects in other states, HMS has found the following data sources offer the most comprehensive foundation of Medicare coverage data:

- BENDEX (Beneficiary & Earnings Data Exchange) File
- Medicare Buy-In Files (Part A & B)
- Medicare Enrollment Database (EDB)

- COLA (Cost of Living Adjustment) File
- Medicare Adjudicated Claims File
- Medicaid Paid Claims File/PCF Extract (where the presence of a crossover claim to Medicaid indicates Medicare coverage)

These files help HMS assemble complete data records for Medicaid recipients who appear likely to have Medicare coverage. Indicators such as recipient age, disability, and/or a record of a Medicare paid claim for a recipient may imply Medicare enrollment. HMS's experience finds that many of these "implied" Medicare beneficiaries do in fact have Medicare coverage and collectively represent significant recovery potential.

Medicare Part B Direct Electronic Billing

Each year, HMS bills millions of Part B claims directly to Medicare carriers as part of our Medicare third party recovery service. Wherever possible, we establish CPU-to-CPU transmission of claims to speed adjudication. To reduce the burden on MDCH, we offer the capability to receive electronic remittances from Medicare in ANSI 835 format rather than paper remittances.

HMS has already established the capability to submit Medicare Part B claims electronically (ANSI 837 format) to Wisconsin Physicians' Service (WPS), Michigan's Part B carrier. In December 2002, HMS received the Medicare Provider Number file from WPS, as part of a Freedom of Information request. After receiving this file, HMS was able to protect several hundred thousand dollars worth of claims under a statement of intent (see section below), and bill them after the timely filing limitation. After thorough transaction testing with WPS, all Medicare Part B claims for Michigan are electronically billed to WPS. Since July 2003, HMS has recovered over \$140,000 in Medicare B claims, and HMS continues to bill these claims monthly.

HMS Secures Full Medicare Payment/Medicaid Liability Coordination of Benefits

HMS will use the Medicare Adjudicated Claims (ACF) history data and our time-tested longitudinal analysis processes to ensure that where there is a combination of payments for a service between Medicaid and Medicare, Medicaid does not pay more than the patient liability or its obligation under the state plan. Occasionally, when Medicare pays primary and Medicaid is a secondary payor, or where there is a Medicare ancillary payment and Medicaid pays primary, the patient liability that is due from Medicaid is overstated—resulting in Medicaid overpayment. This is often impossible to determine at time of claim adjudication due to frequent claim adjustments by Medicare. Using the Medicaid claims history and the Medicare ACF, HMS can ensure proper coordination of benefits between Medicare and Medicaid, and ensure that Medicaid does not pay more than its appropriate liability. Examples of this include:

- Medicare pays part of an inpatient claim, but due to exhausted benefits, Medicaid pays the rest
- Provider understates the amount of Part B ancillary payments received during an inpatient or skilled nursing facility stay

- Emergency room/inpatient services are unbundled and billed separately to Medicare and Medicaid for Part B beneficiaries

Medicare Filing Limit Waivers

HMS's record of preserving expiring Medicare claims and obtaining Medicare timely filing waivers has no equal in the revenue recovery industry. In many

instances, HMS implemented or received client approval for a Medicare revenue recovery project during the latter months of a calendar year. These instances required that HMS obtain a Medicare timely filing waiver from the Medicare intermediaries and or carriers (with CMS approval) or submit protective filings. In these cases, HMS prepared the letters of request to the Medicare Part A intermediaries and Part B carriers on behalf of our clients and obtained timely filing extensions in accordance with federal CMS and SSA regulations.

HMS has secured over 100 Medicare waivers and protective filings for 26 states.

Recently, CMS proposed that the protective filing procedure, referred to as filing a "Statement of Intent," be discontinued and no longer available as a mechanism to extend the timely filing period for submission of Medicare claims. HMS ensured that all of our state clients were aware of the proposed rule revision to allow them to voice any objections they might have.

Exhibit C2-12 lists those states that received timely filing waivers as a result of HMS's requests to Medicare.

Exhibit C2-12: HMS Has Received Approval for 117 Medicare Protective Filings/Waivers

State	Part A	Part B	DMERC	Home Health	SNF	Rx
Arizona	1					
Arkansas	3	3				
California	4	3				
Colorado		2				
Connecticut			1			
District of Columbia	3	1				
Florida	7	1				
Georgia	1	1				
Indiana	2	2				
Iowa	3	1				
Kansas	1	1				
Kentucky	3	2				
Louisiana	7	2				
Maine		1				
Maryland		2	1			
Massachusetts	7	6	1			
Michigan		2				
Missouri	1					
Nevada	1					
New Jersey	4	1	2	3	1	1
New York	5	2				
Ohio	1					

State	Part A	Part B	DMERC	Home Health	SNF	Rx
Pennsylvania	2	2	1			
South Carolina	2	2				
Virginia	5	1	1			
West Virginia	2	2				
Total Waivers	65	40	7	3	1	1

Medicare Staff Expertise

HMS employs healthcare industry professionals with expertise in all aspects of coordinating benefits with Medicare. These professionals understand and can apply knowledge of:

- ◆ Medicare eligibility and coverage guidelines
- ◆ Medicare reimbursement procedures
- ◆ Hospital and skilled nursing facility rate schedules (e.g., DRG rate schedules, outpatient APGs, SNF RUGs)
- ◆ Medicare benefit periods
- ◆ Medicare deductibles and coinsurance
- ◆ Lifetime Reserve Day (LRD) guidelines
- ◆ Responsibilities of Medi-gap insurers and Medicare HMOs
- ◆ Cost report settlement
- ◆ TEFRA target rate appeals
- Medicare appeals (e.g., SNF, home health)

C-2.a.iii.c Medicare Recovery: Contractor Responsibilities

a. Perform Medicare Eligibility Match (Part A and B Services)

Perform an eligibility match from Medicare related data files to identify additional Medicare eligible beneficiaries and eligibility periods for Medicare Part A and Part B services.

HMS will continue to use the following methodology to perform Medicare eligibility data matches for purposes of identifying Medicaid and CSHCS recipients who are Medicare-eligible and additional eligibility periods. HMS affirms that we will continue to perform Medicare eligibility matches once annually, to coincide with the MDCH's fall Medicare run.

1. *Receive and Prepare Data*

- With client support, HMS obtains copies of the following Medicaid/CSHCS and Medicare-related data files:

State Medicaid/CSHCS Files	Medicare-Related Files
MMIS Eligibility File	BENDEX File
Medicaid Paid Claims File (or PCF Extract)	Buy-In (Parts A and B)
MPR File	COLA
Provider Extract File	Medicare Adjudicated Claims
	Medicare Enrollment Database

- Perform data extraction and reformat files to standard HMS file format. (Note: HMS's project team handles all reformatting. HMS is highly experienced in reading and processing these files for our other state Medicaid agency clients.)
- Add Medicaid eligibility files to HMS's Medicaid Recipient Master File.

2. *Identify Medicare Coverage for Medicaid and CSHCS Recipients*

- Identify and apply Medicare coverage to the Master File. HMS has existing data structures and programming logic to apply most standard Medicare files (BENDEX, Buy-in, and SDX) to HMS's Master File with little or no programming modifications. We can also rapidly implement alternate or state-specific formats.
- Continually update this database as new Medicare enrollment information becomes available.
- Augment any data records that lack essential billing information (e.g., complete enrollment dates) with information from additional data sources such as the Medicare Adjudicated Claims File and the online TPQY System.

3. *Identify Medicaid Paid Claims Billable to Medicare Part B*

- Match all recipients with Medicare coverage identified from HMS's data matches and with MDCH's MPR file to the Medicaid Paid Claims Files (or PCF Extract) to identify claims that MDCH paid during Medicare's current timely filing period when Medicare coverage was available.
- Identify Medicaid payments having primary Medicare coverage during the targeted dates of service.

b. Produce MPR Extract File

Produce an MPR Extract File of newly identified Medicare eligible beneficiaries and eligibility periods. The file shall be produced within three weeks of receiving the MDCH files identified in 1.b., above. The MDCH contract administrator shall approve the match criteria.

As the outcome/deliverable of the Medicare eligibility data match described under item (a), immediately above, HMS will produce an electronic MPR Extract File of newly identified, Medicare-eligible recipients and eligibility periods unknown to MDCH. HMS affirms that we will produce this file within three weeks of receiving the necessary data files from MDCH.

HMS will continue to produce the MPR file to convey new and expanded Medicare coverage to MDCH. For example, HMS would not send Medicare A coverage information for the same start and end dates that MDCH had on its MPR file. However, if HMS's processes identified Medicare A coverage for that recipient for different dates, we would provide an eligibility segment if HMS showed an earlier start date or later termination date than appears on the MDCH file.

HMS also provides coverage information only for recipients who had some active Medicare A or B coverage for the federal fiscal year (October – September) that is about to expire under Medicare timely filing regulations, for which MDCH was not previously aware.

In 2004, HMS provided 1,434 new coverages and 4,503 modified coverages for the new expiring year of Medicare claims. In total, HMS has provided over 260,000 new coverages and over 75,000 expanded coverages since our contract began in 1999.

c. Submit Part B Claims

Submit claims for Medicare Part B services to the Medicare Part B intermediary within 30 days of receiving the PCF Extract File from the MDCH.

As of July 2003, HMS bills Medicare B claims electronically to WPS and has recovered over \$140,000 on behalf of MDCH.

Within 30 days after receiving the PCF Extract File from MDCH, HMS will:

- Prepare and submit electronic billings to the Medicare Part B carrier, Wisconsin Physicians' Service, using the National Standard Format, as we currently do. Note: upon approval from MDCH, HMS also proposes to supplement our Medicare B direct billings with recoveries from providers, in cases where data is unavailable or insufficient to complete the direct billing.
- Post all claim information to HMS's automated A/R system.
- Receive copies of checks and remittance data sent to the Michigan Department of Treasury, and update HMS's A/R system. When available, HMS receives and posts electronic remittances.

- Apply rigorous follow-up protocols to ensure proper and complete disposition of each claim and help assure maximum recovery for MDCH:
 - Monitor claims adjudication and follow up on open and pended claims and reprocessible denials.
 - Rebill claims, as required.

d. Establish Lock-Box Process

Establish a Lock-Box process for Medicare Part B payments from carriers that is agreeable to the MDCH.

Under our existing contract with MDCH, Medicare Part B carriers send checks and remittance documentation for HMS's billings to a post office box at the Michigan Treasury. Copies of the checks and documentation are forwarded by Treasury to MDCH Accounting and then sent to HMS. To avoid confusion with third party payors, HMS recommends maintaining this lock-box arrangement.

HMS proposes the following lock-box protocols:

- As suggested by the RFP, HMS will continue to use the current lock-box arrangement with the Department of Treasury.
- Alternatively, HMS will establish the lock-box, in MDCH's name, at an agency-approved institution. HMS will bear all costs of the lock-box throughout the duration of the contract. HMS is satisfied with its current relationship with the Michigan Treasury lock-box, and all HMS requested protocols are being followed. If MDCH would like to investigate alternatives under the new contract, HMS is presently analyzing lockbox product offerings on behalf of other clients, and can suggest banks for MDCH's consideration.
- HMS will specify that checks are to be made payable to the State of Michigan will identify the lock-box address within our correspondence. Placing this information on the bills reminds carriers to send remittance correspondence to the correct payee and address—thereby expediting recoveries. HMS will instruct carriers to include with the check either a remittance advice or third party documents identifying the recipient, the type and date of service, and the amount of payment.
- The Treasury will deposit all checks into the designated HMS TPL account and will forward a copy of the checks, remittance documentation, and deposit slips to MDCH Accounting.
- Daily, MDCH will send remittance correspondence to HMS's keypunch vendor in Troy, Michigan. HMS will post updates to our A/R system.
- Monthly, the Treasury will send a bank statement to HMS, showing all the activity in the lock-box account during that month.

HMS monitors claims adjudication and follows up on outstanding and denied claims through our claims follow-up process.

e. Review and Reconcile Contested Claims

Review and reconcile Medicare Part B claims contested by the Medicare Part B intermediary.

HMS affirms that we will review and reconcile Medicare Part B claims that the Part B carrier contests.

HMS monitors claims adjudication through the A/R system. We follow up on unprocessed claims to obtain the adjudication status of all billed claims. Our billing platform includes a sophisticated prioritization and calendaring function that our staff can use to identify the appropriate point to initiate telephone follow up with carriers and third parties. We analyze, correct, and resubmit rejected claims until we can determine that third parties have correctly paid or processed all claims.

Additional information about HMS's A/R system—and how we use this system to review and reconcile contested claims—appears under this Tab in Section C-2.1.a.ii.b (Commercial Insurance Recoveries: Contractor Responsibilities), item (d) (Reconcile Claim Payments and Rejections).

f. Produce Invoice

Invoice the MDCH for Medicare recoveries:

30 days after the Automated Claim Adjustments are processed by the MDCH for Part A services.

Monthly for Part B services.

HMS will invoice MDCH for Medicare A and B recoveries according to the RFP-required timetable (above).

For Medicare A: HMS affirms that we will invoice MDCH for 90% of Medicare A amounts after 30 days elapses from the date that the automated claim adjustment appears on the provider's remittance advice. We acknowledge that MDCH will retain the remaining 10% of the fee for 12 months for claim reconciliation purposes. If providers identify recoupment errors exceeding the 10% amount that MDCH retains, HMS will return—within 60 days after notification—the portion of the contract payment associated with contested amounts in excess of the 10%. HMS understands that we will have an opportunity to review and refute contested claims. HMS is providing a previously submitted Medicare invoice as proof of our understanding of the invoice process (Proposal **Attachment 2**).

For Medicare B: HMS will invoice MDCH monthly for all deposits forwarded to the state during the invoice period.

Refunds Related to Erroneous Recoveries

Medicare B carriers occasionally determine that they have incorrectly paid a reclamation claim from HMS. We typically receive these refund requests through the project lock-box. First, we look up the related claims on our Accounts Receivable system to verify that we received payment and that the carrier has specified a valid reason for the refund. Next, we forward the carrier notice and a refund memo to the state agency and ask the agency to reimburse the carrier. Finally, on our next invoice, we credit the agency for fees associated with the inaccurate recovery.

C-2.1.b Project #1: Optional Services

HMS previously submitted a proposal for the following optional services under our existing contract, which MDCH reviewed and approved.

C-2.1.b.i Hospital and Long-Term Care Provider Audits

The following narrative describes the HMS Team's proposed approach to the RFP requirements for on-site Hospital and Long-Term Care Provider Audits. HMS proposes to work with CDR Associates, LLC to conduct audits of hospitals and nursing homes in the State of Michigan to identify and recover credit balances and other overpayments made by the state's Medicaid program. [HMS and CDR have worked together successfully to serve Medicaid agencies in nine states, producing recoveries of nearly \\$115 million.](#)

To supplement the on-site audits, HMS also offers—as an enhancement—a multi-tiered provider self-audit process, which is typically lower-cost than the on-site process. [Provider self-audits have produced more than \\$3.0 million in recoveries for Michigan under HMS's present TPL contract.](#) Additional information about HMS self-audits appears under this Tab in Section C-2.1.c, Project #1: Additional HMS Projects (see: Provider Self-Audits and Automated Self-Audits).

Provider Audit Overview

Erroneous Medicaid payments to hospitals serving indigent populations represent a significant recovery opportunity for state Medicaid agencies. Both the Centers for Medicare & Medicaid Services and the Health and Human Services Inspector General have performed studies and audits identifying hundreds of millions of dollars in credit balances, at hospitals throughout the country, that are owed Medicaid. These bodies also recognize that staffing and technology constraints impede recovery efforts. Difficulties arise because credit balance audits must be performed on-site to enable reviews of providers' accounts receivable and billing records.

Credit balances arise, in part, from the complexity of managing the coordination of benefits process. For various reasons, providers receive revenue from multiple sources and often experience difficulties in reconciling accounts. Additionally, the speed at which providers seek payment for services further impedes the third party payment process by causing errors in documentation. Although many Medicaid agencies perform their own on-site audits of hospitals and long-term care facilities, agency auditors often select only a small number of providers to audit and/or a small sample of claims paid by Medicaid, foregoing a significant portion of potential recoveries. In response, CDR Associates offers a comprehensive provider audit program to help state Medicaid agency clients maximize recoveries due from providers.

a. Audit Approach

The foundation of our audit philosophy is to provide a highly professional service that adds value for our clients by recovering dollars that otherwise might never have been collected. We identify all overpayments but take credit only for those overpayments that go unattended by the providers. As such, our clients pay a fee for only those accounts that they would otherwise not have recovered without our professional audit services.

We conduct on-site, comprehensive, periodic (monthly, quarterly, or annual) audits of each provider's patient accounting system and supporting documentation. Our periodic audit process allows time for the majority of overpayments to be recovered independently by insurance companies through their existing processes or through voluntary refunds by providers without intervention by outside vendors, while also ensuring that unidentified overpayments are recovered timely and consistently through the on-site audit process.

We believe strongly in representing only one client at a time on each provider audit engagement. This philosophy runs contrary to the practice of other firms, which represent dozens or even hundreds of payors at the same time during an audit. Our approach eliminates the possibility of any conflicts of interest and avoids confusion in the provider community pertaining to whom our firm represents during the audit.

CDR stresses a highly professional, non-adversarial approach that requires minimal effort on the part of our clients or the providers we audit. Accordingly, we maintain positive relationships with the providers that result in enhanced provider relations for our clients.

The key to detecting all overpaid accounts at a provider depends on both having a comprehensive knowledge of the provider's patient accounting system and performing the audit procedures described above.

Accordingly, in addition to finding overpayments in the form of individual credit balance accounts, we find other overpayments that are no longer present on the provider's current trial balance accounts. Through our audit process, we identify overpayments that are camouflaged as being:

- Written off to bad debts
- Written off to allowance/discount accounts
- Accounts payable hold accounts
- Unapplied cash accounts
- Refund accounts
- Refunded to the wrong insurance company

Over 30% of the overpayments we have historically identified and recovered were no longer credit balance accounts at the time of our audit. This is a significant and substantial difference between CDR's services and seemingly similar services other credit balance vendors offer. Our services directly increase total recoveries for our clients.

In summary, our philosophy and approach emphasize:

- Providing a value-added service
- Performing periodic, on-site, comprehensive audits
- Employing a professional, non-adversarial approach
- Maximizing recoveries

b. Criteria for Prioritizing Audits

Hospitals

MDCH makes payment to approximately 175 hospitals in the State of Michigan for Medicaid covered services. To maximize recoveries in the shortest time possible, our initial approach would target the hospitals statewide (71) that have more than 100 beds total, and list these hospitals in descending order of Medicaid claims payment volume. Hospitals of this size typically represent more than 90% of total Medicaid payments. If feasible, or at the request of MDCH, CDR will also conduct audits of the remaining Medicaid hospital providers.

HMS/CDR will work in collaboration with MDCH to schedule these hospital audits and will obtain prior consent from MDCH before scheduling an audit at any particular provider.

Long-Term Care Providers

MDCH makes payment to approximately 430 nursing homes and other long-term care providers in the State of Michigan for Medicaid covered services. Our initial approach would be to conduct a pilot program to encompass a review of the accounts receivable and other documentation from approximately 10 nursing homes of differing size and demographic criteria. Once the results of the pilot program have been determined, HMS/CDR will make a recommendation to MDCH regarding the feasibility of conducting audits of all nursing homes with more than 50 beds statewide.

c. Areas Included in Audits

Hospital Audits

CDR developed and has thoroughly tested the unique audit scope for this project over the last 14 years. This proven, comprehensive approach involves retrospective on-site audits at identified providers.

Our hospital-based audit aggressively tracks payments through a hospital's system, checking for: (i) uniformity of patient data between registration, medical charge, and account detail information; (ii) accuracy in financial transactions; and (iii) adherence to hospital policies and procedures as they relate to the posting of payments. Mistakes in these areas often result in improperly documented claims and remittance information.

CDR's hospital credit balance services focus on identifying and recovering three primary types of incorrectly paid and processed Medicaid claims:

- Duplicate/similar claim overpayments
- Coordination of benefits (COB) errors
- Payments in excess of contractual requirements

Long-Term Care Provider Audits

Our audit focuses on identifying and recovering Medicaid claim and patient resource overpayments to Michigan nursing homes and other long-term care facilities. The scope of the audit includes:

- Accounts paid twice by Medicaid
- Accounts paid once by Medicaid and once by another insurance resource, including coordination of benefits errors
- Understated recipient resource amounts and/or miscalculated private pay periods prior to Medicaid eligibility
- Accounts with identified liability for third party payors within the timely filing requirement

We identify overpayments based on a comparative analysis between provider supplied Medicaid financial histories, and information contained in the MMIS and eligibility systems. We will thoroughly research all identified overpayments and submit them to the appropriate provider representative for review. We will perform our project on a supplemental basis, ensuring that we do not duplicate any internal efforts of MDCH or other agencies and contractors.

d. Audit Time Frames

Hospital Audits

Each CDR provider engagement is a true periodic audit, intended to identify and recover clients overpayments that need the involvement of an outside vendor. As such, each audit engagement has a definitive beginning and end. CDR typically conducts audits quarterly or annually, depending on facility size and our historical recovery experience at that facility. Our experience

has been that the time required for on-site audits and subsequent analysis of provider documentation varies widely—from 5-15 days—depending primarily on a given provider's size the degree of focus that the provider places on credit balances. [A typical hospital audit—from the audit start date to the hospital review and approval of all identified overpayments—has an average duration of 45 days.](#)

With full commitment from MDCH, CDR expects to complete the fieldwork and subsequent analysis relative to the 71 largest facilities within 16 weeks of the date of the first scheduled audit. We expect that these 71 facilities will yield more than 90% of anticipated total recoveries for the project as a whole.

Long-Term Care Provider Audits

CDR's audit process for a long-term care facility differs significantly from that of a hospital audit. Because long-term care facilities tend to view a patient "account" as all activity for the entire length of stay for each resident, the resident's account balance rarely gives an accurate indication of whether or not a particular Medicaid covered period was properly paid. As a result, CDR must review all financial activity for each Medicaid resident throughout the duration of their stay at the facility, resulting in a substantially longer review process to identify each potential overpayment. Reviewing and analyzing a single provider's account documentation can take from two to four weeks. [A typical long-term care provider audit—from the audit start date to the provider review and approval of all identified overpayments—has an average duration of approximately 90 days.](#)

We anticipate that completing the first round of audits for all nursing homes having more than 50 beds will take approximately 24 months. These facilities should yield more than 90% of anticipated total recoveries for the project as a whole.

Audit Tasks

Our proposed audit tasks are described below:

Hospital Audits

Task 1: Identify and Prioritize Providers to be Audited

During the initial phase of the project, HMS/CDR will generate a listing of the highest paid MDCH provider facilities, including approximate claim volume, which we will use to prioritize scheduling of the audits. CDR will work with MDCH to schedule these hospital audits and will obtain prior consent from MDCH before scheduling an audit at any particular provider.

Task 2: Notify Provider and Conduct Entrance Conference

CDR will submit for MDCH's approval a draft Letter of Introduction. This letter informs providers about the pending review. For each facility, we will provide MDCH with current addresses, business office contacts (usually Chief Financial Officer or Patient Accounts Manager), and telephone numbers. We will forward the approved letter to a provider

approximately two to three weeks conduct an entrance conference with provider management to describe the scope of the audit and to review the audit process.

Task 3: Obtain Source Documentation from Provider

The CDR audit focuses on all unrefunded credit balance accounts that are on a provider's patient accounting system or have been written-off the system. As such, provider generated source documentation is an integral aspect of the on-site audits. CDR will review a variety of provider documentation, including but not limited to the following:

- **Credit Balance Report.** CDR will require that each provider present a current month-end Credit Balance Report, detailing all accounts with a credit balance and also having a Medicaid insurance plan code in the A/R system. This methodology ensures that CDR is able to review all Medicaid credit balance accounts, including those for which Medicaid is not listed as the primary payor source.
- **Trial Balance Report.** CDR will request a sample of several historical month-end Aged Trial Balance Reports. We use these reports to follow a sample of Medicaid credit balance accounts through the A/R cycle to determine how the account terminated in a zero balance. In addition, we will use the reports to identify credit balances and ensure the accuracy of the Credit Balance Report.
- **Unapplied Cash Reports.** Providers occasionally receive Medicaid and other insurance payments and are unable to determine the patient or specific date of service against which to post the payment. Since the provider cannot post the payment to a specific account, the provider posts it to an Unapplied Cash Account pending additional research by provider staff. CDR will examine the Unapplied Cash Report or Unapplied Cash Account to determine if an inordinate amount of Medicaid funds fall into this category and if potential Medicaid overpayments exist.

Task 4: Perform On-Site Audit

a. Review of Current (Active) Accounts

After establishing the audit schedule and guidelines, the CDR team:

- Reviews admission policies and procedures
- Performs a detailed review of current (active) hospital accounts, including trial balances, credit balance reports, unapplied cash ledgers, and registration documents to verify insurance coverage, billing information, and collection data
- Examines Medicaid discharges to determine if the hospital is correctly identifying and billing the appropriate primary and secondary payors
- Tracks a representative sample of Medicaid payments through the hospital system from receipt of payment to payment posting

b. Review of Historical Accounts (Write-Offs)

CDR has an unparalleled level of experience in detecting individual or systematic accounting adjustments by providers that eliminate credit balances from provider accounts receivable reports and records. Our experience shows that, overall, 20% of the dollar volume of accounts

we recover originate from accounts that a provider has previously written off. To ensure that CDR recovers all MDCH overpayments, regardless of whether or not they are still active credit balances, our auditors:

- Perform a detailed review of hospital cash posting and write-off policies
- Evaluate historical accounts (write-off) and related documents, including historical trial balance reports, cash reports, adjustment reports, special reports, and related hospital documentation and correspondence
- Recreate complex accounting transactions used by staff to write accounts off the hospital's books. This allows auditors to trace payments through the hospital system and identify overpayments and credit balances due Medicaid that have been previously written off.
- Identify patterns and/or trends that will allow CDR to restore and recover historical accounts from microfiche or microfilm when they are no longer accessible on the provider patient accounting system.

CDR is the only vendor with extensive experience in identifying and recovering credit balance write-offs.

Task 5: Identify and Verify Overpayments

Based on the findings of the preceding activities, the CDR team:

- Identifies current and/or historical accounts that do not reflect accurate payment arrangements or do not correctly adhere to coordination of benefits (COB) regulations
- May confirm or verify payment status using our on-line link to Medicaid eligibility and paid claims data
- Analyzes each account and calculates the amount due back to Medicaid
- Records claim information for all overpayments due Medicaid, including amounts paid by other liable parties.

Task 6: Submit Listing to Hospital

In finalizing the audit process, the CDR team:

- Outlines audit findings and meets with the provider to discuss results
- Develops a Report of Overpayments that provides supporting documentation for adjustments such as: (i) the name of the primary payor and justification for designation as primary; (ii) multiple dates on which the hospital recorded payment for the same claim; and (iii) identification of data-entry errors as recorded in the hospital accounting system
- Allows hospitals 30 days to review findings and refute recoupment of claims with the submission of appropriate documentation. CDR will proceed with recoupment of all claims for which the provider fails to provide appropriate documentation.
- Conducts negotiations with the hospital to obtain concurrence with CDR findings

Task 7: Eliminate Claims Previously Identified by HMS and MDCH

CDR will perform a match of identified overpaid claims to a cumulative file of Medicaid adjudicated claims and our Accounts Receivable system to eliminate any claims voided by MDCH and claims identified for recovery as a result of previous HMS TPL projects.

Task 8: Recoupment Procedures

CDR proposes to recover claims through one or a combination of the following methods:

- Recoupment file and/or report
- Paid Claim Adjustment Requests
- Financial transactions (gross adjustments)
- Payment (via check) from provider

CDR will work with HMS and MDCH to identify the most effective and expeditious method(s) for recovering overpaid claims.

CDR completes the audit cycle by performing the following procedures:

- We will confirm that the provider submits a refund check in full or will notify the provider that the overpayment will be recouped or offset against future provider payments.
- For recoveries to be repaid by check, we will inform the provider that the checks should be made payable to the State of Michigan and forwarded directly to the designated project lock-box.

Nursing Home Audits

Task 1: Project Start-Up

During the initial phase of this project, CDR will:

- Obtain and review applicable MDCH provider payment and billing regulations and policies, and meet with the Department before starting the audits to assess existing system edits and audits. We will also review other cost avoidance programs, clarify any policy questions, ensure accurate interpretation of the types of recoveries to be identified, and discuss any issues not addressed in the Medicaid policy manuals.
- Develop audit methodology intended to maximize recoveries. CDR will evaluate the Medicaid program's policies and procedures, payment characteristics, system edits, and cost avoidance programs and develop a customized audit program designed to identify claims and patient-paid recoveries efficiently.

Task 2: Notify Provider and Conduct Entrance Conference

- Work with MDCH to schedule the audits. We will present MDCH with a list of providers to be audited; this will include the time frame for contacting each provider through an introductory letter from MDCH. At this point, MDCH can provide any appropriate guidance to CDR regarding providers that should be added to or deleted from the list or deferred for audit.
- Work with MDCH to release introductory letters. We will provide MDCH with a draft Letter of Introduction, as well as a complete list of names, titles, and addresses of the nursing homes to notify regarding the upcoming reviews. The Letter of Introduction names CDR as a designated agent of MDCH and notifies each provider of the purpose and scope of the upcoming audit. The letters are sent to the Administrator of each the nursing home on state Medicaid agency letterhead, using Federal Express or registered mail. CDR will be responsible for mailing the letters after MDCH's review and approval.

- Approximately five (5) business days after the Letter of Introduction has been mailed, the CDR Entrance Letter is mailed to each provider that is scheduled for an upcoming audit. The letter informs the provider of the date and time of the scheduled audit, explains the purpose of the review, and lists the audit materials the facility is expected to have ready and available for pick-up at the time of the entrance conference.
- CDR normally allows providers 30 days to prepare the materials required for the audit. The CDR staff auditor follows-up with the Administrator five to seven business days before the entrance conference to confirm the scheduled audit date and time. CDR will work with the provider if special circumstances preclude scheduling the audit within 30 days of the entrance letter and will keep MDCH advised of schedule changes and reasons for such changes.
- CDR conducts an entrance conference, attended by the provider's selected representatives. These individuals usually include the Administrator, Business Office Manager, and Accounts Receivable Bookkeeper. The purpose of this meeting is to detail and define the parameters of the audit. At this meeting: (i) the auditor is introduced; (ii) the major steps of the review process are explained; (iii) the auditor asks specific question relating to the particular facility's accounting systems and procedures; and (iv) the expected time frames for the audit are discussed. All requested provider source documentation is collected at this time. CDR reviews all documentation at CDR offices.

Task 3: Obtain Provider Source Documentation

Provider generated source documentation is an integral aspect of the CDR long-term care audit program. Provider supplied documentation that CDR will review includes, but is not limited to, copies of the following:

- A census report of all Medicaid recipients who were admitted or discharged during the audit period
- A copy of the admission card or admission face sheet **or** another document that contains each recipient's Medicaid identification number
- A detailed financial history report generated from the facility's accounting system(s) for each Medicaid recipient that includes all financial activity for the audit period and from all payer sources. We will need these reports for all Medicaid recipients regardless of whether the recipient is currently in-house, discharged, or deceased.

Task 4: Conduct Audit/Identify Overpayments

CDR proposes to identify overpayments for the audit period by comparing provider supplied patient financial histories and other documentation to MDCH's eligibility and MMIS systems.

We will perform a detailed review and comparative analysis of the financial history accounts for all Medicaid patients having resided in each facility for the audit period. We review all payor classes for each Medicaid resident to identify duplicate claims, and to ensure Medicaid is the payor of last resort and that COB regulations have been followed. These payor sources include both Medicare A and B and commercial health insurance, in addition to private payments made during pre-Medicaid eligibility spend-down periods and utilization of security deposits collected upon admission for private-to-Medicaid patients.

CDR will review the patient account and MDCH eligibility files to identify variances in the monthly resource amount between the amount that the facility actually collected and the amount the state applied toward any claims processed and paid for that month.

Task 5: Submit Initial Audit Findings to Provider

CDR prepares preliminary audit results:

- After completing an analysis of each account, CDR prepares reports of potential overpayments and sends them to the provider for review and approval.
- CDR submits two reports to the provider—one that details claim-specific overpayments and one that details resource amount overpayments. To expedite the review process, each section gives detail-level data elements that facilitate the provider’s review. These data elements include: recipient’s name, Medicaid number, date-of-service, amount overpaid, reason for overpayment, and a comment section for any additional information that may assist the provider in its review.
- CDR allows each provider 30 days to review the report and submit documentation for any case where the provider feels that there is a variance and/or discrepancy with the audit findings. Acceptable documentation includes, but is not limited to: copies of cancelled checks, remittance advices, and adjustment journals and cash receipt journals. After CDR receives the provider’s response to the initial report, CDR produces a second report identifying any accounts that need additional documentation or further explanation from the provider. The provider has 14 days to review this second report and submit the requested information. CDR then reviews the provider’s subsequent response and makes a final determination. Any cases that the provider still refutes, but for which CDR has received inadequate or incomplete back-up documentation, will be marked as “disputed” on our Final Recovery Report and referred to MDCH for recovery.

Task 6: Finalize Audit Findings with Provider

CDR will submit to the provider a Demand Letter and a Final Recovery Report. These documents identify all accounts CDR will forward to MDCH for recovery. The Demand Letter details the recovery process and allows the provider five days to contact CDR to schedule a formal exit conference regarding any account(s) for which there is still a dispute. The exit conference is the provider’s final opportunity to provide additional information or explanation regarding the disputed cases. A CDR Manager will review all relevant provider documentation, as well as the MMIS and eligibility systems with the provider’s designated representative(s). If necessary, CDR will produce an adjusted Final Recovery Report and Demand Letter.

Task 7: Eliminate Claims Previously Identified by HMS and MDCH

CDR will perform a match of identified overpaid claims to a cumulative file of Medicaid adjudicated claims and our Accounts Receivable system to eliminate any claims that MDCH has voided and claims that previous HMS TPL projects have identified for recovery.

Task 8: Recoupment Procedures

CDR proposes to recover claims through one or a combination of the following methods:

- Recoupment file and/or report
- Paid Claim Adjustment Requests
- Financial transactions (gross adjustments)
- Payment (via check) from provider

CDR will work with MDCH to identify the most effective and expeditious method(s) for recovering overpaid claims.

CDR completes the audit cycle by performing the following procedures:

- We will confirm that the provider submits a refund check in full or will notify the provider that the overpayment will be recouped or offset against future provider payments.
- For recoveries to be repaid by check, we will inform the provider that the checks should be made payable to the State of Michigan and forwarded directly to the project lock-box.

Task 9: Provider Education

CDR has a proven record of educating the provider community and responding to provider concerns and issues during all provider audit engagements. During our routine meetings with MDCH, CDR will inform the Department of potential issues, trends, and problems occurring across providers that may require additional provider education. In addition, upon MDCH request, CDR will develop comprehensive written materials to help providers prepare for and respond to all aspects of the CDR audit. We will update or amend these materials when necessary. The materials can be presented in cooperation with relevant provider advocacy organizations and associations.

At the request of MDCH, CDR will also supply the provider community with an annual report detailing the types of overpayments recovered during the previous calendar year and the associated recovery amounts.

CDR is also available to attend provider education and project status meetings that MDCH sponsors.

f. Estimated Recoveries from Audits

Hospital Audits

We anticipate total hospital recoveries of approximately \$3 million - \$5 million from the initial round of audits and \$1 million - \$2 million from each subsequent periodic round of audits.

Long-Term Care Audits

We anticipate total recoveries of approximately \$20 million - \$25 million from the initial round of auditing all long-term care facilities having more than 50 beds and \$4 million - \$5 million from each subsequent round of audits, which we propose to conduct approximately every two to three years.

g. Audit Products/Reports to MDCH

Hospital Audits

Within 30 days after finishing an initial provider audit, CDR will submit to MDCH a report containing the following patient-specific information:

- Recipient's name
- Recipient's Medicaid number
- Hospital account number
- Dates of service
- Amount of credit balance
- Reasons for credit balances including the names of the COB insurance carriers and policy number
- Why the accounts identified as paid in error were not identified and returned by the provider
- Summary total amount of credit balances recovered for the provider

In addition, each month, CDR will:

- Prepare for HMS an invoice detailing all recovery activity in the previous month
- Distribute monthly status report and other deliverables to HMS and MDCH detailing year-to-date and project-to-date audit results and recoveries

For all completed audits, CDR will provide HMS and MDCH with both an electronic and paper file that contains the following information:

- Provider name
- Provider number
- Admission type
- Patient name
- Medicaid number
- Hospital account number
- Service date
- COB insurance name/number
- Reasons for overpayment including, if appropriate, the name(s) of the insurance carrier(s) and any other insurance information available to the contractor
- Hospital charges
- Payment date
- Amount paid
- Amount overpaid
- CRN number

CDR agrees to purchase and maintain any and all data processing equipment necessary for the accumulation and reporting of the credit balance data to MDCH. CDR further affirms that we will provide the data in an automated format approved by HMS and/or MDCH, and in a format that is compatible with and is able to interface directly with MDCH system hardware and software, as well as the MMIS system.

At least annually, or more often if required by HMS and/or MDCH, CDR will report and make recommendations concerning the detection and correction of all improper, unallowable, and/or unusual costs to MDCH associated with Medicaid credit balances.

CDR will provide all reports in paper and/or electronic format at the request of HMS and/or MDCH. In addition, we will submit all electronic reports in a format that is compatible with MDCH hardware and software requirements.

Long-Term Care Audits

Within 30 days after finishing an initial provider audit, CDR will submit to MDCH a report containing the following patient-specific information:

- Recipient's name
- Recipient's Medicaid number
- Provider account number
- Dates of service
- Amount of refund
- Reasons for credit balances including the names of the COB insurance carriers and policy number
- Type of refund (claim or patient resource)
- Benefit month of service
- Summary total amount of credit balances recovered for the provider

In addition, each month, CDR will:

- Prepare for HMS an invoice detailing all recovery activity in the previous month
- Distribute monthly status report and other deliverables to HMS detailing year-to-date and project-to-date audit results and recoveries

For all completed audits, CDR will provide HMS with both an electronic and paper file that contains the following information:

- Provider name
- Provider number
- Recovery type (claim or patient resource)
- Patient name
- Medicaid number
- Provider account number
- Service date/benefit month

- COB insurance name/number
- Reasons for overpayment including, if appropriate, the name(s) of the insurance carrier(s) and any other insurance information available to the contractor
- Total charges
- Payment date
- Amount paid
- Amount overpaid
- CRN number

CDR agrees to purchase and maintain any and all data processing equipment necessary for accumulating and reporting credit balance data to HMS. CDR further affirms that we will provide the data in an automated format approved by HMS and/or MDCH, and in a format that is compatible with and is able to interface directly with MDCH system hardware and software, as well as the MMIS system.

At least annually, or more often if required by HMS and/or MDCH, CDR will report and make recommendations concerning the detection and correction of all improper, unallowable, and/or unusual costs to MDCH associated with Medicaid credit balances.

CDR will provide all reports in paper and/or electronic format at the request of HMS and/or MDCH. In addition, we will submit all electronic reports in a format that is compatible with MDCH hardware and software requirements.

h. Summary of Staff Qualifications/Experience

CDR Offers Exceptional Provider Credit Balance Recovery Experience

CDR has performed over **700 audits** and has produced more than **\$30 million** in credit balance recoveries for state Medicaid agencies.

CDR has performed more than **4,000 audits** for commercial insurance carriers, 17 Blue Cross/Blue Shield plans, and 8 state Medicaid agencies.

CDR Associates was founded in 1989 solely to represent state Medicaid agencies, Blue Cross/Blue Shield Plans, and other commercial insurers in the identification and timely recovery of overpaid healthcare claims. The benefits of our services are simple—the recovery of millions of dollars in overpayments that were previously undetected by health care payors. Over the last 15 years, we have recovered in excess of \$400 million for our clients—and have performed over 4,500 provider audits for nine state Medicaid agencies, 17 large BC/BS Plans, and commercial

insurance carriers across the country. CDR was also selected to conduct a highly successful project for the Office of the Inspector General.

No other credit balance recovery vendor can approach CDR's level of performance and experience with state Medicaid agencies. Our comprehensive audit process ensures that Medicaid remains the payer of last resort under the federal rules governing the program.

CDR has worked successfully with HMS to serve Medicaid agencies in nine states, producing recoveries of nearly **\$115 million** (see **Exhibit C2-13**).

Exhibit C2-13: CDR Provider Audit Recoveries for State Medicaid Agencies

State	Hospital Audit Recoveries (\$ million)	Nursing Home Audit Recoveries (\$ million)	Total Recoveries (\$ million)
Colorado	\$0.45	\$0.35	\$0.80
Connecticut	0.82	67.75	68.57
Florida	2.52	--	2.52
Maryland	10.70	14.00	24.70
Maine	3.40	--	3.40
New Jersey	11.47	--	11.47
Ohio	1.10	--	1.10
Pennsylvania	0.80	--	0.80
Virginia	1.60	--	1.60
Total:	\$32.86	\$82.10	\$114.96

Because we are a small business, we can provide a superior level of customer support—and can focus on and adapt to unique requirements more easily than can a large organization. Our Managing Partners are actively involved in client service on a daily basis.

Detailed information about the qualifications and experience of CDR and our staff appears in Proposal Tab C3 (Prior Experience).

i. Price Proposal

Pricing appears under Tab H, per RFP requirements.

C-2.1.b.ii Medicare Claims Appeals and Eligibility Audits

HMS proposes to perform Medicare Claims Appeals and Eligibility Audits with assistance from Elder Law of Michigan (ELM). The HMS Team responds to the specific RFP requirements below. Because the project protocols vary, we have presented our proposed approach to each of the following projects:

- Medicare claims appeals: home health
- Medicare claims appeals: skilled nursing facilities
- Medicare eligibility audits

C-2.1.b.ii.a Claims Appeals: Home Health

a. Project Approach

Medicare covers up to 35 hours of home health care per week for *homebound* recipients requiring part time or intermittent *skilled* nursing or therapy. Care must be provided by a Medicare certified home health agency (HHA) and be pursuant to a treatment plan maintained by a physician.

HHAs, not the Medicare fiscal intermediary, determine if a patient is “homebound” and if nursing and therapy care qualifies as “skilled.” Although Medicare provides guidelines, this determination is subject to the way in which HHA staff interpret both the case and Medicare guidelines. Determinations to bill Medicare are subject to audit by the Medicare fiscal intermediary, and penalties can be imposed (medical review, delay in claim payment, loss of Waiver of Liability protection) if an audit identifies erroneous coverage determinations.

Medicare reimburses HHAs under the Prospective Payment System (PPS). HHAs receive payment based on a national rate scale based on the intensity of care required by the patient, as determined by a standardized patient assessment process. Although providers can receive cost outlier payments under certain circumstances, this payment system poses some financial risk for the HHA, and is generally more difficult to bill under than the usual Medicaid fee for service structure.

Because of the complexity and potential financial risk involved with billing Medicare, in states where Medicaid reimbursement levels are equivalent to Medicare’s, there is incentive to bill Medicaid rather than Medicare. A provider who needs to determine whether a patient is homebound may decide to make the easy choice and bill Medicaid. In addition, many providers do not believe Medicare covers chronic conditions, when in fact the statute has no provision against the coverage of chronic care. As a result, Medicaid often pays for healthcare that is covered under and should be paid by Medicare.

On July 5, 2001, in a Letter to State Medicaid Directors, CMS clarified the right of Medicaid agencies to undertake Medicare appeals on behalf of Medicaid recipients without prior recipient authorization.

The Medicare appeal process can be lengthy, depending on backlogs at the intermediary and Administrative Law Judge level, taking anywhere from 6-18 months. The process is resource intensive for both the contractor and the intermediary, and for HHAs as well, as they must provide copies of medical records and other necessary documentation. HMS believes the key to a good appeals project is to select the appropriate cases for appeal, which maximizes the recovery potential while minimizing effort spent (by everyone involved) on cases with little potential.

HMS, working with home health providers and industry experts, has developed a case-based approach that targets cases based on an analysis of a patient's entire claims history, not only the home health claims. The analysis allows us to target cases where there is a high likelihood that the patient is homebound and receiving skilled care. Selected cases are then presented to HHAs, who are asked to review their Medicare coverage determinations. In many cases, providers reverse their determination and bill Medicare at this stage without the need for appeal. If they do not reverse their decision, they are asked for some additional information about the case, which is used to determine whether to initiate an appeal for that case. This methodology ensures that only the reversible cases enter the appeal process, which minimizes the workload for both agencies and the home health intermediary, and the backlog of appeals.

b. Information/Data Needed to Perform Project

Data Required for Project

- Paid Claims history 2003 forward containing Medicaid recipient identification information, provider of service identification information, standard UB92/1500 form claim values, and Medicaid payment and adjudication information
- MMIS Medicaid Eligibility data containing Medicaid recipient ID numbers, name, SSNs, and dates of birth
- Provider Reference File containing provider identification numbers, names, and addresses
- Annual and quarterly EDB response files (HMS can initiate DUA and inquiry if required)

Optional Data

- Medicare Adjudicated claims file (HMS can initiate DUA and cross-match process)
- Monthly BENDEX and Annual BENDEX COLA file
- Monthly State Buy-in files

Note: HMS currently receives the data files listed above under our existing contract with MDCH.

c. Frequency of Reviews and Appeals

- HMS proposes to review two years of claims history semi-annually
- Appeal of cases/claims will be ongoing throughout the life of the contract

d. Tasks

Project Initiation

- HMS will meet with MDCH to review the project and initial case findings.
- HMS will meet with the HHA Association(s) to explain the project and the process, and incorporate provider concerns into the project design. Throughout the project, HMS will communicate with the HHA Association(s) to keep them informed of the status and issues relating to the project.
- HMS will meet with UGS, the Medicare home health intermediary for Michigan, to introduce the project and establish the specific protocols for submitting claims and appeals to UGS. HMS will also notify the CMS regional office of the project. Throughout the project, HMS will work with UGS and the CMS regional office to help ensure smooth operations of the appeal process.

Identification of Cases and Initial Medicare Coverage Review

- Semi-annually, HMS will analyze Medicaid claims history data to identify home health claims for Medicare/Medicaid dual eligibles where there is a high likelihood that the patient is homebound and that the care is skilled. Medicare eligibility will be obtained from the Medicare EDB, as well as from the monthly BENDEX, Buy-in, Medicare Adjudicated Claims Files (if available), and other data sources that HMS regularly uses in our TPL identification processing. Home health is covered under Medicare Part A, but it is also covered under Part B if Part A is not available.
- Targeted cases will be printed on a “Potential Medicare Coverage Review” listing and sent to the provider of service (i.e., the HHA). The listing informs the provider that the case selection process has identified this case as one with potential Medicare coverage. HHAs are asked to review their coverage determinations and indicate why the case is not covered under Medicare. The listing is structured so that it is easy for the HHA to respond (i.e., the listing requires minimal writing). HHAs will have 60 days to review the cases and respond. In many cases, the HHA will reverse its coverage determination and bill Medicare at this point. Medicare then pays the provider for the claim.
- HMS will effect a recoupment of Medicaid payment for claims paid by Medicare.
- HMS project/provider relations staff will review HHA responses and information and will select cases for appeal.

Medicare Appeal Level 1: Request for Reconsideration

- For claims selected for appeal, HMS will produce a “Notice of Appeals” listing and sent this listing to the HHA with a letter from Medicaid indicating that Medicaid is exercising its right to appeal these claims, and that the HHA is required to bill the claim to Medicare (called a demand bill) with a request for medical review. HHAs will have 60 days to bill the claim to Medicare. HHAs will bill the claims to the Medicare home health fiscal intermediary (FI) with a request for medical review. This is also known as a request for reconsideration.

- The Medicare FI will review submitted claims and request medical records from the HHA as necessary. The FI will issue either payment or a denial to the HHA. The HHA will notify HMS provider relations staff of the results of the initial request for reconsideration. For denied claims, the HHA will send a copy of the medical records to HMS.
- HMS will effect a recoupment of Medicaid payment for claims paid by Medicare.
- HMS will review the medical records relating to denied claims and select those cases that qualify for the second level of appeal.

Medicare Appeal Level II: Administrative Law Judge Appeal

- For claims selected for appeal to an Administrative Law Judge (ALJ), HMS will schedule an ALJ hearing and notify the HHA, as necessary. A separate ALJ hearing is required for each case (however it is possible to hear more than one case in a session).
- A member of the HMS Team will attend the ALJ hearing and advocate for Medicare payment of the case/claims. The ALJ will issue a decision either instructing the FI to pay the claims or upholding the denial of the claims.
- HMS will effect a recoupment of Medicaid payment for all claims paid by Medicare.

e. Estimated Revenue

HMS estimates that 25% of MDCH payments for home health agency services for dual eligibles can be recovered via a successful Medicare appeals project. We estimate this to be \$5 million - \$6 million per year of service.

However, the results of a home health and/or skilled nursing facility (SNF) appeal project ultimately depend on the willingness of the state Medicaid agency to compel providers to cooperate with the appeals process, and on the cooperation of the Medicare fiscal intermediaries.

Depending on backlogs at the Medicare FI and the ALJ caseload, the Medicare appeal process can take 6-24 months, which affects the timing of recoveries to MDCH.

Consequently, HMS requests that the contract entered into between the state and HMS specify that HMS will receive contract fees for all successful appeals initiated under the contract, even if the appeal is not resolved until after the contract expires.

f. Projects/Reports and Frequency

The HMS Team proposes to provide the following project deliverables and reports under this project:

- Initial project plan and timeline
- Reports outlining meetings with provider associations and providers, as needed
- Monthly appeals status report outlining volume/status of cases at each level of appeal
- Quarterly or monthly claims recoupment tape or listing needed to effect recovery on behalf of Medicaid for claims that Medicare subsequently paid

g. Qualifications/Experience of Staff

Information about the qualifications and experience of all proposed staff appears under Tab C4, per RFP requirements.

HMS has used the methodology described in this narrative to recover more than \$6 million for one client to date (New Jersey). In addition, recently, HMS entered into a strategic partnership with the Center for Medicare Advocacy (CMA), to develop Medicare appeals projects for our clients. CMA is one of the nation’s leading Medicare advocacy organizations and has been performing Medicare appeals on behalf of state Medicaid agencies since 1987, recovering more than \$100 million for Medicaid as a result of these efforts. Please note that we are not currently proposing CMA as a subcontractor in Michigan. However, Michigan should benefit from HMS’s relationship and effort with CMA, as the Medicare Home Health fiscal intermediary for Michigan is UGS. HMS and CMA are currently working with UGS and CMS to establish a Medicare appeals process for New Jersey Medicaid. This experience will enable HMS to implement an appeals process for MDCH more effectively and quickly. Proposal **Attachment 3** includes information about the capabilities of primary CMA staff with whom HMS is likely to consult under this Michigan Medicare Eligibility Audits/Appeals project.

h. Price Proposal

Pricing appears under Tab H, per RFP requirements.

C-2.1.b.ii.b Claims Appeals: Skilled Nursing Facility

a. Project Approach

For individuals with Part A coverage, Medicare covers up to 100 days of skilled nursing facility (SNF) care per benefit period. Medicare pays 100% of the first 20 days. For days 21-100, Medicare requires a daily cost sharing, or coinsurance, payment equal to one-eighth of the deductible amount for that year.

In order for a SNF stay to be covered by Medicare, the following conditions must be met:

- The patient must have a three-day “qualifying” hospital stay within the 30-day period prior to the SNF admission (the hospital stay must be related to the SNF care required).
- The patient must be in a Medicare certified bed.
- The patient must require daily skilled care.

It is up to nursing facility staff to determine if a claim qualifies for Medicare coverage. Because of Medicaid billing practices for long-term SNF residents, the complications of billing Medicare under the PPS system, and misperceptions by some nursing facility staff regarding Medicare coverage, claims for dual eligibles who are hospitalized and then re-admitted to a certified bed in the SNF are sometimes erroneously billed to Medicaid when Medicare coverage is available for that care.

HMS has developed a case analysis process that can identify SNF claims with a three-day qualifying hospital stay, and can target cases (based on analysis of a patient’s entire claims history) where there is a high likelihood that the patient is receiving skilled care.

HMS presents selected cases to the SNFs and asks them to review their Medicare coverage determinations for those cases. In many cases, once presented with the case evidence (assuming the patient is in a certified bed), a SNF will reverse its coverage determination and bill Medicare for at least a portion of the 100 days following the hospitalization. For other cases, HMS reviews the clinical record to determine if the patient received care that could be considered skilled. When the bed is certified and the care appears to be skilled, HMS can initiate an appeal of the claim on behalf of the state Medicaid agency.

On July 5, 2001, in a Letter to State Medicaid Directors, CMS clarified the right of state Medicaid agencies to undertake Medicare appeals on behalf of Medicaid recipients without prior recipient authorization.

b. Information/Data Needed to Perform Project

Data Required for Project

- Paid Claims history 2003 forward containing Medicaid recipient identification information, provider of service identification information, standard UB92/1500 form claim values, Medicaid payment and adjudication information
- MMIS Medicaid Eligibility data containing Medicaid recipient identification numbers, name, SSNs, and dates of birth
- Provider Reference File containing provider identification numbers, names, and addresses
- Annual and quarterly EDB response files (HMS can initiate DUA and inquiry if required)

Optional Data

- Medicare Adjudicated Claims File (HMS can initiate DUA and cross-match process)
- Monthly BENDEX and Annual BENDEX COLA file
- Monthly State Buy-in files

Note: HMS currently receives all the required and optional data files listed above under our existing contract with MDCH.

c. Frequency of Reviews and Appeals

- The HMS Team proposes to review claims history semi-annually for case selection.
- Appeal of cases/claims will be ongoing throughout the life of the contract.

d. Tasks

Project Initiation

- HMS will meet with MDCH to review the project and initial case findings.
- HMS will meet with the nursing home association(s) to explain the project and the process, and incorporate provider concerns into the project design. Throughout the project, HMS will communicate with the nursing home association(s) to keep them informed of the status and issues relating to the project.

- HMS will meet with UGS and the other large SNF Medicare Part A intermediaries in Michigan to introduce the project and establish the specific protocols for submitting demand bills and appeals to UGS. HMS will also notify the CMS regional office of the project. Throughout the project, HMS will work with UGS and the CMS regional office to help ensure smooth operations of the appeal process.

Identification of Cases and Initial Medicare Coverage Review

- SNF care is covered under Medicare Part A. Semi-annually, the HMS case analysis process will analyze Medicaid Paid Claims History data to identify SNF claims where: (i) the individual has Medicare Part A coverage, (ii) Medicaid has paid for SNF care following a three-or-more-day hospital stay, and (iii) associated claim suggests a high likelihood that the care is skilled. The HMS Team will obtain Medicare eligibility from the Medicare EDB—as well as from the BENDEX, Buy-in, and Medicare Adjudicated Claims Files (if available), and other data sources that HMS uses in our regular TPL identification processing.
- HMS will present targeted cases on a “Potential Medicare Coverage Review” listing and will send this listing to the SNF. This listing informs the provider that the HMS Team has identified this case as having potential Medicare Coverage. SNFs are asked to review their coverage determinations and indicate why the case is not covered under Medicare. The listing is structured so that it is easy for the SNF to respond (i.e., the listing requires minimal writing). SNFs will have 60 days to review the cases and respond. In some cases, the SNF will reverse its coverage determination and bill Medicare at this point. Medicare then pays the SNF for the claim.
- HMS will effect a recoupment of Medicaid payment for claims that Medicare paid.
- HMS project/provider relations staff will review SNF responses and will select for appeal those cases where the bed was Medicare certified and the care seems to be skilled and related to the hospital stay.

Medicare Appeal Level 1: Request for Reconsideration

- The HMS Team will produce a “Notice of Appeals” listing for each case we select for appeal and will send this listing to the SNF. We will also include a letter from Medicaid indicating that Medicaid is exercising its right to appeal these claims, and that the SNF is required to bill the claim to Medicare (called a demand bill) with a request for medical review. SNFs will have 60 days to bill the claim to Medicare. SNFs will bill the claims to the Medicare Part A intermediary with a request for medical review. This is also known as a request for reconsideration.
- The Medicare FI will review submitted claims and request medical records from the SNF, as necessary. The FI will issue either payment or a denial to the SNF. The SNF will notify HMS provider relations staff of the results of the initial request for reconsideration. For denied claims, the SNF will send a copy of the medical records to HMS.
- HMS will effect a recoupment of Medicaid payment for claims that Medicare paid.
- HMS will review the medical records relating to denied claims and select cases that qualify for the second level of appeal.

Medicare Appeal Level II: Administrative Law Judge Appeal

- For claims selected for appeal to an ALJ, HMS will schedule an ALJ hearing and notify the SNF, as necessary. A separate ALJ hearing is required for each case (however, it is possible to hear more than one case in a session).
- A member of the HMS Team will attend the ALJ hearing and advocate for Medicare payment of the case/claims. The ALJ will issue a decision either instructing the FI to pay the claims or upholding the denial of the claims.
- HMS will effect a recoupment of Medicaid payment for all claims that Medicare paid.

e. Estimated Revenue

HMS estimates that 4% of MDCH payments for SNF care for dual eligibles can be recovered through a successful Medicare appeals project. We estimate this to be \$3 million - \$4 million per year of service.

However, the results of a SNF appeal project ultimately depend on the willingness of the state Medicaid agency to compel providers to cooperate with the appeals process, and on the cooperation of the Medicare FI(s).

Depending on backlogs at the Medicare FI and the ALJ caseload, the Medicare appeal process can take 6-24 months, which affects the timing of recoveries to MDCH.

Consequently, HMS requests that the contract entered into between the state and HMS specify that HMS will receive contract fees for all successful appeals initiated under the contract, even if the appeal is not resolved until after the contract expires.

f. Projects/Reports and Frequency

The HMS Team proposes to provide the following project deliverables and reports under this project:

- Initial project plan and timeline
- Reports outlining meetings with provider associations and providers, as needed
- Monthly appeals status report, outlining volume/status of cases at each level of appeal
- Quarterly or monthly claims recoupment tape or listing needed to effect recovery on behalf of Medicaid for claims that Medicare subsequently paid

g. Qualifications/Experience of Staff

Information about the qualifications and experience of all proposed staff appears under Tab C4, per RFP requirements.

In our first project using a similar methodology, HMS recovered in excess of \$5 million in skilled nursing facility payments for one of our clients. A second project is underway. To better develop our appeals knowledge and experience, HMS has entered into a strategic partnership with the Center for Medicare Advocacy (CMA) to develop appeals projects on behalf of our clients. CMA is one of the nation's leading Medicare advocacy organizations and has been performing Medicare SNF/home health appeals on behalf of state Medicaid agencies since 1987, recovering more than \$100 million for Medicaid as a result of these efforts. However, please

note we are not currently proposing CMA as a subcontractor for this project. Nonetheless, we believe this strategic relationship will enable us to leverage our expertise and results in the SNF recovery arena. Proposal **Attachment 3** includes information about the capabilities of primary CMA staff with whom HMS is likely to consult under this Michigan Medicare Eligibility Audits/Appeals project.

h. Price Proposal

Pricing appears under Tab H, per RFP requirements.

C-2.1.b.ii.c Eligibility Audits

a. Project Approach

Medicare coverage represents the single largest third party resource among Medicaid eligibles. Identifying available Medicare Parts A and B coverage can help Medicaid agencies save over \$5,000 per recipient annually.

The Social Security Administration (SSA) is responsible for establishing Medicare coverage for the Supplemental Security Income (SSI) subset of the Medicaid population. SSA data flow directly and indirectly to state Medicaid agencies via electronic data transactions in the SDX, Medicare Buy-in, and BENDEX files. The process has many opportunities for error. Over time, unless Medicaid diligently applies resources to correcting the errors, significant levels of SSI-entitled Medicaid recipients reside on the Medicaid database without the Medicare coverage to which they are entitled.

In one state, the error rate was over 8%, resulting in thousands of Medicaid recipients being listed without Medicare identified as their primary payor. That lack of recorded coverage cost the state over \$20 million in a two-year period.

The vast majority of errors occur at intake, when data are improperly entered into the SSI Beneficiary Record. These errors follow recipients throughout the transaction process that leads to Medicaid entitlement. Because the recipients already have health coverage through Medicaid, they have no incentive to follow through on missed Medicare coverage.

Under existing Medicare Buy-In rules, virtually no SSI beneficiary over 65 years of age should be without Medicare Part A and B coverage. Any individual whose coverage is missed costs the Medicaid agency thousands of dollars annually in payments that could be shifted to Medicare. Thousands of individuals missed translate into millions of dollars in overpayments.

The HMS team proposes to set up a team of law students, paralegals, and administrative assistants that would work with Elder Law of Michigan (ELM) attorneys to review the cases that have been identified as a potentially incorrect denial of eligibility.

b. Information/Data Needed to Perform Project

- Paid Claims history 2000 forward containing Medicaid recipient identification information, provider of service identification information, standard UB92/1500 form claim values, Medicaid payment and adjudication information
- MMIS Medicaid Eligibility data containing Medicaid recipient identification numbers, name, SSNs, and dates of birth
- Provider Reference File containing provider identification numbers, names, and addresses
- Annual and quarterly EDB response files (HMS can initiate DUA and inquiry if required)
- Medicare Adjudicated Claims File (HMS can initiate DUA and cross-match process)
- Monthly BENDEX and Annual BENDEX COLA file
- Monthly State Buy-in files
- SDX files

c. Frequency of Reviews

HMS will initially review five years of Medicaid claims and eligibility data (Medicaid and Medicare), including those claims that indicate denial of Medicare coverage, seeking cases where patient profiles and/or Medicare eligibility denials indicate potential unrealized Medicare coverage with a cost reduction benefit to the state. The cases identified as a result of this review, along with any existing referrals from MDCH enrollment activities, will form the case base for our review team. This team will conduct ongoing eligibility review and appeals.

Subsequent to the initial five-year review, we will perform ongoing review of any referred cases, and will review claims/eligibility data to identify new cases semi-annually.

Appeals casework will be ongoing.

d. Tasks

The HMS/ELM Team proposes the following approach to handle eligibility denials:

- Identify cases to review.
 - Receive information on cases where Medicare has denied the claim due to the patient's ineligibility.
 - Receive and coordinate information from Social Security concerning retroactive SSI determinations and potential retroactive enrollment of recipients in Part A and Part B of Medicare.
 - Identify potential cases through analysis of claims history, SDX, BENDEX, and Buy-in data, seeking cases where demographics, patient medical history (e.g., disability/renal dialysis), and inconsistent or missing Social Security data indicate coverage should exist.
 - Enter cases in HMS's case tracking system

- For each identified case, the HMS/ELM Team will:
 - Research and review the reason for a person’s ineligibility. This may involve researching whether the patient has worked the number of quarters required to qualify for Medicare and has paid into the Medicare system. Also, we would need to determine whether the person elected not to have Part B coverage. If so, we would determine if that person is eligible for the state to help pay the Part B monthly premium (i.e., Part B Buy-In) and would then initiate the process to help the person enroll. This would provide a future savings to the state, as well.
 - Review findings with the regional SSA office to appeal the eligibility determination and ensure the recipient is accreted to the enrollment database.
 - If buy-in is required, HMS will research the cost effectiveness of a retroactive buy-in and will make a recommendation to MDCH.
 - Ensure that relevant historical claims are submitted to Medicare (and paid) so that MDCH can realize the cost savings of the retroactive enrollment. HMS can do this by working with providers directly or through existing MDCH recovery processes.
 - Report any new eligibility obtained to MDCH for ongoing cost avoidance purposes.

e. Estimated Revenue

\$2 million - \$3 million per year of service

f. Projects/Reports

HMS will provide monthly status reports indicating:

- Number of new cases identified that month and project to date
- Number of cases completed that month and project to date
- Amount of recoveries that month and project to date
- Issues encountered and opportunities for improvement to the enrollment process

g. Qualifications/Experience of Staff

Information about the qualifications and experience of all proposed staff appears under Tab C4, per RFP requirements.

h. Price Proposal

Pricing appears under Tab H, per RFP requirements.

C-2.1.b.ii.d Enhancements to Maximize Medicare Eligibility and Buy-In

Upon request from MDCH, HMS can also provide the following services to produce enhanced results from the Medicare Claims Appeals and Eligibility Audits project.

- **Modification to State Medicaid/Medicare Buy-In Status.** State Medicaid programs elect their Medicare Buy-In status. Michigan can increase its Medicare recoveries by modifying its Medicare Buy-In status, which will enable MDCH to retroactively enroll dually eligible Medicaid and Medicare beneficiaries and also pursue retroactive Medicare recoveries. The HMS Team will review the Medicare and Medicaid regulations regarding Buy-In and will develop the appropriate application material required to modify the state's Medicare Buy-In status. Finally, HMS will incorporate retroactive Medicare recovery associated with the newly identified retroactive enrollment.
- **Medicare Social Security Administration (SSA)/Supplemental Security Income (SSI) Project Support.** SSA has indicated that there are at least 120,000 beneficiaries, and perhaps as many as 500,000 beneficiaries, who were eligible for Medicare in the past but who were not indicated as such on the beneficiary data exchange processes due to SSA administrative error. Retroactive Medicare eligibility may be available for these beneficiaries if states act within six months after identifying the error. HMS is helping a number of client states in the identification/tracking and cost effectiveness evaluation, retro-enrollment, and recovery of Medicaid payments for these recipients where Medicare should have been the primary payor.
- **Medicare Enrollment Maximization (No Buy-In).** The SSA establishes Medicare coverage for the Medicaid population with SSI. SSA data flow directly/indirectly to Medicaid agencies via electronic data transactions in the SDX, Medicare Buy-in, and BENDEX files. The process has many chances for error. Unless Medicaid diligently applies resources to correcting the errors, significant levels of SSI-entitled Medicaid recipients reside on the Medicaid database without the Medicare coverage to which they are entitled.

After isolating incorrect data, HMS will work with MDCH to amend recipient records on the state's third party file. When necessary, HMS will also work with the appropriate federal agency—CMS or SSA—to update the MBR to reflect the accurate Medicare status. Once the files are corrected, HMS will identify any Medicaid overpayments that resulted from errors in the Medicare identification process and will coordinate with MDCH to recover those overpayments.

C-2.1.c Project #1: Additional HMS Projects

HMS understands that MDCH is interested in working with a contractor to identify specific initiatives that have the potential to expand cost avoidance and third party recoveries for Medicaid—and that MDCH may also permit the contractor to implement and perform the recovery project(s) associated with the identified area(s) of opportunity.

HMS is the knowledge leader in best practices to investigate and resolve billing irregularities. By performing the following services, HMS has identified and recovered overpayments and erroneous payments amounting to approximately **\$115 million** for our clients. We have the ability to draw on our experience performing revenue recovery services for our present client base (more than 20 clients, the vast majority of which are state Medicaid agencies), and, if appropriate, will contact these agencies during project development to determine if and how we can tap their experience to benefit Michigan's TPL program.

By partnering with clients representing a broad diversity of claiming environments, HMS has developed innovative methods to identify overpayments and potential fraud and abuse in the Medicaid program. The HMS approach is not off-the-shelf, nor limited to a few, small, and recent engagements. HMS offers a comprehensive system that includes:

- Expertise in Medicare coordination of benefits, fraud detection, data processing, healthcare billing and payment methodologies, provider relations, and claims recoupment
- Comprehensive review of existing policies, regulations, and claim edits
- Access to a catalog of proven algorithms
- Robust software applications that rapidly reformat data, identify potential overpaid claims, and disposition erroneous paid claims through the recovery process
- Established overpayment identification and recovery processes

HMS's proposed approach for identifying and resolving overpayments and erroneous payments in Michigan is modeled on the process we use in other states and includes the following general steps:

- Identify and discuss irregularities and potential overpayments with MDCH
- Review state billing and reimbursement policies and regulations
- Perform feasibility studies
- Review findings with MDCH
- Review sample claims with providers
- Refine claim selection and obtain approval from MDCH to proceed with the recovery project
- Report results to MDCH

HMS will apply algorithms we have used successfully in other states and will also develop algorithms specific to Michigan—based on review of edits and discussion with MDCH staff—to identify and recover claim overpayments. These algorithms include, but are not limited to, the following:

- Coordination of benefit overpayments
- Inappropriate use of override codes
- Duplicate payments
- Overlapping payments (i.e., nursing home room & board, coinsurance, and patient payments)
- Payments after a recipient's date of death (both fee-for-service and managed care)
- Overlapping fee-for-service and managed care capitation payments
- Claim unbundling (lab test, ER visits, preadmission testing)
- Inappropriate hospital readmissions and transfer payments
- Pharmacy overpayments
- Multiple physician office and therapy visits
- Crossover payments beyond Medicaid's liability (Medicare repricing)
- Inappropriate amount recorded in other-third-party (OTP) field

HMS would implement and perform these projects only after consultation with MDCH. Because some of these initiatives have a higher level of complexity and require greater effort and resources to perform than the RFP-required Core TPL services, these projects are not included under the Project 1/Medicaid TPL rates presented in HMS's Price Proposal (Tab H). HMS will require a separately negotiated fee if MDCH chooses to implement them.

Medicare Deductible and Coinsurance Project

Medicare and Medicaid occasionally pay claims for the same or overlapping dates of service and—in the process—do not coordinate benefits properly. Medicaid overpayments also occur when Medicare pays a claim, forwards that claim to Medicaid for payment of the residuals, and then subsequently adjusts or retracts Medicare's payment (effectively leaving an unnecessary Medicaid payment "on the books"). HMS has developed a number of algorithms—working with other states' Medicaid and Medicare Adjudicated Claims Files—to determine where coordination of benefits with Medicare commonly results in duplicate, excess, or overlapping Medicaid payments. In the Deductible and Coinsurance project, HMS examines patient, provider, and claim attributes longitudinally across a patient's adjudicated claim history to identify inappropriate or excess crossover payments.

Skilled Nursing Facilities Enhanced Recoveries

- **Ancillary Services During Medicare Covered Skilled Nursing Facility (SNF) Stays.** Medicare Part A per diem payments to skilled nursing facilities cover certain ancillary services, such as pharmacy, DME equipment/supplies, and therapies. Accordingly, a SNF should not bill Medicaid for ancillary services covered under the Medicare per diem payment. HMS identifies and recovers Medicaid payments for ancillary service claims when Medicare Part A has also paid the SNF for the same date(s) of service. HMS analyzes both Medicare and Medicaid paid claims data to identify these overpayments.
- **Recovery of Medicare Skilled Nursing Facility Excess Payments.** Overpayments for dually eligible (Medicaid/Medicare) long-term care (LTC) patients occur when Medicaid pays a provider for a day of care that Medicare Part A has also reimbursed. To identify these occurrences, HMS compares longitudinal Medicaid Paid Claims and Medicare Adjudicated Claims data, to properly coordinate benefits between Medicare and Medicaid and determine the Medicaid overpayment. HMS also identifies overlapping coinsurance payments by Medicaid and overpaid patient pay amounts.

Medicare Part B Enhanced Recoveries

Medicaid agencies often find it difficult to bill and recover on nontraditional Part B claims. Often, the agency does not receive the claim information (i.e., level of care indicators) or documentation (i.e., physician certification) required to properly bill these claims. HMS will collect this information from providers and other sources. HMS uses newly developed techniques and the Medicare Adjudicated Claims files to identify, bill, and recover nontraditional Part B claim types, including:

- ◆ Immunosuppressive drugs
- ◆ Oral anti-cancer drugs
- ◆ Diabetic testing supplies
- ◆ Nebulizer drugs
- ◆ Blood clotting factors
- ◆ Procrit
- ◆ Durable medical equipment
- ◆ Transportation/ambulance
- Outpatient mental health

Medicare Part B Ancillary Payments

Medicare Part B also pays for certain ancillary services during an inpatient acute care, chronic, or psychiatric hospital stay when the recipient has Part B coverage only or the recipient has exhausted Part A benefits. In these situations, Medicaid is *de facto* the primary payor for the inpatient stay, but Medicare Part B is primary for any covered Part B services. To ensure proper coordination of benefits, providers should submit a primary bill to Medicaid, with the payment for Medicare Part B services noted on the bill. This information allows Medicaid to adjudicate a claim correctly by calculating its primary liability and then subtracting the previous Medicare Part B payment and any corresponding Medicaid crossover payments.

However, Medicaid overpayments occur when providers do not accurately submit the amount Medicare paid—either at the time billing or through a subsequent adjustment. HMS identifies and recovers these overpayments, which represent the difference between what Medicaid paid, and what Medicaid should have paid—given the associated Part B payments.

Hospice Medicare/Medicaid Coordination of Benefits

Medicaid pays a significant amount in hospice benefits for dually eligible Medicare/Medicaid recipients. The coordination of hospice benefits between Medicare and Medicaid for dually eligible recipients can be difficult to manage for providers and MMIS staff at the time of claim reimbursement. Using our longitudinal claims database of both Medicaid and Medicare paid claims, HMS can effectively identify where both programs covered a service, or where Medicaid covered a service that should have been covered and paid under Medicare.

Medicare Crossover Repricing

The Balanced Budget Act of 1997 reconfirmed that states have the right to limit payment for "crossed over" deductible and coinsurance charges for dually eligible recipients when payment in full (Medicare and Medicaid) would result in the provider receiving payment that exceeds the amount the provider would have received under Medicaid alone. The common term for this limitation is "repricing" of crossover claims. [Institutional providers can obtain CMS reimbursement for the majority of payment limitations via the Medicare bad debt program.](#)

For a state to implement repricing, the state plan must indicate the state will pay cost sharing only up to the Medicaid allowed amount for dual eligibles. HMS can assist the state in ensuring full repricing of these claims by using the Medicare ACF to complete manually submitted crossovers and help reprice LTC ancillary crossovers, outpatient services, and other services.

HMS is currently helping two client states with retroactive repricing of Medicare Part A and Part B claims. In addition, we are helping to specify MMIS modifications that will enable ongoing repricing of claims during crossover claim adjudication. To support this effort, HMS will:

- **Develop an understanding of the state's pricing policy and structures, including repricing impact on non-direct payments.** HMS works with state policy and MMIS subject matter experts (including consultants) to understand and model the state's pricing mechanisms on HMS systems. HMS also works to understand and account for any impact that repricing may have on non-direct payments to providers (e.g., cost report adjustments, pass through payments).
- **Perform retroactive review of historical Medicare/Medicaid claims data and repricing activity, and develop specifications for implementing repricing on the state's claim adjudication system.** HMS can process multiple years of historical claims data on our systems. If Medicaid crossover claims history data do not contain sufficient detail for repricing, HMS will obtain historical Medicare claims data from CMS and fiscal intermediaries/carriers. If desired, HMS can continue to reprice claims on an ongoing daily, weekly, monthly, or quarterly basis, or we can convert our algorithms and tables/files into specifications for implementation on the state's MMIS system.

An effective repricing policy/project can result in significant cost savings to the state. A state can often avoid or recoup as much as 85% of inpatient and 25% of outpatient crossover payments. Providers can then receive reimbursement for 75% of these amounts via the Medicare Bad Debt program.

Excess Payments in Regard to Date of Death

Following the death of a Medicaid recipient, there is often a delay before the Medicaid agency is able to update all eligibility and claim payment systems. Excess Medicaid payments sometimes occur during this delay. HMS aggregates various national and local eligibility and vital statistics files into a database. We then compare recipient claims to the date of death database to determine if Medicaid paid for services not rendered (i.e., where the date of service is after the date of death). When HMS identifies inappropriate or excess payments, we pursue recovery.

Pharmacy Overpayment Recovery

HMS identifies and recovers duplicate or overlapping payments resulting from pharmacy billing and payment anomalies, including:

- ◆ Confusion regarding days supply
- ◆ Improper early refills
- ◆ Overpayments due to missing or inappropriately applied edits
- ◆ Fee-for-service payments for pharmacy payments included in capitation rates
- Full billings for partial dispensings (prescriptions paid twice but not dispensed twice)

HMS analyzes Medicaid recipient, dates of service, prescription number, and NDC code data to identify potential overpayments. HMS refines the population of overpaid claims by reviewing applicable policies and regulations.

J-Code Rebate Collection

In March 2003, the US Department of Health and Human Services, Centers for Medicare and Medicaid Services, issued a letter encouraging states to identify Medicaid drugs—specifically drugs with Healthcare Common Procedure Coding System (HCPCS) J-codes—by their National Drug Codes (NDCs) so that rebates can be collected for these drugs. Identifying these drugs has been a problem for traditional rebate processes and systems, resulting in millions of dollars in uncollected revenues. As quoted in the letter from CMS, “We strongly encourage each state to collect rebates for all cancer and injectible drugs billed to the Medicaid program and to establish a conversion system which would permit the collection of rebates on any J-coded drug.”

Drug pricing remains in the compliance spotlight, and a significant opportunity exists for states to achieve cost savings by stepping up efforts to collect rebates on certain drugs.

HMS offers a recovery-focused initiative that will generate additional collections for MDCH and require no additional federal or state funds. The project focuses on maximizing the state’s identification and recovery of already negotiated drug rebates due from Pharmaceutical Manufacturers and Labelers for “J-Code” class drugs. HMS would be analyzing medical and drug-related claims that MDCH would make available to HMS under this contract.

There are two types of J-code recoveries, single- and multi-source as defined below.

- Single-source: J-codes for which there is a one-to-one correspondence with a single NDC code that can then be used to determine the rebate amount
- Multi-source: J-codes that correspond to multiple NDC codes

HMS has developed several different methodologies to maximize rebate recovery for *both* single source and multi-source J-Codes. However, if MDCH currently converts single source J-Codes to its corresponding NDC codes, this project will focus solely on obtaining rebates for multi-source J-Codes.

TPL for Michigan Elder Prescription Insurance Coverage

HMS proposes to apply our TPL services to the EPIC program, to ensure that only eligible seniors (i.e., those without other prescription drug coverage, except for Medicare or Medicare supplemental insurance) are using its benefits.

HMS has provided TPL services for senior pharmacy programs in the following states:

- **Connecticut.** HMS has worked closely with Connecticut's senior program, the Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled, for which we have recovered **\$500,000** from third parties.
- **New Jersey.** In addition to the Medicaid program, New Jersey's generous entitlement benefits include the Pharmaceutical Assistance to the Aged and Disabled program and the AIDS Drug Distribution Program. To date, HMS has recovered more than **\$31 million** from third parties on behalf of these state-funded programs.
- **Pennsylvania.** The Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE) recently engaged HMS to assist with maximizing recoveries available for recipients enrolled under both PACE and Medicaid.

Inpatient/Outpatient Unbundling

Billing, coordination of benefits, and payment errors cost MDCH millions of dollars per year. These errors occur, for example, when providers bill twice for a service provided on a given day, when an inpatient/outpatient service is incorrectly unbundled, or when Medicaid pays a claim in excess of the authorized reimbursement amount. HMS uses the following approaches to identify these excess Medicaid payments:

- **Within claim type.** HMS applies longitudinal analysis to historical Medicaid paid claims data. Through this process, we identify claims for the same patient—on the same or overlapping dates of service—that providers submitted and Medicaid paid in error.
- **Inpatient/outpatient unbundling.** HMS analyzes overlapping inpatient and outpatient claims for the same patient on the same or related dates of service. Through this process, HMS identifies claims for which the provider inappropriately unbundled outpatient services and Medicaid consequently paid an excessive amount. By analyzing the payment history of inpatient and outpatient claims associated with an inpatient stay, in light of applicable state regulations/policy, HMS determines Medicaid's true liability (with outpatient services appropriately bundled) and recovers Medicaid payments above that amount.

Overlapping Capitated Managed Care and Fee-For-Service Payments

HMS proposes to identify and recover fee-for-service (FFS) Medicaid payments to providers where there is also an overlapping capitation payment to a contracted Medicaid managed care organization (MCO). These overpayments can happen due to retroactive enrollment of newborns and newly enrolled managed care recipients that create overlapping FFS and managed care enrollment periods. In some cases Medicaid's cost avoidance matrix is not properly set to deny the FFS or coordinate payment. HMS can exclude from recovery all claims associated with exempt provider/claim types and services that are "carved out" of (i.e., not included under) the capitated managed care plan and contracts.

Excess Managed Care Premiums in Regard to Date of Death

An area that is often problematic for state Medicaid programs, especially those with a high penetration of Medicaid managed care recipients, results when premiums are paid to MCOs after a recipient's death. Similar to the situation that occurs with fee-for-service processing, delays in updating eligibility and payment systems result in erroneous premium payments to the MCOs. Furthermore, many states do not have effective retroactive recovery methodologies to help recover inappropriate premium payments. HMS obtains recipient date of death date information from various files, including Medicaid eligibility, national files, and state vital statistics files. We then analyze this information and compare it to the premium payment information. In cases where Medicaid paid premiums after the Medicaid managed care member's date of death, the files are immediately flagged as overpayments. HMS isolates these inappropriate premium payments and subsequently considers them for recovery from the MCO via a disallowance process.

Medicaid MCO Come-Behind TPL

Approximately 70% of Michigan's Medicaid population is enrolled in capitated Medicaid managed care plans (either commercial or Medicaid-only plans).¹⁰ As of March 1, 2004, 17 MCOs were providing coverage and services to Medicaid recipients throughout the state.¹¹ Under this program, the MCOs have the responsibility to recover monies from any liable third party for services rendered to Medicaid recipients.

Historically Medicaid MCOs have not devoted the necessary resources to adequately maximize third party liability recoveries. Since states usually account for a certain amount of these recoveries in their rate-setting models, it is important for MCOs to achieve the established goals. To assist states and the Medicaid MCOs in achieving their goals, HMS provides come-behind TPL recovery services for Medicaid MCOs. HMS can either work with each MCO independently to enhance its current recovery processes or it can provide these services under MDCH's third party liability recovery contract in a coordinated fashion.

¹⁰ CMS, *2002 Medicaid Managed Care Enrollment Report*.

¹¹ MDCH Web site: *List of Medicaid Health Plans and Where they Operate*, updated March 1, 2004.

Interstate Overpayments

HMS identifies additional areas of overpayment that result from recipients enrolling in Medicaid programs in multiple states. In working with the Administration for Child and Families (ACF), HMS can identify recipients enrolled in multiple state Medicaid programs. The ACF has developed the Public Assistance Reporting Information System (PARIS) to identify those recipients enrolled across multiple state Medicaid programs. This opportunity can identify claims or premiums paid by Medicaid when the reimbursement was actually the responsibility of another Medicaid program—or work together with the Medicaid agencies to coordinate benefits.

Supplemental Casualty Recovery

HMS believes there may be the occasional opportunity to support MDCH's casualty recovery efforts—in cases where the agency experiences staff constraints limiting the number of casualty cases it can efficiently and effectively handle. As such, we propose to assist MDCH by working referrals on any backlog of cases that may exist presently and/or during peak work loads. Without duplicating MDCH efforts, HMS's supplemental casualty recovery services would result in: (a) more timely recovery and closure of cases; (b) more manageable workload for MDCH staff; and (c) maximized recoveries from this third party resource. HMS has implemented casualty recovery programs in Arizona, Colorado, Connecticut, Florida, New Jersey, Iowa, and Ohio and has successfully recovered more than **\$111 million** for these states.

Estate Recovery

HMS's proactive estate recovery program would mean significant additional incremental revenue for MDCH. Estate recoveries have long represented high-potential opportunities in Medicaid TPL recovery, but actual recoveries have proven difficult. The estate recovery process is difficult because of: (i) the necessity for political and legislative support, (ii) the complexity of integrating disparate data sources, such as probate and property tax data, (iii) the labor-intensive manual effort required to develop cases and file claims, and (iv) the complexity of state probate laws. HMS has a broad understanding of the components comprising a successful estate recovery effort and hands-on experience with the various approaches to implementing such programs. HMS has performed estate recovery as part of its revenue recovery programs for Medicaid agencies in Arizona, Colorado, Florida, and Iowa, and has successfully recovered more than **\$105 million** for these states.

Provider Self-Audits and Automated Self-Audits

Section C-2.1.b.i, under this Tab, describes HMS/CDR's proposed approach to the RFP requirements for on-site Hospital and Long-Term Care Provider Audits. To supplement the on-site audits, HMS also offers—as an enhancement—a provider self-audit process—as described below—which is typically lower-cost than the on-site process. **Self-audits have produced more than \$3.0 million in recoveries for Michigan under HMS's present TPL contract.**

This multi-tiered approach to performing provider audits will ensure maximum recoveries for MDCH. HMS performs these audits on various provider types including hospitals, nursing homes, dialysis clinics, and others.

Provider Self-Audit Project

HMS will produce and mail to providers a package containing a letter explaining the self-audit process, an overpayment worksheet, worksheet instructions, and a sample completed worksheet. The letter will instruct providers to review credit balances for prior years and will identify a timeframe for the providers to respond. Providers then review their records, identify credit balances at the claim level, and forward the worksheet (and reimbursement of overpayments, if they choose) to HMS. HMS will consolidate (electronically or keypunched), into a single database, the worksheets and documentation that providers submit. HMS will identify to MDCH any providers who do not cooperate with the self-audit process and will obtain MDCH's approval to initiate the next step—automated self-audits.

Provider Automated Self-Audits (Claims Review)

HMS's automated self-audit project supplements our self-reporting project described above by identifying suspect paid claims. Much of the approach described above is the same for our automated audits. The difference is that HMS employs algorithms to identify claims for which credit balances may exist and sends a listing of these claims to the providers for review.

To support this recovery initiative, HMS will produce and mail an audit package containing listings of suspect claims for provider review along with a provider letter describing the project and a detailed and provider-specific review worksheet. These suspect claims include denials that HMS has received from insurance carriers, stating payment was previously made to the provider. Based on the specific claim and account information in the review package, providers will review their records, identify Medicaid credit balances, and forward payment with the completed worksheet to MDCH. HMS will manage the entire process using our provider relations team and our operational processes for payment remittances, and we will provide any additional third party coverage data to MDCH for update of its TPL Coverage File.

If providers do not cooperate with the self-audit projects, as described above, HMS usually recommends an on-site audit—as described in Section C-2.1.b.i, under this Tab (Hospital and Long-Term Care Provider Audits).

Readmissions and Transfers

HMS analyzes hospital claims and, in accordance with the state agency's readmission and transfer reimbursement policies, identifies inappropriate payments. HMS can perform this project for states that reimburse hospitals under a DRG or case payment system. HMS recovers payments for inpatient hospital stays that are medically related to a previous stay. Payment for services rendered during the readmission are included in payment for the previous stay. HMS also recovers payments to transferring hospitals where Medicaid should have paid a per diem rate instead of a full case payment.

C-2.1.d Project #2: Locate Commercial Health Insurance and Medical Support

Enforcement

The HMS Team offers a full-scope medical support enforcement (MSE) program, including all of the RFP-required components:

- Commercial health insurance locate services
- Insurance enrollment
- Process backlogged NMSNs

HMS will perform the commercial health insurance locate function. As a natural adjunct to our core revenue recovery services, HMS performs commercial health insurance locate activities for the following state child support enforcement agencies:

- ◆ **Ohio:** Identification and verification for the full state child support caseload
- ◆ **Connecticut:** Identification and verification for the full state child support caseload
- **Colorado:** Data match to full state child support caseload
- **Maryland:** Identification and verification for the full child support caseload and enrollment in one county

In addition, HMS will begin performing insurance locate services for the child support agencies in Florida and Washington by May 2004.

HMS proposes to subcontract to MAXIMUS, which would perform insurance enrollment and NMSN backlog processing. MAXIMUS professionals have been conducting successful child support projects for more than 27 years and are currently performing NSMN enrollment activities in Illinois.

Enforcing medical support is complex and time-consuming. Traditionally, states have succeeded in establishing medical support orders but have hesitated to expend child support resources on efforts to secure actual medical insurance.

However, the long-standing federal requirement for cooperation between state Medicaid and child support programs underscores the importance of identifying and using available health insurance resources for all children.

The HMS/MAXIMUS MSE program helps state Medicaid and child support enforcement agencies to:

- Identify noncustodial parents (NCPs), custodial parents (CPs), and other guardians who have available healthcare coverage
- Enroll children of NCPs onto the NCP policy¹²
- Meet future performance incentives as required by federal mandates

C-2.1.d.i Insurance Locate Services

C-2.1.d.i.a Insurance Locate Services: MFIA Responsibilities

1. Insurance Inquiry File

Provide the contractor a monthly Insurance Inquiry File.

HMS understands that OCS will provide a monthly Insurance Inquiry File, listing cases in which parents are not providing court-ordered health insurance for their dependent children. HMS will match this file against our commercial health insurance database to identify available coverage unknown to the Friends of the Courts (FOC) and OCS. We describe the proposed data match process below, in Section C-2.1.d.i.a (Insurance Locate Services: Contractor Responsibilities), item (c) (Perform Monthly Match). HMS can accept the Insurance Inquiry File in any format and media.

2. Reimburse Contractor

Reimburse the contractor within 30 days after receipt of an approved invoice.

HMS will prepare invoices, with supporting documentation regarding the insurance locate services, for MDCH.

HMS will customize each invoice to meet MDCH requirements.

¹² HMS can also apply our MSE services to identifying available coverage through custodial parents and enrolling children under this coverage, if the state desires.

C-2.1.d.i.b Insurance Locate Services: Contractor Responsibilities

a. Provide Carrier List

Provide the OCS with a list of health insurance carriers it has agreements with to allow beneficiary file matches. The OCS expects that potential contractors responding to this project will demonstrate their ability to perform beneficiary file matches with the top twenty health insurance carriers in Michigan. The contractor shall update the list as new agreements are finalized.

HMS will not only perform electronic matches between OCS's monthly Insurance Inquiry File and the top 20 commercial health insurers in Michigan (as required under the RFP), but we will also match to our full national health insurance database to identify situations where dependents are not appropriately enrolled in an available health insurance plan.

HMS's successful, ongoing experience with insurance data matches for state Medicaid and child support agencies—including MDCH—is evidence of our ability to successfully perform commercial insurance locate services for OCS. HMS has data match agreements in place with an established, broad-reaching network of carriers—in Michigan and nationwide.

Note: Unless otherwise instructed by MFIA/OCS, HMS proposes to include eligibility matches with BC/BS Michigan within the scope of our insurance locate services. HMS already has an existing eligibility match agreement and process in-place with BC/BS Michigan—the state's largest insurer—on behalf of the Great Lakes Health Plan, an MCO for which we perform TPL services. During this proposal process, we have approached BC/BS Michigan to request the plan's cooperation with performing eligibility matches under MFIA's insurance locate project.

HMS Has the Largest National Data Match Network

HMS has assembled the most comprehensive health insurance data exchange network that exists today for purposes of identifying other third party coverage (please see **Exhibit C2-1: HMS Crossmatch & Billing Agreements**). Our in-place carrier network far exceeds the similar capabilities of any other vendor. HMS is the first revenue recovery contractor to have more than 100 carriers in our network nationwide, including the majority of commercial insurers in Michigan. Because of this network, HMS can ensure that we will identify the maximum number of available health insurance coverages for OCS, including coverage for NCPs living out-of-state.

HMS Has the Largest Michigan Carrier Network

HMS's national network is only part of the story. We realize that our effectiveness in identifying available private health insurance for OCS depends directly on the scope of HMS's network in Michigan. Accordingly, we provide **Exhibit C2-14**, which lists HMS's existing and in-process data exchange agreements with the top 20 health insurance carriers in the state (see left side of this exhibit). For purposes of identifying insurance coverage under the MSE project, HMS's carrier network presently includes 16 of the top 20 carriers in Michigan, including BC/BS Michigan, Aetna, Health Alliance Plan, and CIGNA. This network represents 80% of the top 20 carriers (and more than 90% of eligibility records among the top 20 carriers) in Michigan.

In addition to BC/BS Michigan, HMS is able to enhance BC/BS coverage identifications by performing matches to other plans—including some of the largest plans operating in the country, which insure Michigan residents living in-state and out-of-state. These plans include Anthem (Ohio), BC/BS Florida, BC California, BS California, and BC/BS Massachusetts.

Exhibit C2-14 (right side of exhibit) also lists the top 20 carriers in the state, as identified in the state’s answers to vendor questions. With respect to the state’s list, HMS notes that:

- The list does not appear to be “listed from largest to smallest”—as the state has indicated. For example, Aetna—which has nearly one million members in Michigan—is listed near the bottom of the list, below many smaller plans.
- Medical support insurance is not applicable for 20% (four) of the carriers on the state’s list. These carriers are Medicaid-only MCOs (i.e., Community Choice Michigan, Cape Medical, Midwest Health Plan, and McLaren Health Plan). The objective of the medical support locate project should be to identify available **private** health insurance and not cases where a child is enrolled in a Medicaid MCO.
- The state’s list includes three additional plans (Delta Dental, Michigan Dental Plan, and Vision Service Plan Insurance Co.) that have limited service lines and, therefore, very limited opportunity for medical support coverage—despite having large enrollments. The objective of the medical support locate project should be to identify comprehensive medical insurance (hospital and medical coverage). Thus, dental and vision coverage should not be a primary focus.

In addition, HMS would like to draw MDCH’s attention to the fact that the lack of a data match statute in Michigan has enabled some large insurers to “opt out” of eligibility matches. For example, M-Care—one of the state’s largest carriers, with 165,000 members—declined HMS’s past request to participate in data matches. Given the significant third party liability represented by this carrier’s large enrollment, HMS plans to appeal M-Care’s decision. Establishing a strong data match statute would compel all carriers to participate in eligibility data matches and enable maximum third party coverage identifications for MFIA/OCS.

Top 20 Carriers (HMS Analysis)			Top 20 Carriers (State-Specific)		
Carrier	Enrolled Volume in Michigan (All Medical) ¹³	HMS Network Status	Carrier	Enrolled Volume in Michigan	
				Medical	Dental
1. BC/BS Michigan	1,090,000	Yes ¹⁶	1. Health Alliance Plan of Michigan	417,980	
2. Aetna	969,100	Yes	2. M-Care, Inc. ¹⁷	164,931	
3. Health Alliance Plan	417,980	Yes	3. Priority Health	242,009	
4. CIGNA	291,200	Yes	4. HealthPlus of Michigan, Inc.	66,551	
5. United Health Care	258,386	Yes	5. Physicians Health Plan, Inc. (MI)	31,400	
6. Priority Health	242,009	Yes	6. Care Choices HMO (MI)	121,241	
7. United Health Care	190,860	Yes	7. Delta Dental Plan of Michigan, Inc.	N/A	
8. M-Care, Inc. ¹⁸	164,931	Declined	8. Wellness Plan	17,521	

¹³ Source for participating carrier enrollment numbers: HMS file counts of actual data received from these carriers. Source for non-participating carrier enrollment numbers: National Association of Insurance Commissioners, 2002

¹⁴ Source for participating carrier enrollment numbers: HMS file counts of actual data received from these carriers. Source for non-participating carrier enrollment numbers: National Association of Insurance Commissioners, 2002

¹⁵ Enrollment is either dental, vision, or Medicaid MCO (limited to no opportunity for medical support anticipated among this population)

¹⁶ Unless otherwise instructed by MFIA/OCS, HMS proposes to include eligibility matches with BC/BS Michigan within the scope of our insurance locate services. HMS already has an existing eligibility match agreement and process in-place with BC/BS Michigan—the state’s largest insurer—on behalf of the Great Lakes Health Plan, an MCO for which we perform TPL services. During this proposal process, we have approached BC/BS Michigan to request the plan’s cooperation with performing eligibility matches under MFIA’s insurance locate project.

¹⁷ M-Care has, in the past, declined HMS’s request to participate in data matches—a decision that HMS plans to appeal. Michigan presently does not have a statute requiring carriers to participate in eligibility matches, and carriers are free to decline participation requests.

¹⁸ M-Care has, in the past, declined HMS’s request to participate in data matches—a decision that HMS plans to appeal. Michigan presently does not have a statute requiring carriers to

Carrier	Enrolled Volume in Michigan (All Medical) ¹³	HMS Network Status	Carrier	Enrolled Volume in Michigan	
				Medical	
9. FORTIS	142,221	Yes	9. SelectCare HMO, Inc.	69,337	
10. Care Choices HMO	121,241	Under consideration	10. OmniCare Health Plan	27,592	
11. UNICARE	98,441	Yes	11. Community Choice Michigan	N/A	
12. Principal	81,092	Yes	12. Total Health Care, Inc.	9,194	
13. American Medical Security	80,982	Yes	13. Cape Medical (d/b/a Cape Health Plan)	N/A	
14. FEP	79,208	Yes	14. Midwest Health Plan	N/A	
15. CIGNA	78,599	Yes	15. Grand Valley Health Plan, Inc.	20,224	
16. SelectCare HMO, Inc.	69,337	In negotiation	16. Aetna Health Inc.	969,100	
17. Health Plus of Michigan	66,551	Yes	17. McLaren Health Plan	N/A	
18. Employers' Health, Inc.	58,000	Yes	18. Vision Service Plan Insurance Co.	N/A	
19. Physician Health Plan of Southern Michigan	31,400	In negotiation	19. Paramount Care of Michigan	4,000	
20. BENESIGHT	31,176	Yes	20. Michigan Dental Plan, Inc.	N/A	
Total Enrolled Volume:	Medical: 4,562,714	In HMS Network: 4,175,805 ¹⁹ (92%)	Total Enrolled Volume:	Medical: 2,161,080 Enrolled in HMS Network: 1,516,883	

¹⁹ Based on HMS's Top 20 Analysis, HMS has already established eligibility matching agreements with 80% of the Top 20 carriers in Michigan (including BC/BS Michigan)

HMS's ultimate goal is to expand our network to cover the entire Michigan health insurance universe.²⁰ Hence, our data matches with insurers will tap virtually the entire health insurer-based universe in the state—as well as insurers operating in states that border Michigan and that may provide employer group health insurance to Michigan residents. HMS currently receives eligibility data from carriers in two of the three states contiguous to Michigan—Ohio and Indiana—which allows us to cross-match border populations for coverage in those states.

As Michigan's current TPL vendor, HMS continually works to increase recruitment of third party administrators by researching Michigan's state data match regulations that govern fully insured and self-funded plans.

HMS has recently completed our first Michigan eligibility match with Wal-Mart—one of the largest self-insured employers in the country. This match yielded 5,398 confirmed Medicaid/Wal-Mart dual-eligibles in Michigan. HMS will also match the Wal-Mart eligibility data with the child support Insurance Inquiry File.

HMS Aggressively Builds our Network of Third Party Payors

HMS traditionally seeks to include in our data match network the major carriers that we know are operating in our client states. But we don't stop there. HMS has already undertaken and will continue to undertake extensive and aggressive efforts to identify the maximum number of third party resources in Michigan and to include them in our network. HMS identifies these additional third party coverage resources by:

- Contacting the major municipalities, counties, and private self-insured employers and self-insurance pools in the state
- Working with the Department of Insurance
- Conducting research using industry data sources (e.g., the National Underwriters' ERISA Database, National Association of Insurance Commissioners (NAIC) health insurer reports, the Judy Diamond Database, managed care directories)
- Performing employer wage matches and conducting employer surveys
- Examining third party administrator (TPA) directories
- Analyzing the eligibility data files that our network carriers provide to identify liable subcontractors who may be working with primary payors (e.g., PBMs, behavioral health plans)

²⁰ Inclusion of all Michigan carriers may not be feasible, as some carriers may not underwrite health coverage in the state.

Using NAIC Data Sources

As part of our ongoing efforts to identify the broadest possible range of third party resources, HMS is now using the customized Health Insurance Reports from the NAIC. These reports will provide a variety of data specific to health insurers operating in Michigan, including:

- ◆ Balance sheet
- ◆ Statement of revenue and expenses
- ◆ Underwriting and investment exhibit
- ◆ Five-year historical information
- Exhibit of premiums, enrollment, and utilization

HMS will use these reports to enhance our Michigan network development efforts and to facilitate targeted recruitment by covering as broad a base as possible and ensuring that we focus on insurers that are likely to cover the largest number of state residents.

Additional information about HMS’s extensive commercial insurance data match network and associated capabilities appears in Section C-2.1.a.i.b of this Tab (Eligibility Matching: Contractor Responsibilities), item (a) (Provide List of Health Insurance Carriers).

b. Provide List of Agreements under Negotiation

Provide the OCS, within two weeks of the contract award date, with a list of those health insurance carriers that it does not have agreements with, but with which it has been negotiating for an agreement to allow beneficiary file matches.

As required by RFP section IV-C.2 (Technical Work Plans), HMS’s proposal includes a list of carrier eligibility matches that HMS is presently negotiating, including the status of negotiations and anticipated date of agreement execution (**Exhibit C2-15**).

Exhibit C2-15: HMS Data Match Agreements Under Negotiation as of 4/26/04

Carrier	Status of Negotiations	Anticipated Date of Agreement ²¹
M-Care, Inc.	Carrier’s declination is under appeal	Unknown
Care Choices	In negotiation	5/31/04
SelectCare HMO	In negotiation	8/31/04
Physician Health Plan of Southern Michigan	In negotiation	8/31/04
OmniCare Health Plan	In negotiation	8/31/04

²¹ Agreement dates are estimated—based on HMS’s experience negotiating similar agreements with other network carriers—and are also contingent upon each carrier’s willingness to participate in data matches. Michigan presently does not have a statute requiring carriers to participate in eligibility matches, and carriers are free to decline participation requests.

c. Perform Monthly Match

Perform a monthly match against insurance carrier files.

HMS affirms that we will perform monthly matches against insurance carrier files. This section of HMS's proposal identifies the various types of third party insurers that HMS's electronic eligibility matches will include and also describes the process we propose for performing matches and verifying the coverages identified.

The RFP requires the contractor to perform matches for cases where parents (potential or actual subscribers) are not providing court-ordered health insurance for their dependent children. Additionally, at OCS's request, HMS would also match for those cases without a court order, so that OCS can add a medical support provision to the order, if applicable.

Overview of Data Match Resources

Specific third party insurance resources from which we propose to obtain eligibility data for data matching are listed below. These third party resources have historically generated significant volumes of verifiable coverage identifications for HMS's clients, including MDCH.

- **Health Insurance Carriers, Self-Funded Plans, and TPAs.** HMS receives eligibility files from 109 commercial carriers, TPAs, large employers, and municipal, county, and state groups nationwide. For purposes of identifying other insurance coverage for medical support enforcement, HMS has existing eligibility match agreements with the majority (80%) of the top 20 commercial insurance carriers in Michigan, representing more than 90% of eligibility records among the top 20 carriers. Furthermore, HMS is presently negotiating with several large carriers that are not now part of our data match network in Michigan and have requested their cooperation with future data matches (see **Exhibit C2-15**).
- **Managed Care Organizations.** HMS will also identify other health coverage for Michigan residents who are enrolled in managed care organizations (including HMOs and PPOs). HMS already receives eligibility files from several large MCOs operating in Michigan.
- **CHAMPUS/TRICARE.** HMS's enhanced TRICARE TPL capabilities will ensure the maximum number of eligibility matches for OCS. HMS has performed TRICARE eligibility match projects for 23 state Medicaid agency clients during the past 18 years and, through this work, has developed the most effective DEERS matching methodology for TRICARE identification and recovery.
- **Pharmaceutical Coverage Plans/Pharmacy Benefit Managers (PBM).** HMS has implemented identification processes for third party pharmacy coverage with most of the largest PBMs operating in the country (including: AdvancePCS, Medco Health, ExpressScripts, MedImpact, Aetna Pharmacy Management, and Argus). HMS uses our PBM match information to locate the primary insurer and healthcare policy.

HMS's Strong Data Matching Expertise

To identify third party coverage leads, HMS performs a complex series of electronic data matches. These matches will help HMS identify third party coverage that OCS has not yet detected. We perform many different types of data matches and tailor each individual match to accommodate the characteristics of the source data we use.

HMS data matches are on a level of technical sophistication that exceeds the capabilities of data match operations of competing vendors. HMS is able to identify many cases of new third party coverage because we use specialized software that produces the highest possible number of

accurate “hits” (i.e., identifications of eligibility for third party coverage). Using multiple, successively applied match keys, we obtain eligibility information despite data discrepancies that may exist in records for the same recipient on various files.

Examples of our specialized match criteria include:

- Social Security Number (SSN), full last name, and first three positions of first name, combined with:
- Percentage matches on the following fields: first name, sex, date of birth, and other demographic variables of the recipient

Although technically complex, multiple match keys are effective tools that help identify the maximum number of third party coverages, despite discrepancies in data that may appear on various files. For instance, a person's demographic information may vary between insurance carrier files and OCS's Insurance Inquiry File—a different first or last name, possibly no SSN, or an SSN with a one-digit difference.

HMS's approach overcomes these problems—and generates accurate third party coverage leads despite discrepancies in source data files. As a result, we can produce a significantly greater volume of eligibility match "hits."

Approach to Verifying Match Results

HMS has detailed and accurate processes for verifying third party insurance coverage leads identified through eligibility matches.

Although the RFP does not specifically require the contractor to perform verification of its data match results, this step is imperative, as the eligibility data provided by insurers and other third parties is often dated or inaccurate. Without a verification process that removes policies identified in the data matches that may no longer provide active coverage or that don't provide comprehensive coverage (i.e., medical and hospital), OCS would receive data match information that could be as high as 40% inaccurate. This inaccuracy rate could result in a significant number of NMSNs being generated and mailed to employers where no insurance is available.

Therefore, HMS strongly recommends that each policy identified in the data match be thoroughly verified before being passed to OCS on the Insurance Response File and that OCS and MDCH ensure that all vendor bids contain this step. HMS's proposal includes these verification activities.

Data Fields to Be Verified

When investigating coverage leads from our data matches, HMS will verify all required data fields for carrier- and benefit-related information on the Insurance Response File, including:

- Carrier name
- Carrier FEIN
- Carrier address and contact information
- Employer information
- Policy number and group number
- Name of policyholder
- Relationship to policyholder member
- SSN of policyholder
- Policy type (family, individual, employee-only)
- Type of policy and coverage, including:
 - Benefit type (general medical, major medical, pharmacy, dental, vision, psychiatric)
 - Covered types of services under the policy
 - Coverage effective and expiration dates
- Is dependent enrolled?
- Are other dependents enrolled?

Verifying Eligibility Online

HMS verifies health insurance coverage eligibility online with a select group of carriers (see **Exhibit C2-16**). We access this functionality through WebMD Transaction Services or direct Internet connections. Online verification (by individual subscriber or batch) speeds the coverage identification process. Because of the efficiencies associated with online verification, HMS is actively developing verification interfaces with additional carriers.

Exhibit C2-16: Carriers for which HMS Verifies Eligibility Online

- | | |
|-------------------------------------|------------------------------|
| ▪ Aetna/Prudential | ▪ Horizon Blue Cross |
| ▪ Americhoice | ▪ Humana |
| ▪ BC/BS Florida | ▪ Medica |
| ▪ BC/BS Louisiana | ▪ MedcoHealth (PBM) |
| ▪ BC/BS Massachusetts | ▪ Methodist Health System |
| ▪ Blue Cross California (Wellpoint) | ▪ Nationwide |
| ▪ TRICARE | ▪ Oxford |
| ▪ CIGNA | ▪ Pacificare |
| ▪ Coventry | ▪ Principal |
| ▪ Empire Blue Cross | ▪ Tufts |
| ▪ Family Health System | ▪ United Healthcare/Met Life |

HMS uses the website of United Healthcare (UHC, the largest commercial insurance plan in the United States) to check real-time eligibility from the most reliable eligibility source. Refreshed nightly, this source's benefit plan detail includes data for pharmacy benefits managers (PBMs).

When carriers are able to support Web-based eligibility verification, HMS enhances our on-line verification processes by using automated software agents, or “data entry robots.” (See **Exhibit C2-17: Sample Web-based Eligibility Verification Screen.**) Whereas an individual performing Web-based eligibility inquiries might be able to verify 20 policies an hour, the “robots” can complete and document several hundred verifications an hour! Operating according to rules that HMS assigns, these automated agents follow an automated inquiry process to verify third party coverage—including coverage types, group numbers, and effective and termination dates. These automated agents can also create an output file that contains the requested information as well as a range of other data output files from the verification process. Because automated agents are faster and less expensive than human personnel, we can assure that we will perform coverage verification quickly and cost effectively for OCS.

Exhibit C2-17: Sample Web-based Eligibility Verification Screen

ECARE: HMS's Proprietary Internet Verification Tracking System

When coverage cannot be verified online, HMS verifies policy information via phone contact with the carrier or employer.

To serve our clients proficiently, we have perfected the art of the verification phone call via our proprietary *Eligibility Verification System*, known as **ECARE**. **ECARE** is a work management tool used to verify and document commercial insurance coverage information for our clients. The **ECARE** system is initially loaded automatically with policies to be verified, and the system is worked in conjunction with sophisticated inbound/outbound call management technology for maximum efficiency. **ECARE**, when used in conjunction with a call script, allows HMS to:

- ◆ Verify current policy/coverage information
- ◆ Capture any missing information
- Change information that may have become outdated

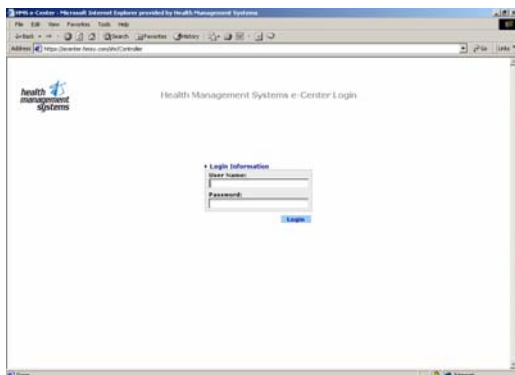
ECARE is a distributed, interactive work management system, which:

- Presents policies requiring verification in a structured way
- Allows for interactive updating of coverage information while on a call with a commercial insurance customer service representative
- Allows HMS to update policyholder status for further verification, or closure

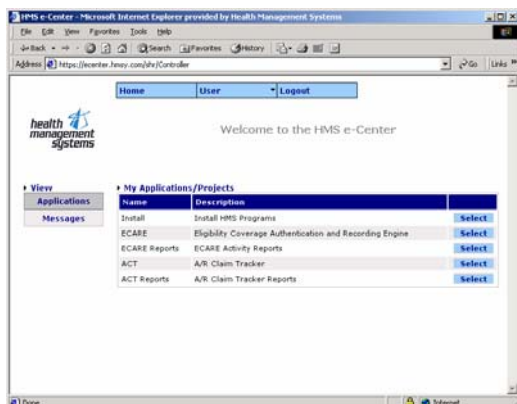
Because **ECARE** is a distributed system, clients may also access the system and analyze HMS's progress on verification of policies. The screen shots included here as **Exhibit C2-18** give an overview of functionality available to HMS expert staff performing verifications and a sample of reports available to clients. *All data depicted in these examples are dummy data.*

Exhibit C2-18: ECARE

The **ECARE** System is accessed through a fully secured Web site, the HMS e-Center.



Each user has a unique login and password to the HMS e-Center. The login controls which applications and data are accessible to the user. All users must execute a Confidentiality Agreement in order to access the e-Center website.



There are many applications available on the e-Center. The ECARE (Eligibility Coverage Authentication and Recording Engine) application can be found here.

Carrier Name	Code	Office	Location	Phone	Priority
ADVANCED PARADIGM	APH	RX01	.		A
AETNA PHARM MANAGMENT	AETRX	RX01	PO BOX 298106 HONOLULU, HI 96839	(808) 594-6453	A
AETNA USHEALTHCARE	60054	USHC	PO BOX 1125 BLUE BELL, PA 19422	(800) 323-9930	A
AETNA USHEALTHCARE	60054	V001	P.O. BOX 28187 GREENSBORO, NC 27402-8187	(877) 810-9180	A
AETNA USHEALTHCARE	60054	V004	80 BOX 1125 BLUEBELL, PA 19422	(800) 323-9930	A
AETNA USHEALTHCARE	60054	0004	.	(800) 342-0876	A
AETNA USHEALTHCARE	60054	0109	3500 COLISEUM BLVD E FORT WAYNE, IN 46805-1667	(800) 523-7979	A
AETNA USHEALTHCARE	60054	0109	7400 W CAMPUS RD NEW ALBANY, OH 43054-8725	(800) 414-0767	A
AETNA USHEALTHCARE	60054	0132	7676 HAZARD CENTER DR SOUTH PL SAN DIEGO, CA 92108-4503	(619) 231-4200	A
AETNA USHEALTHCARE	60054	0168	PO BOX 98156 EL PASO, TX 79998	(800) 540-2521	A

Insurance information that needs to be verified is sorted and prioritized as it is loaded into the application. HMS and the client work together to determine these priorities.

Within each priority level, policies are grouped and listed by carrier/office. By clicking on a “Select” button, an HMS verification representative loads a work queue with policies associated with a carrier/office group to be verified. In the first work step, the HMS verification representative verifies the carrier/office group information. The system is flexible and allows recording of information received by phone contact, fax, or mail. The HMS verification representative then moves to verifying individual policyholder information.

When verifying individual information, the verification representative works with a call script to ensure quality and follows a detailed set of screens verifying information, or recording new data if data are missing. HMS staff identify any dependents covered under a policy and/or if the health coverage plan allows for dependent coverage. If the plan shows minor dependents enrolled, staff are automatically directed to a “related individuals” screen within **ECARE** to verify dependent coverage and other information. When possible, employer data are also verified.

Policy Info

Start Date: 01/01/2000
Termination Date:
Policy Type:

Coverage

Emergency Care: Yes No
Hospitalization: Yes No
Lab Services: Yes No
Maternity Care: Yes No
Physician Office Visits: Yes No
Prescription Drugs: Yes No
Mental Health: Yes No
Dental: Yes No
Vision: Yes No
Family Planning: Yes No
Homecare: Yes No
Skilled Nursing: Yes No
Private Duty Nurse: Yes No
Hospice: Yes No

HMS is able to validate eligibility coverage to the level specified by the client. Certain fields within the eligibility verification screens are required, and work is not considered complete until those fields are populated.

ECARE - Follow Up Verifications

Carrier: AETNA PHARM MANAGMNT AETRX R001 Phone: (952) 594-6461
 Location: PO BOX 398104 MINNEAPOLIS, MN 55429

Group	Policy	Last Name	First Name	SSN	DOB	Status	
MCFF	8881X3AB	BRITT	CLIFTON	733-21-2336	07/12/1957	ELGVER	Select
MCFF	8881X6XA	COLLIER	WILSON	580-22-0568	10/17/1952	UNPRCSD	Select
MCFF	8881X6XB	COLLIER	WILSON	888-17-0468	10/17/1952	UNPRCSD	Select
MCFF	8881X6XD	COLLIER	WILSON	955-21-9082	10/17/1952	UNPRCSD	Select
MCFF	8881X6XE	COLLIER	WILSON	000-21-3336	10/17/1952	UNPRCSD	Select

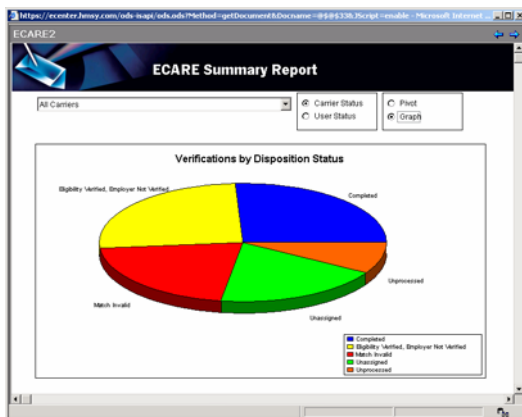
After a record has been processed, its status is updated to reflect work completed. Verification work can now be started again with a new policyholder record, presented automatically by the ECARE queue.

Summary reports from **ECARE** are also available to clients and HMS management via the HMS e-Center. These reports can be used to obtain a quick analytic view on work in progress; they also provide a summary-level audit trail.

The screenshot shows the ECARE Summary Report interface. At the top, there are filters for 'All Carriers' and 'Carrier Status' (set to 'User Status'). Below the filters is a table with the following columns: Carrier, Completed, Eligibility Verified, Employer Not Verified, Match Invalid, Unassigned, Unprocessed, and Total. The data is as follows:

Carrier	Completed	Eligibility Verified	Employer Not Verified	Match Invalid	Unassigned	Unprocessed	Total
BC CALIFORNIA	143	154	118	97	39	543	
AETNA FINANCIAL MANAGEMENT	67	72	54	45	10	258	
AETNA US HEALTHCARE	47	51	39	32	13	181	
ADVANCED PARADIGM	36	10	29	39	24	138	
CIGNA	31	33	25	20	9	118	
UNITED HEALTHCARE	27	29	22	18	8	106	
PANO PRESCRIPTIONS	19	20	15	13	5	72	
WELLPOINT	18	20	15	12	5	70	
PCSB INC	15	16	12	10	4	57	
MOSELE	5	2	5	6	4	23	
GREAT WEST	5	6	4	4	2	21	
CHAMPUS	5	6	4	4	2	21	
HOME LIFE INSURANCE	4	4	3	3	1	15	
HEALTHNET CA	4	4	3	3	1	15	
BS CALIFORNIA	4	4	3	3	1	15	
FORTIS	4	4	2	2	2	14	
GREENWICH	3	3	3	2	2	13	

Reports can be fully customized to a client's specification. These are examples of reports using results from ECARE. The data can be displayed in a number of formats, including graphs for clear, concise representation.



The HMS **ECARE** System is designed for maximum efficiency and automated audit trail support. In addition, it affords full visibility to a client on eligibility verification work in progress, from the detail policy level up through summary reports. The result of HMS's successful eligibility verification is current, updated information regarding benefits available under a policy for an identified individual.

Upon completion of insurance verification, HMS will format verified records according to OCS's specifications for the Insurance Response File. Policies that have not been verified (based on information received from carriers) are also available from **ECARE**, completing the audit trail of work performed.

HMS and the ANSI 270/271 Transactions

HMS is in the process of becoming certified in all HIPAA transactions through Claredi—and has already obtained Claredi certification for the 270 transaction (Eligibility Inquiry).

HMS is currently testing the ANSI 270/271 transaction with WebMD to submit eligibility status requests to Aetna US Healthcare. We will continue the same process for all of the other major carriers that participate with WebMD. We are also testing with TRICARE to obtain DEERS eligibility. We also plan to begin testing this transaction with Medunite to send requests to the carriers that participate with this vendor. Additionally, some insurance carriers have approached HMS and asked us to use the 270 transaction to obtain eligibility information, and we are testing directly with the carriers.

HMS is currently working with United Healthcare (UHC) on using their B2B product. This product includes an ANSI 270/271 component that will allow HMS to send the ANSI 270 transaction directly to UHC as opposed to going through a clearinghouse such as WebMD. It will also allow for real time eligibility responses.

HMS has already made significant progress in using the 270/271 transactions and anticipates extensive future use of these transactions.

d. Produce Insurance Response File

Produce in electronic format an insurance response file by matching the information in the Insurance Inquiry File to the insurance carriers' files and send the file to OCS for processing into the MiCSES system.

HMS affirms that the deliverable/output of our Insurance Locate services will be an electronic Insurance Response File, formatted according to OCS requirements. As specified in the RFP, HMS will produce a file that includes the following eight record types, ordered by subscriber:

Header

Sender

Subscriber (identifies subscriber's address as reported by the carrier, indicator if no insurance is found for subscriber)

Member

Carrier (identifies the insurance carrier, carrier FEIN, address, contact information, group number)

Employer (identifies the employer or other source of the insurance, including FEIN and address)

Benefit (identifies policy number (or subscriber's SSN), effective date, expiration date, insurance type (commercial, Medicaid, Medicare, other state program), and benefit type). The benefit record will be repeated once for each benefit on the policy. The benefit record(s) will also be repeated under each member the benefit(s) apply to.

Trailer

If the child is enrolled in private insurance and the Michigan Medicaid or CSHCS program, HMS will also provide the insurance coverage to MDCH in a format acceptable to MDCH.

C-2.1.d.ii Insurance Enrollment

In the sections to follow, HMS/MAXIMUS provides:

- Our understanding of the National Medical Support Notice (NMSN) process, including the federal requirements
- Our general approach based on our experience
- A direct response to the tasks outlined in RFP section II-C. We will explain how our NMSN experience and knowledge will translate into producing the best possible medical support enforcement program in the country.

Understanding of Importance

If the 1990s was the time for focusing on improvements in the financial and emotional support for single-parent children, this decade looms as the time for ensuring that all children who qualify for health insurance coverage have it. Congress has authorized the Federal Office of Child Support Enforcement (OCSE) to issue the National Medical Support Notice (NMSN) in conjunction with the U.S. Department of Labor. Every state child support agency now generates the NMSN at the time a new employer is discovered for an NCP who has been ordered to provide health insurance if reasonably available at his or her place of employment. Coverage is key for so many children, who depend on health insurance to cover exorbitant costs for illnesses and injuries.

In the 2001 Annual Report to Congress, OCSE stated that Michigan had over 380,000 cases in FY01 in which health insurance was ordered, and that health insurance was actually provided in only 60,000 (or 16%) of these cases. Michigan no doubt has made progress since that report, and with the advent of MiCSES, the number of compliant cases is undoubtedly rising rapidly. This project will accelerate the percentage of cases with health insurance ordered in which it is provided, as we will provide the back-end service to the NMSN—the enrollment and the enforcement aspects. Michigan will become a leader in the child support community in medical support enrollment percentage.

This summer OCSE is expected to issue its proposed medical support indicator, which Congress required under the Child Support Performance and Incentive Act of 1998. If Congress adopts an indicator in the coming years, states will have to perform medical support enrollment—and most likely enforcement—at comparatively competitive levels to sustain or boost federal performance incentives. In other words, a good medical support enforcement program should not only help children get the private health insurance coverage to which they are entitled, but it will also bring more dollars to the treasury of the state that performs well in this category.

The NMSN and Federal Regulations

Like income withholding, the NMSN depends on finely tuned automation, timely and accurate generation of a notice, employer cooperation, parental cooperation—or at least compliance—with an order, and extra legwork by staff when the process is not completed successfully. The NMSN is the culmination to date of efforts to enforce medical support and make it a priority child support function.

While it is admittedly somewhat tedious to review the regulations, it is important that OCS understands that the HMS/MAXIMUS Team knows the regulations and has carefully considered approaches to addressing the issues they raise. This subsection briefly recaps the regulations and the Team’s work in response to them.

Federal Title IV-D rules in Title 45 of the Code of Federal Regulations (CFR) require courts to issue health insurance coverage orders:

§ 302.80 Medical support enforcement.

“... (b) The State plan must provide that the IV-D agency shall secure medical support information and establish and enforce medical support obligations in accordance with the requirements contained in §§303.30 (IV-A, IV-E and Medicaid) and 303.31 of this chapter.

Through the efforts of Michigan-experienced HMS, the Team will have the best health carrier information obtainable at the start of the contract period, and will combine that knowledge with the data provided by OCS and the employers.

§ 303.30 Securing medical support information

The IV-D agency shall obtain certain case information, including... *“(6) Name and address of noncustodial parent's place of employment; (7) Whether the noncustodial parent has a health insurance policy and, if so, the policy name(s) and number(s) and name(s) of person(s) covered...”*

§ 303.31 Securing and enforcing medical support obligations.

For NCPs who are employed, if ordered to provide health insurance, and health insurance is available at the place of employment, the NCP must provide it: *“(a) For purposes of this section:*

- (1) Health insurance is considered reasonable in cost if it is employment-related or other group health insurance, regardless of service delivery mechanism...”

OCSE has stated that it will release a new medical support regulation (not including the performance indicator recommendation) this summer, and that reasonable cost may be redefined. The Team will work with OCS to implement any change in an accurate and all-encompassing manner to ensure Michigan compliance with the change and full coverage for its affected children.

Under current regulations, OCS and the courts need to include health insurance coverage orders in any child support order that is new or modified, and take all necessary enrollment steps under these circumstances:

“(b) With respect to cases for which there is an assignment as defined in §301.1 of this chapter in effect, the IV-D agency shall:

- (1) Unless the custodial parent and child(ren) have satisfactory health insurance other than Medicaid, petition the court or administrative authority to include health insurance that is available to the noncustodial parent at reasonable cost in new or modified court or administrative orders for support.
- (2) *Petition the court or administrative authority to include medical support as required under paragraph (b)(1) of this section whether or not--*
 - (i) Health insurance at reasonable cost is actually available to the noncustodial parent at the time the order is entered; or
 - (ii) *Modification of current coverage to include the child(ren) in question is immediately possible.*

The HMS/MAXIMUS Team will work with OCS to implement the following requirements:

- “...Establish written criteria to identify cases not included under paragraphs (b)(1) and (b)(2) of this section where there is a high potential for obtaining medical support based on--*
- (i) *Evidence that health insurance may be available to the noncustodial parent at a reasonable cost, and*
 - (ii) *Facts, as defined by State law, regulation, procedure, or other directive, which are sufficient to warrant modification of the existing support order to include health insurance coverage for a dependent child(ren)...*
- (7) If health insurance is available to the noncustodial parent at reasonable cost and has not been obtained at the time the order is entered, take steps to enforce the health insurance coverage required by the support order and provide the Medicaid agency with the information referred to in §303.30(a) of this part.”

The team will provide the file information necessary so OCS and FOC staff can: *“...[p]etition the court or administrative authority to modify support orders for cases identified in paragraph (b)(3) of this section to include medical support in the form of health insurance coverage.”*

The Team, under the terms of the contract, will also serve as the conduit between parents and children who need medical support information and the provider of that information, whether it be the employer’s benefits administrator or the health insurance carrier.

“...(5) Provide the custodial parent with information pertaining to the health insurance policy which has been secured for the dependent child(ren) pursuant to an order obtained under this section.”

The Team will form a seamless operation with OCS and the employer community to ensure the generated NMSN leads to enrollment where appropriate. The relatively new NSMN regulation covers this:

§ 303.32 National Medical Support Notice.

(a) Mandatory State laws. States must have laws, in accordance with section 466(a)(19) of the Act, requiring procedures specified under paragraph (c) of this section for the use, where appropriate, of the National Medical Support Notice (NMSN), to enforce the provision of health care coverage for children of noncustodial parents who are required to provide health care coverage through an employment-related group health plan pursuant to a child support order and for whom the employer is known to the State agency.

(b) Exception. States are not required to use the NMSN in cases with court or administrative orders that stipulate alternative health care coverage to employer-based coverage.

We will work with OCS to implement the procedures involved when a NCP changes jobs and the NMSN must be transferred to a new employer:

(c) Mandatory procedures. The State must have in effect and use procedures under which:

(1) The State agency must use the NMSN to transfer notice of the provision for health care coverage of the child(ren) to employers.

(2) The State agency must transfer the NMSN to the employer within two business days after the date of entry of an employee who is an obligor in a IV-D case in the State Directory of New Hires.

(3) Employers must transfer the NMSN to the appropriate group health plan providing any such health care coverage for which the child(ren) is eligible (excluding the severable Notice to Withhold for Health Care Coverage directing the employer to withhold any mandatory employee contributions to the plan) within twenty business days after the date of the NMSN...

(6) Employers must notify the State agency promptly whenever the noncustodial parent's employment is terminated in the same manner as required for income withholding cases in accordance with §303.100(e)(1)(x) of this part.

(7) The State agency must promptly notify the employer when there is no longer a current order for medical support in effect for which the IV-D agency is responsible.

(8) The State agency, in consultation with the custodial parent, must promptly select from available plan options when the plan administrator reports that there is more than one option available under the plan.

The Team will bring experience, skill, and forethought in determining the best way to coordinate with employers and parents. We will work with OCS to develop procedures to cover:

- Employer noncompliance with an order when insurance is available
- Employer delay in compliance
- Employer noncompliance with an order when insurance is thought to be available but is not
- Employer's multiple health plan choices in public assistance cases in which OCS, in consultation with the CP, can make a decision regarding which plan is best for the covered children
- Ensuring the swift, secure, and accurate transfer of cards for and information about a plan in which the dependent children are enrolled
- Referring Consumer Credit Protection Act (CCPA) issues to OCS when an NCP does not have enough money for the full amount of the employee share of the premium and current support
- Out-of-state employment that provides local Michigan coverage
- Out-of-state employment that does not provide local Michigan coverage
- In-state employment that does not provide coverage where the child resides
- Unions with health insurance plans and enrolling dependents in those plans

The NMSN and Michigan State Regulations

Michigan has gone beyond some of the federal requirements to be able to order the custodial parent to have coverage for his or her children as well as the noncustodial parent. The Friend of the Court determines who covers whom in the initial or modified child support order. Recently,

now that MiCSES is statewide, the Friend of the Court turned over the function of generating the NMSN to the state.

There is a strong parallel between the centralized state requirements for generating the income withholding order and those for the NMSN, as both require serving the employer with an order to take certain measures regarding the employee who is an NCP.

552.626 Notice of income withholding; failure of parent to obtain or maintain health care coverage for child; duties of friend of the court.

(1) For a friend of the court case, within 2 business days after a new hire report is entered into the state directory of new hires, as created under section 453A of title IV-D, 42 U.S.C. 653a, or a payer's or parent's employer is otherwise identified, the office shall, when appropriate, provide the new employer with a notice of income withholding or a notice of the order for dependent health care coverage, or both, on behalf of a payer who is subject to income withholding or a parent or payer who is required to provide dependent health care coverage.

(2) If an order for dependent health care coverage was entered before September 30, 2001, the office shall, at the time notice of the order is sent to the employer under subsection (1), provide the payer or parent with instructions on how to request a review or hearing to contest the availability of dependent health care coverage at a reasonable cost.

(3) Notwithstanding subsection (2), if a parent fails to obtain or maintain health care coverage for the parent's child as ordered by the court, the office of the friend of the court shall, as applicable, do either of the following:

(a) Petition the court for an order to show cause why the parent should not be held in contempt for failure to obtain or maintain dependent health care coverage that is available at a reasonable cost.

(b) Send notice of noncompliance to the parent. The notice shall contain all of the following information:

(i) That the office will notify the parent's employer to deduct premiums for, and to notify the insurer or plan administrator to enroll the child in, dependent health care coverage unless the parent does either of the following within 21 days after mailing of the notice:

(A) Submits written proof to the friend of the court of the child's enrollment in a health care coverage plan.

(B) Requests a hearing to determine the availability or reasonable cost of the health care coverage.

(ii) That the order for dependent health care coverage will be applied to current and subsequent employers and periods of employment.

History: *Add. 1995, Act 236, Eff. Mar. 28, 1996 ;--Am. 1998, Act 334, Imd. Eff. Aug. 10, 1998 ;--Am. 2001, Act 106, Eff. Sept. 30, 2001 ;--Am. 2002, Act 572, Eff. Dec. 1, 2002 .*

The following statute is the crux of the work that HMS/MAXIMUS will perform—ensuring that we record provided enrollment information and pursue this information if it is not forthcoming.

552.626a Eligibility of parent for health care coverage through employer; duties of employer.

(1) If a parent is eligible for health care coverage through an employer doing business in the state, within 20 business days after the date of an order or notice of an order for dependent health care coverage, the employer shall notify its insurer or plan administrator and take

other action as required to enroll that parent's child in its health care coverage plan or plans, without regard to any enrollment period restrictions, when all of the following exist:

(a) The parent is required by a court or administrative order to provide health care coverage for the parent's child.

(b) The child is eligible for coverage under the plan. A child cannot be denied enrollment or coverage on the grounds that the child was born out of wedlock, is not claimed as a dependent on the parent's federal income tax return, does not reside with the parent or in the insurer's service area, or is eligible for or receiving medical assistance.

(c) The employee applies for coverage for the child or, if the employee fails to apply, the friend of the court or child's other parent through the friend of the court applies for coverage for the child. Application by the friend of the court shall be in the form of the order for dependent health care coverage or a notice of the order for dependent health care coverage.

(2) If coverage is available through the parent's employer, the employer shall withhold from the employee's income the employee's share, if any, of premiums for dependent health care coverage not to exceed the amount allowed under section 8 and pay that amount to the insurer or plan administrator.

(3) An employer shall not disenroll or eliminate health care coverage of a child eligible for coverage and enrolled under subsection (1) unless the employer is provided with satisfactory written evidence that 1 of the following applies:

(a) The court or administrative order requiring health care coverage is no longer in effect.

(b) The child is or will be enrolled in comparable health care coverage that takes effect not later than the effective date of the disenrollment from the existing plan.

(c) The employer has eliminated dependent health care coverage for all of its employees or members.

History: *Add. 1995, Act 236, Eff. Mar. 28, 1996 ;--Am. 1998, Act 334, Imd. Eff. Aug. 10, 1998 ;--Am. 2001, Act 106, Eff. Sept. 30, 2001 .*

The following state statute, amended in 2001, reflects Congressional intent that the NMSN can be considered a Qualified Medical Child Support Order (QMCSO), which means that employers subject to Employee Retirement Income Security Act of 1974 (ERISA) provisions recognize the NMSN as meeting the QMCSO exception to the preemption of state laws. In other words, the NMSN allows states to order employers to comply with the health insurance order, notwithstanding any other ERISA federal preemption of state law.

552.626b Order or notice for dependent health care coverage; requirements.

(1) An order or notice for dependent health care coverage entered under this act shall include the information required in a qualified medical child support order as specified in section 609 of part 6 of subtitle B of title I of the employee retirement income security act of 1974, Public Law 93-406, 29 U.S.C. 1169, if the health care coverage plan of the individual who is responsible for providing a child with health care coverage is subject to that act and shall comply with standards of the national medical support notice as required to meet federal law and regulations.

(2) An order or notice of an order for dependent health care coverage served on an employer shall direct the employer to withhold from the employee's income the employee's share, if any, of premiums for dependent health care coverage and pay that amount to the insurer or plan administrator. The order or notice shall also direct that the amount withheld for support, fees, and health care premiums shall not exceed the amount allowed under section 303(b) of title III of the consumer credit protection act, Public Law 90-321, 15 U.S.C. 1673.

(3) An order or notice of an order for dependent health care coverage under this section may be combined with or accompany an order or notice of income withholding under section 9.

History: *Add. 1995, Act 236, Eff. Mar. 28, 1996 ;--Am. 1998, Act 334, Imd. Eff. Aug. 10, 1998 ;--Am. 2001, Act 106, Eff. Sept. 30, 2001 .*

Any modification in the order will lead to a new NMSN that the state will generate centrally, even if ordered by the FOC.

552.626c Order for health care coverage; modification notice.

Sec. 26c.

If the court modifies an order for health care coverage that may affect the provision of dependent health care coverage, the office of the friend of the court shall send a notice of the modification to the employer, insurer, or plan administrator.

History: *Add. 1995, Act 236, Eff. Mar. 28, 1996 .*

As the contractor, HMS/MAXIMUS would take on this function, although any information that the FOC obtains independently of the services we provide would be added to MiCSES for the caseworker's use. We would urge that third-party identification of the coverage be shared via file transfer with HMS/MAXIMUS for our database of information and to prevent any possible redundant outreach or enrollment activities.

552.626d Notice to department of social services identifying health care coverage.

Sec. 26d.

The office of the friend of the court shall notify the state department of social services if the office identifies health care coverage that has been obtained or is being maintained by a parent for a child who is a recipient of public assistance or medical assistance. The notice shall include available information on the name and address of the insurance company, health care organization, or health maintenance organization; the policy, certificate, or contract number; the effective date of the coverage; the name and birth date of the individual for whose benefit the coverage is maintained; and the name and social security number of the policyholder.

History: *Add. 1995, Act 236, Eff. Mar. 28, 1996 .*

Frequently Asked Questions Related to State NMSN Policies

The MFIA/OCS Web site states: "Reasonable cost for medical coverage, when added to the withholding order amount, should not exceed 50% of the disposable income of the employee. When the amount exceeds 50% of disposable income, please complete the bottom section of the NMSN, entitled 'Withholding Limitation Exceed' and return to the court." We will implement this policy.

Other cases of ineligibility, as outlined in state policy, include:

- "If the employee is not eligible because he/she has not passed probationary period as a new hire, complete the bottom of the NMSN with a check in the appropriate box and in the space provided, give the date that the employee will be eligible and return to the court."

- “If the employee is not eligible because he/she does not have any medical coverage for themselves, complete the bottom of the NMSN with a check in the appropriate box and return to the court.”

We will also follow state policy and the court order if the order states that the NCP is to provide coverage even if the CP has dependent health care coverage.

Unless the state reconsiders its policy, the medical cards and plan information will go directly to the CP at the address listed on the NMSN. However, HMS/MAXIMUS will adapt our protocols to reflect changes in state policy, as they occur.

We will implement the following policy listed on the website, although the OBRA 1992 provisions may make HMOs comply with an NMSN for an out-of-state dependent through agreements with other providers in the dependent’s state. We would investigate these matters on behalf of the state and make appropriate recommendations.

“If a custodial parent is not living in the state of Michigan, HMOs are not accepted out-of-state. If the employer offers national providers, such as Blue Cross, and it's at a reasonable cost, the employer is obligated to switch providers.”

Using our NMSN Implementation Experience to Produce Solutions

MAXIMUS and HMS have strong backgrounds in medical support enrollment. Since September 1997, MAXIMUS has operated the Cook County, Illinois, medical support enforcement efforts—along with its income withholding notice generation and review and adjustment work. MAXIMUS has worked with the Illinois Department of Public Aid to address issues arising from Illinois implementation of the NMSN. HMS has generated NMSNs and followed up with employers and plan administrators under a pilot project for Anne Arundel County in Maryland. We look forward to working with Michigan to apply many of those successful insurance enrollment procedures compatible with OCS’s approach and the Michigan environment.

In Cook County, MAXIMUS developed a network of business relationships with employers, plan administrators, and even some union contacts that allow our experienced Medical Support Enforcement Specialists to act quickly, decisively, and accurately when following up on incomplete responses. Through the experience MAXIMUS gained delivering NMSN services since implemented by Illinois, in addition to its six years of Illinois medical support enforcement, MAXIMUS has trained staff, developed a proven procedural workflow, and implemented quality assurance measurements in-place to ensure all NMSN compliance activities are achieved.

Over the last six years in Cook County, MAXIMUS has successfully completed medical support enforcement reviews—processing an average of 2,365 reviews each month. Due to its experience, MAXIMUS has learned many lessons and has streamlined its procedures so that Specialists spend their time bringing cases into compliance while Data Entry Clerks enter completed responses. The MAXIMUS quarterly contract reports have consistently measured compliance in this area.

In addition to resolving inquiries received via mail or the Illinois KIDS system worklists, the MAXIMUS Cook County Medical Support Enforcement Specialists assist customers over the phone and in person. MAXIMUS’s past performance illustrates its commitment to providing quality service to customers. MAXIMUS will continue this tradition of providing quality service

to help the State of Illinois comply with all NMSN processes. MAXIMUS will bring this same level of professionalism to its efforts in Michigan.

MAXIMUS will use its MAXSTAR automated networked system with its own server on-site for internal work. This system will generate files compatible with MiCSES and offer seamless service without adding dozens more MiCSES terminals.

MAXIMUS has more call center experience than any other human services vendor, operating child support call centers at multiple sites in Georgia and Tennessee and full-service offices and statewide call centers in Tennessee and Iowa. [As a company, MAXIMUS handles over 250,000 calls per month around the nation.](#) It can provide Spanish-speaking specialists, and if OCS desires, specialists who speak other languages as well.

MAXIMUS is also pleased to offer the services of its Center for Health Literacy, which it can use for review of MSE letters and materials for their readability, and for translation services if OCS chooses.

C-2.1.d.ii.a Insurance Enrollment: MFIA Responsibilities

1. Produce/Mail NMSNs

Generate and mail the NMSN to employers.

The HMS Team understands that MFIA—through MiCSES—will generate and mail the NMSN to employers.

We realize that NMSN processing and handling are the foundation of an effective enrollment program, and we will combine technology and skill to enroll as many dependents as possible. Our efforts in this regard will include:

- Working with employers through Web information we can provide, either on the MFIA/OCS website or on our own Web site
- Establishing a toll-free number for employers to call
- Providing general informational outreach developed jointly with OCS as well as targeted outreach for electronic response transmission
- Conducting interviews or briefings—with the state’s permission—in a manner, time, and place the state approves

2. Provide Insurance Enrollment Request File

Provide the contractor a daily Insurance Enrollment Request File.

The HMS Team understands that MFIA will provide a daily Insurance Enrollment Request File, listing the NMSNs that MiCSES has generated and mailed. If we find any possible errors in the file—such as employer addresses or enrollment information—we will work with the appropriate party or resource to verify the correct information and report it to OCS if the discrepancy was found on its file, or make changes to our data if it is our outdated or incorrect information

We will download the file information onto our system and immediately begin working the cases. We of course will ensure compatibility with the files as transmitted by MiCSES.

3. Reimburse Contractor

Reimburse the contractor within 30 days after receipt of an approved invoice.

We will prepare invoices, with supporting documentation regarding our enrollment activity, for MFIA and MDCH. We will customize each invoice to meet MFIA requirements.

C-2.1.d.ii.b Insurance Enrollment: Contractor Tasks

HMS/MAXIMUS will work closely with OCS in regard to enrollment. Often the information we provide to OCS will form the basis for generating a new NMSN to an employer, and we will be able to highlight and track those cases to ensure compliance. If we find any possible errors in the OCS Insurance Enrollment Request File, such as employer addresses or enrollment information, we will work with the appropriate party or resource to verify the correct information and report it to OCS if the discrepancy was found on its file, or make changes to our data if it is our outdated or incorrect information

We will download the file information to our system and immediately begin working the cases. Of course, we will ensure compatibility with the files as transmitted by MiCSES.

C-2.1.d.ii.b(i) Insurance Enrollment Overview

This section of our proposal begins with a description of specialized capabilities that HMS's proposed subcontractor, MAXIMUS, would bring to the Michigan child medical support enforcement project. In the following section, we address the RFP-specified requirements for the insurance enrollment function.

MAXIMUS Capabilities

MAXIMUS has first-hand knowledge of what prompts NMSN service, and the time frames that employers and plan administrators have to return the NMSN. The federal mandate allows employers 20 days to respond with Part A of the NMSN and plan administrators 20 days to respond with Part B.

MAXIMUS understands that accurate order entry is critical to enforcing medical insurance coverage. It will have a designated quality assurance team member, rotating among the experienced enforcement specialists, who will conduct sampling quality assurance tests to ensure accuracy.

Mail Receiving and Sorting

MAXIMUS staff will open, sort, and process all mail received—processes that the company has repeated for countless documents in hundreds of projects nationwide. MAXIMUS will work with the Michigan Medicaid Enrollment Call Center staff to coordinate post office runs to ensure separate and secure mail.

MAXIMUS anticipates receiving several hundred pieces of mail a day under this project. Staff will carefully open and time-stamp the mail, and will work to ensure that nothing is lost, misplaced, torn, or mutilated. Mailroom workers will be trained for accuracy, security, and timeliness.

MAXIMUS's experience in other projects has shown that it is best to categorize the mail received on the front end and distribute the mail for processing by category. For instance a Data Entry Clerk processes complete returned mail while a Medical Support Enforcement Specialist receives returned responses indicating there is more than one choice available.

Exhibit C2-19 lists the categories of mail that are likely to arrive under this project:

Exhibit C2-19: Categories of NMSN Mail

Checks (Child Support Payments)
NMSN Mail
PART A Returned Undeliverable
PART A Returned No Dependent Coverage
PART A Returned NCP Not Eligible
PART A Returned NCP Terminated
PART A Returned NCP Does Not Make Enough Money
PART A Returned Union
PART A Returned Incomplete
PART B Returned Complete
PART B Returned Incomplete
PART B Returned Incomplete/No Signature
PART B Returned More Than One Choice
PART B Returned Waiting Period
PART B Returned QMCSO Requested
Returned Order Notices to Withhold Income
Order Notice Returned NCP Currently Employed
Order Notice Returned Undeliverable
Order Notice Returned Terminated
Miscellaneous

Processing Mail and Faxes

Through NMSN work in Illinois, MAXIMUS found that a tiered approach to returned mail and fax processing, as well as resolving customer inquiries and worklists referrals, works best for enforcing NMSN. This will be integrated into the Michigan workplan.

Checks

Through experience receiving and sorting mail received at the NMSN post office box, MAXIMUS has found that some employers use the postage paid envelope received with the NMSN to remit a child support garnishment. Received checks are photocopied and immediately delivered to the Mail Room. The Support Clerk who identifies a check in the mail forwards the mail containing the check to the Clerical Support Supervisor. A copy of the check is made, and the Operations Manager maintains all copies of stored checks. The Mail Room staff then mail these checks to the SDU.

MAXIMUS understands how important it is for employers to remit payments directly to the SDU. MAXIMUS will work with OCS to enhance the NMSN mail retrieval by managing the post office box, thereby decreasing the time needed for mail to reach the MAXIMUS office for sorting and processing. In addition, MAXIMUS will work with OCS to develop an outreach plan to those employers who remit payments this way.

NMSN Mail

MAXIMUS's approach to processing returned NMSN responses divides responses into three tiers:

- **Tier One:** Responses that are scanned by state-of-the art OCRs, which will translate responses into data in the MAXSTAR system and simultaneously image the documents for storage
- **Tier Two:** Responses that are not readable by the scanner and require simple manual data entry based on the data elements needed by OCS
- **Tier Three:** Responses that require follow-up by enforcement specialists

In Tier One, MAXIMUS plans to use the following OCRs to scan the responses:

- Hummingbird Document Manager – 30-user license, includes Kofax Ascent Capture software for OCR
- Imaging Application Server - Dell 2650 Windows 2003, Dual CPU, 4 GB RAM, 5x73 GB 15k RPM SCSI, PERC4 Raid; same-day, four-hour, three-year support
- Dell PowerVault 220/221, SCSI Storage Enclosure with seven 73 GB hard drives; same-day, four-hour, three-year support
- PowerVault Tape Backup 122T 8 slot Autoloader with 20 tapes
- SQL Server 2000 License A
- Netvault back-up software with SQL 2000 Agent (direct to tape configuration)
- Two Kodak 3500D Duplex scanner with three-year extended warranty, Kofax Adrenaline 1700 Image Processing Accelerator SCSI controller, cable

The responses will be electronically transferred through the imaging system to the database for storage on MAXSTAR files for eventual transfer to files and use for reports. A Data Entry/Imaging Specialist will ensure that the system correctly translated the typed or handwritten responses and will verify the accuracy at the time of entry of the data. Also, the Specialist will verify the identification match of the response or other document with the appropriate case and dependent child.

MAXIMUS proposes two Kodak 3500D Duplex scanners for two reasons—to distribute the work burden and to have a back-up in case one scanner malfunctions, ensuring that operations will continue to run smoothly.

In Tier Two, MAXIMUS will identify documents that are imaged but for which responses were not readable (predicted to be about 20% of the mail); Clerks will complete the data entry process manually. This assumes that the information is complete. If Data Entry Clerks notice missing information, they will refer the file to a queue for the Medical Enforcement Specialists.

Tier Three involves research and disposition of incomplete returned NMSN mail. These NMSNs would be forwarded to Medical Enforcement Specialists, who will contact employers, NCPs, CPs, plan administrators, and unions to research the incomplete mail and conduct inquiry to resolve missing items.

Data Entry of Returned NMSN Mail

The following returned NMSN responses will be processed by the Scanners and/or the Data Entry Clerks. All responses received are imaged and stored.

- **PART B Returned Complete.** When a completed PART B of the NMSN is returned, the Scanner/Imager and the Data Entry Clerks would update the insurance carrier information, the coverage types, the dependent coverage begin dates, and all other information received into the medical screens for the file exchange with OCS. If the policyholder is someone other than the NCP (e.g., the NCP's spouse), the Specialist would have another step in this process.
- **PART A Returned Undeliverable.** Data Entry Clerks would record this mail response in the medical screens documenting the bad address. If possible, the correct address is found and updated.
- **PART A Returned No Dependent Coverage.** Scanners read and record a blank entry, which a Specialist then verifies, or Data Entry Clerks enter the appropriate status code.
- **PART A Returned NCP Not Eligible.** Scanners read and record an entry of ineligibility, which a Specialist then verifies. If an entry is not verifiable or is unreadable, a Data Entry Clerk enters the appropriate status code.
- **PART A Returned NCP Terminated.** Scanners read an entry that the NCP no longer works for an employer—which a Specialist records and verifies—or a Data Entry Clerk enters the appropriate status code triggering that the employer coverage is ended.
- **PART A Returned NCP Does Not Make Enough Money.** Scanners read an entry that indicates the NCP does not earn enough money to pay for the premium, and it is recorded and verified by a Specialist, or a Data Entry Clerk enters the appropriate status code.
- **Research and Follow-up of Incomplete Returned NMSN Mail.** The following returned NMSN responses are entered and categorized by a Scanner or a Data Entry Clerk. At this point, a referral is made to the Medical Enforcement Team for research and resolution of the returned mail, fax and or inquiry.
- **PART A Returned Union.** The Specialist reviews the returned documentation if the name and/or address of the union is provided, and notify the OCS for generation of a NMSN to be sent to the union. If the union is not provided, the Specialist contacts the NCP, employer, and/or plan administrator to identify which union needs to be served. All actions are documented and placed on file. MAXSTAR is used to prompt the Specialist to follow-up on the case until it is in compliance with the NMSN process.
- **PART A Returned Incomplete.** The Specialist contacts the employer and communicates what information is needed from the employer to ensure it remains in compliance with the NMSN process. This may include faxing the NMSN for quicker resolution. If the employer notifies the Specialist of the plan administrator, the Specialist mails an NMSN to the plan administrator directly, or if the state prefers, it may be generated by OCS a second time. All actions would be documented. MAXSTAR would be used to prompt the Specialist to follow-up on the case until it is in compliance with the NMSN process.
- **PART A Returned Incomplete/No Signature.** The Specialist contacts the employer and notifies it that its response was received but it was not signed. The Specialist works with the

employer to fax the response and requests that the form is signed and faxed back. All actions are documented. MAXSTAR is used to prompt the Specialist to follow-up on the case until it is in compliance with the NMSN process. Once the case reaches a compliant status the data are forwarded to OCS.

- **PART B Returned Incomplete.** The Specialist contacts the plan administrator and communicates what information is needed from him or her to ensure he or she remains in compliance with the NMSN process. This may include faxing the NMSN for quicker resolution. All actions would be documented. MAXSTAR is used to prompt the Specialist to follow-up on the case until it is in compliance with the NMSN process. Once the case reaches a compliant status the data are forwarded to OCS.
- **PART B Returned Incomplete/No Signature.** The Specialist contacts the plan administrator and notifies him or her that the response was received but it was not signed. The Specialist works with the plan administrator to fax the response to him or her and would request that it be signed and faxed back. All actions are documented. MAXSTAR is used to prompt the Specialist to follow-up on the case until it is in compliance with the NMSN process. Once the case reaches a compliant status the data are forwarded to OCS.
- **PART B Returned More Than One Choice.** Subject to OCS policy to the contrary, the Specialist contacts the CP to notify him/her of the choices available. If the CP does not respond within 20 days to the plan administrator or to the Medical Support Enforcement Specialist, the employer is notified to select the default insurance option. All actions would be documented. MAXSTAR is used to prompt the Specialist to follow-up on the case until it is in compliance with the NMSN process. Once the case reaches a compliant status the data are forwarded to OCS.
- **PART B Returned Waiting Period.** The Specialist keys in that a waiting period applies and tracks the referral to follow-up at the end of the waiting period. A MAXSTAR prompt for the Medical Enforcement Team to follow-up would follow. Specialists run reports from MAXSTAR, which includes self-prompts that the Specialist entered to alert them to review the case after the waiting period has passed. All actions are documented. MAXSTAR prompts the Specialist to follow-up on the case until it is in compliance with the NMSN process. Once the case reaches a compliant status all necessary work the data are forwarded to OCS.
- **PART B Returned QMCSO Requested.** The NMSN is a Qualified Medical Child Support Order (QMCSO). However, employers and/or plan administrators may occasionally return the NMSN stating they need a QMCSO. In such cases, the Specialist calls the employer and/or plan administrator to explain that NMSN satisfies the QMCSO requirements. All actions are documented. MAXSTAR prompts the Specialist to follow-up on the case until it is in compliance with the NMSN process. Once the case reaches a compliant status the data are forwarded to OCS.

Non-NMSN Employer Mail and Miscellaneous Mail

All non-NMSN mail received at the post office box would be sorted in the MAXIMUS mailroom into categories of returned employer mail/order notice to withhold income and miscellaneous mail.

Data Entry of Non-NMSN Employer Mail

Based on MAXIMUS's Cook County and other office experience, non-NMSN employer mail that arrives at the NMSN post office box is primarily returned Order/Notices to Withhold Income. Returned income withholding orders/notices are data entered by Data Entry Clerks, and HMS/MAXIMUS will process these as directed by OCS.

Processing of Misdirected Mail

If the HMS/MAXIMUS office receives misdirected mail, we would forward it to the correct address.

Contacting Employers and Others

The Team would have a proven process in place for researching and resolving medical insurance inquiries and enforcing NMSN. Our years of experience in this area have afforded us the opportunity to develop relationships with many employers, plan administrators, and unions. We will follow that procedure in Michigan.

Building a strong relationship with the employer community is an essential component of successful NMSN implementation. Our Team will work closely with employer and manufacturing associations and Chambers of Commerce to get out the message and to reach out to offer assistance. We will coordinate mailings with OCS to ensure complementary activities and outreach. Our staff will draw upon these relationships to follow-up on incomplete returned mail and resolving inquiries from CPs.

Customer Service Specialists and Medical Enforcement Specialists will be trained in phone etiquette and techniques to obtain necessary answers quickly. All contact with customers (employers, plan administrators, unions, CPs, and NCPs) would be documented for later use.

Outreach for Electronic Transmission

In conjunction with the state and based on its plan, HMS/MAXIMUS will reach out to all employers in the state to determine if they want to communicate their responses electronically. The electronic NMSN can be transmitted through e-mail or FTP and will save time and money for everyone involved. We will set goals with the state to have at least one-third of the reports received in electronic format by the end of the contract period. This will be a major undertaking by the Team in conjunction with OCS as the value of electronic transmission cannot be understated.

Our outreach efforts will focus on larger companies initially. We will look for patterns within industries to see if certain types of employers are more likely to sign up, and we will focus on those industries. In addition to company size and industry classification, we will target and reach out to companies that have an established history of filing forms electronically.

Preparation of NMSN Documents for Imaging

As with all case documentation, accurate recording keeping is imperative. We will image the NMSN return information received and any correspondence and other documentation, pursuant to ITB guidelines and OCS directives. We have vast experience in imaging, which we will apply to this task.

We will train all project staff on how to prepare a document for imaging. However, our data entry/imaging and mailroom teams will complete the vast majority of document imaging preparation.

Interstate and International NMSN

HMS/MAXIMUS is eager to foster more successful partnerships on behalf of Michigan with other states and will work with OCS on a plan to have contiguous states and Illinois reciprocate on interstate NMSN and conduct follow-ups. We would, of course, coordinate this activity through the Michigan Interstate Central Registry and consider the use of Interstate Action Transmittals to accomplish some of the requesting for responding state services without the need to open a case. In rare cases where the employer is not cooperating and we have to domesticate the order in the employer's state, we will work with OCS on the best methodology for accomplishing this.

Additionally, we can work with Ontario and any other Canadian Province to ensure compliance. MAXIMUS has operated the British Columbia child support program for 15 years and has established a good rapport with all the provinces.

NMSN Customer Service

The HMS/MAXIMUS Team is passionate about excellent customer service. This extends to accurately resolving inquiries from CPs, NCPs, employers, plan administrators, and other interested parties regarding NMSN operations. Through MAXIMUS's experience in serving Cook County NMSN customers, it developed processes to resolve the common medical support enforcement inquiries including the many instances where NCPs have enrolled the children in their health insurance plans and the CP has not been able to obtain a copy of the medical insurance card.

As required by the RFP, HMS/MAXIMUS will be the liaison between the employer/plan administrators/health insurance carrier and the CP/dependent children. Our networking with employers and plan administrators should also enhance our ability to provide timely and accurate customer service—we will be able to get the answers to questions fast and accurately.

When a caller's inquiries cannot be resolved during the call, our Medical Enforcement Specialists would subsequently resolve the inquiry and then call the customer to notify them of the resolution. Our goal is to ensure that customers are satisfied and understand the process.

Call center operations are a core corporate expertise for MAXIMUS, which is also the leader in child support call center operations. MAXIMUS operates its customer service call centers as both stand-alone projects and as distinct units within projects. Fully trained customer service professionals and state-of-the-art technology, including Automated Call Distribution (ACD) Interactive Voice Response (IVR) and call monitoring systems are features of MAXIMUS call centers. To ensure the highest levels of efficiency and customer satisfaction, MAXIMUS provides its staff with the requisite tools, equipment, and training. The company's comprehensive training program and Quality Assurance plan guarantee its effectiveness at

providing highly skilled, customer-focused, knowledgeable staff and accurate, timely services for all programs.

The average monthly volume of calls across all MAXIMUS health and human service call centers is close to 250,000. Each of these centers operates a toll-free information line. Each of our call centers has contractual standards or metrics that must be met. These metrics drive the relative size of the call center, the telecommunications equipment, and staffing complements.

Added Value and Enhancements

As previously discussed, the Federal Office of Child Support Enforcement will soon add a medical support performance indicator to the federal incentive framework. HMS/MAXIMUS will devote project and company resources to ensure compliance in this area. We invite discussion with OCS to explore areas for enhancing the NMSN process in Michigan.

Our Team also has tremendous experience in the area of Web site development. To enhance customer service, we will work with OCS to maintain a current list of FAQs about the NMSN and to explore areas where the NMSN process can become more electronic—especially allowing employers and plan administrators to submit responses through the MSE project Web site. At OCS's request, we will arrange a meeting with our Web site consultants.

We are well-prepared to provide all compliant activities required by the federally mandated NMSN process and offer unmatched experience in enforcing medical insurance coverage both pre- and post-NMSN implementation. We know the ins-and-outs of NMSN operations and have developed relationships and effective points of contact with some employers and plan administrators across Michigan and nationwide—including with some unions. We have also established efficient processes for the data entry associated with returned NMSN mail.

Quality Assurance

Quality Assurance (QA) is an integral part of this proposed HMS/MAXIMUS operation. We will rotate staff under the supervision of the team leader to conduct monitoring of other staff's work. This serves two functions: comparing one's work with others and learning some best practices. MAXSTAR will generate reports that will include metrics by which to measure contract performance, team performance, and individual performance. Bonuses are available for outstanding performers, and corrective action plans are crafted and implemented for underachieving staff.

Transition

We will work closely with OCS to have a seamless transition so that we are fully operational on July 1, 2004. We plan to be operating routinely by the end of the first week. During the previous month, we will have all the necessary furniture, equipment, additional T-1 lines, automation, and telephony purchased or leased and tested. We will conduct several dry runs with the new staff, hired and trained over the same period of time. Specialized training on child support, medical support enforcement, and specialty areas—such as the OCR Scanners and telephone equipment—will be provided. We will rehearse our procedures and scenarios during the dry runs and will test the new workers on security, confidentiality, and procedures.

If another vendor or the state takes over the project, we will work closely with the successor to guarantee a smooth transition at the end of our contract term.

C-2.1.d.ii.b(ii) Insurance Enrollment: Required Tasks

This section responds to required contractor tasks for the Insurance Enrollment function, as identified on RFP page 35.

1. NMSN Processing and Handling

Process the information returned on the NMSNs from the employers and benefits administrators.

Coordinate with OCS and large employers to implement an electronic NMSN to replace the printing, mailing, and handling of paper NMSNs.

Monitor the aging of NMSN requests per federal, state, and contractual requirements.

NMSN processing and handling are the foundation of an effective enrollment program, and we will combine technology and skill to enroll as many dependents as possible. HMS/MAXIMUS will:

- Work with employers through Web information we can provide, either on the MFIA/OCS website or on our own Web site
- Establish a toll-free number employers can dial
- Provide general informational outreach developed jointly with OCS as well as targeted outreach for electronic response transmission
- Will conduct interviews or briefings—with the state’s permission—in a manner, time, and place the state approves

When the information is complete on the response the form is scanned and automatically converted into electronic data for our MAXSTAR case-processing application on our dedicated server on site in East Lansing. The scanner will also image and store the information. We will generate our nightly file from data inputs that occurred during the day.

If the data are incomplete, or if the response is blank, we will input data to the greatest extent possible and then transfer the case to the Medical Enforcement Specialists’ queue. They will review the case and call the employer for follow up.

We will work with OCS to develop protocols for apparent “dead ends” so that we do not prematurely cut off options to enroll a dependent. When an employer does not respond after our repeated attempts at contact, or if we cannot enforce across state lines when an employer refuses to cooperate, we will notify the state on the Insurance Enrollment Response File for appropriate action. We will let the employer know that information and contact the carrier directly if the employer is still nonresponsive if the state approves. We will use the HMS eligibility matches with insurance carriers to determine if some of the nonresponsive employers do have coverage under which the NCPs might be enrolled.

If the state chooses, we will act as the conduit for the insurance enrollment cards and other documentation and send these materials to the family the next business day after receipt and scanning. We have built this step into our plans, as the business rule has not yet been determined, according to the state’s answers to vendor questions for this RFP. If the state does not want this intermediate step, we can reallocate resources designed to expedite the card documentation and transfer.

In conjunction with OCS, we will begin with a broad outreach to employers and then progress to a targeted outreach for large employers and employers who are members of industries that are highly automated. We will explain to these employers the benefits of electronic response transmission—benefits that extend to the employer, the children, and the state. We may choose to highlight some companies—with their permission and OCS clearance—on the Web site as examples of successful conversions to electronic transmission.

Through MAXSTAR, we will monitor the NMSNs sent to employers for responses. We will send out post card reminders when responses are past due. We will follow up by telephone if employers do not respond to the post cards. We will continually monitor NMSN activity, based on federal and state timeframes—and our contractual obligation to ensure that we receive complete responses so we can enroll each child under available health insurance coverage or determine that insurance is not reasonably available at the NCP's place of employment.

MAXSTAR will daily transfer all electronic files through a T-1 line, in the state-specified, MiCSES-compatible format. MAXIMUS's familiarity with MiCSES comes from its work as a subcontractor during the system's development and as a user on the SDU QA project. Also MAXIMUS sends files routinely to the state on Oracle-based systems similar to MiCSES.

Exhibit C2-20 identifies special features and benefits that MAXIMUS will bring to the NMSN processing effort for OCS.

Exhibit C2-20: NMSN Processing Features and Benefits

National Medical Support Notice (NMSN)	
Objective: To ensure statewide compliance with all activities associated with the Federally Mandated NMSN	
Features	Benefits
MAXSTAR Automated Supplemental Approach	Enhances operational efficiency
Established relationships with employers, unions and plan administrators	Established relationships promote cooperation and ensures trust of vendor More time is spent getting to the right people and less time is spent with directory assistance.
Using over six years of direct Illinois medical support experience and two years of hands on Illinois NMSN experience	We know the ins and outs of the NMSN process and we will transfer compatible practices to Michigan.
Familiarity with MiCSES for interfacing and understanding its functionality	Several MAXIMUS staff during the transition will assist new staff on MiCSES from a macro and micro perspective.
Phone center expertise	Located in the MAXIMUS Medicaid Enrollment Call Center, our customer service specialists will tap into a Michigan-approved automated call distribution and interactive voice response phone system with appropriate modifications for MSE.
Center for Literacy will review and improve Notices	Ensures notices understood by all people

2. Coordinate Insurance Enrollment

Work with the employers as needed to affect health insurance enrollment for the dependents (members) or identify why enrollment cannot be affected.

We will electronically report to OCS on the insurance enrollment response file. We will image the hard copies we will receive, and document all information regardless of its medium.

We will work closely with large employers and OCS to convert to an electronic response version that is compatible with federal requirements and easy-to-use for employers, benefits administrators, and OCS.

We will develop a close working relationship with the health insurance contacts and the benefits administrators, forming master lists of contacts that we will continually update and share with

OCS as this information may impact the NMSN addressee information. We will use state-of-the-art imaging for converting hard-copy documents to an electronic format and MAXSTAR software for internal recordkeeping. MAXSTAR is Y2K compliant, easy-to-use, and has robust functionality to perform all necessary tasks, including interfacing with MiCSES. We will have our own server for the project, backed up nightly.

MAXSTAR is MAXIMUS's proprietary case-tracking system that streamlines all activities involved in the call center and enrollment-related processes. It also monitors individual and team performance and provides data for internal QA statistics. We will also use MAXSTAR to generate reports for the state.

MAXSTAR offers many features that will contribute to the success of this Michigan MSE project:

- **Call Center Case Action Logs.** MAXSTAR provides the capability to log each call received or each action taken, recording such information as the caller's identity, the related child support case, the nature and disposition of the call, the nature and disposition of any complaints received, and any follow-up activity required. Using these reports, we will provide OCS with call trend reports to analyze reasons for calls and to identify why calls are repeated.
- **Automatic Tickler.** Allows Customer Service Specialists (CSSs) or Supervisors to set a tickler for any required follow-up actions
- **Memo Fields.** The MAXSTAR applications builder allows a memo field that permits CSSs to enter text descriptions of the actions on a case or any other information. These fields allow an unlimited amount of text to be entered and are used only to supplement the information transferred to the state via MiCSES.
- **Flexible Report Generator.** Case action codes are used to produce:
 - Statistical reports to measure individual and project performance
 - Aging reports to identify cases before they "fall through the cracks" or are out of compliance
 - Ad hoc reports to identify or analyze problem areas and to streamline work
- **Data Security.** MAXSTAR uses confidential passwords, both at initial login and when a user tries to progress to a new menu branch. In addition, all project staff and authorized MAXSTAR users are identified in a database staff file that records the user's staff category and access authorization level. Each user category has its own specialized menu system that offers access only to appropriate system functions and database views.

MAXSTAR will provide state-of-the-art statistical case tracking and reporting support for the continued achievement of quality child support delivery.

Our proposed outreach plan for employers includes:

- Mailings to employers who have made mistakes on responses for two or more NMSNs, have not responded timely, or have refused to cooperate. We will coordinate these mailings with OCS and will obtain OCS's approval of text for the letters.
- Producing general medical support and NMSN information that will be available on a Web site as a page with FAQs and as a handout that can be mailed regarding the NMSN process and its benefits to Michigan. We will work with OCS on the Web site link to ensure it meets OCS standards.

We will make sure our customer service representatives are sensitive to the issues employers have, understand the common questions and how to answer them, and are able to explain the program and its benefits to employers.

3. Create Insurance Enrollment Response File

The contractor will create a daily insurance enrollment response file based upon the results of processing of the NMSNs and send the file to OCS.

As the “deliverable” of insurance enrollment, HMS/MAXIMUS will daily generate the Insurance Enrollment Response File based on that day's NMSN processing work. We will have up to date information on our interactions with employers and benefits administrators, using the ten records laid out by OCS in the ITB. We will designate why certain dependents cannot be enrolled and give status updates when we have cases where the NMSN has been served on the employer and we have not yet enrolled the dependent or documented a reason for not enrolling. We will have a tickler system on MAXSTAR to ensure that these cases are regularly rotated back in the queue for the enforcement specialist.

We will generate the Insurance Enrollment Response File and send it to OCS via MiCSES using the 10 records OCS prescribes in the RFP and in a compatible file format.

4. Compliance with Timeframes, Accuracy and Multi-Tiered Approach

We will ensure that Michigan complies with federal timeframes for the NMSNs, and that all issues relating to enrollment that could be resolved in favor of enrolling dependent children are handled efficiently, professionally and accurately. The Team will have a seamless matching and enrollment process that will allow us to meet all contractual deadlines for case processing.

Our three-tiered approach relies first on automation to input, store, and verify data. Second, our data entry staff will input returned information that is not readable. Third, our enforcement specialists will work the cases with issues or missing items. We will carefully work cases to ensure that children who can be enrolled are enrolled, as enrollment is the goal of the program, the parents, and the HMS/MAXIMUS Team. If a dependent cannot be enrolled, we will document the case and forward relevant information to OCS on the Insurance Enrollment Response File.

We will work closely with families to ensure that we send their enrollment cards and other health coverage documentation to them as soon as possible. We will establish metrics that will require an immediate turnaround (one or two business days) from the date we receive these materials in

our office to the date we send them to the family. We will image a copy of the card and the case-specific documentation and keep them in our files for reference.

We look forward to providing outreach to employers to see if we can convince a large percentage of them to provide their NMSN responses in electronic format. This will save everyone time and money. OCS has been a pioneer in the concept of serving and transmitting income withholding orders electronically, and the electronic NMSN—under OCSE guidance—should prove to be an equally successful launch. We will develop roll out plans and outreach efforts in conjunction with OCS.

For the Michigan MSE project, the HMS Team proposes to create a Master Michigan Employer database from all employers identified from the state employer files, including the Wage and Earning file, the new hire file, and Michigan business incorporation file. In addition, we will send each large employer in the state an annual questionnaire to gather information on the employer's health insurance plans and benefits package. We will also ask for the proper address to send NMSNs and other related notices.

The employer database file will be linked in a relational database to a file of unique commercial insurance plans that various insurers offer. Consequently, through our data matches and follow-up data gathering techniques, we will develop and maintain a database of Michigan employers and the respective insurance plans that they offer. This information will significantly assist OCS in its efforts to streamline the NMSN mailing process. For example, if it is discovered that an employer does not offer family health insurance or any health insurance, OCS may not want to mail the NMSN but may want to pursue other options for obtaining insurance for the child.

Develop and Maintain MICHild Connection to Refer Cases in which Dependents Are without Insurance Coverage

Since MAXIMUS operates MICHild enrollment and has access to alternative sources of insurance coverage, it can combine HMS data and MAXIMUS data to create a unique, seamless source of insurance. Once it is determined that the NCP does not have health insurance, the state may then send a file to MICHild enrollment to determine if the dependent qualifies for Medicaid or SCHIP (MICHild) services. In this way, HMS/MAXIMUS can help the state meet the laudable goal of providing private insurance for as many children as possible and ensuring that children who cannot access health insurance through their parents can be covered through a state-sponsored program. HMS/MAXIMUS offers this as an add-on service that can help make Michigan a national leader in healthcare coverage rates for its children.

C-2.1.d.iii Process Backlogged NMSNs

C-2.1.d.iii.a Process Backlogged NMSNs: MFIA Responsibilities

1. Identify and Transfer Backlogged NMSNs

Identify and transfer to the contractor the backlogged NMSN forms that need to be processed.

The HMS Team understands that we will receive a backlog of approximately 30,000 – 40,000 NMSN forms from MFIA, each of which we will process as a regular insurance enrollment task.

(Our Team’s proposed approach to insurance enrollment is described under Section C-2.1.d.ii, above.)

2. Reimburse Contractor

Reimburse the contractor within 30 days after receipt of an approved invoice.

We will prepare invoices, with supporting documentation regarding the NMSN and enrollment activities for MFIA. We will customize each invoice to meet MFIA requirements.

C-2.1.d.iii.b Process Backlogged NMSNs: Contractor Responsibilities

Process each NMSN as an insurance enrollment as described under Insurance Enrollment.

Create a file similar/same as the insurance enrollment response file described under Insurance Enrollment, and send it to OCS on a weekly basis until the project is completed.

HMS/MAXIMUS will dedicate extra staff at the start of the project to work through the backlog of hardcopy NMSNs that has accumulated. We will image them, convert them to data for file transfer, and begin working them immediately, with our goal being to finish within three months from the date of the project’s start.

We will work closely with the FOCs that issued them initially, but we will follow the same procedures as we do with the insurance enrollment cases in dealing with employers and benefits administrators, as described in the previous section.

We will use our imaging equipment in combination with our MAXSTAR application to enter data from the hardcopies of the NMSNs and create a parallel file for backlogged NMSNs that will be similar to the insurance enrollment response file that will be daily issued for ongoing NMSNs.

The Michigan Department of Management and Budget (DMB) and the Office of Child Support (OCS) of the Family Independence Agency (FIA) will benefit from a plan that guarantees the most comprehensive efforts to enforce medical support orders in the nation. By retaining the HMS/MAXIMUS team, DMB is procuring the top health insurance carrier data collector in the country and the leader in child support operations, including the most experienced medical support enforcement company in the country. Both companies have a long and proud history of serving Michigan well and will do everything they can to continue to provide outstanding client and customer service. By choosing our Team, Michigan will have a state-of-the-art National Medical Support Notice (NMSN) enforcement program that provides the highest possible penetration level of health-insurance coverage, particularly commercial-health-insurance coverage, for Michigan’s children not living with both parents.

C-2.1.e Project Control and Reports

C-2.1.e.i RFP-Required Project Control Tasks

a. Provide Service to MDCH and MFIA

The contractor will carry out the project under the direction and control of the MDCH and MFIA. The MDCH will manage Project #1 and the MFIA will manage Project #2.

HMS understands that project operations will be carried out under the direction and control of two agencies: MDCH and MFIA/OCS. HMS affirms our ability and willingness to work with these agencies, individually, to ensure the success of both the TPL and medical support enforcement programs in Michigan.

HMS has successfully demonstrated our ability to serve in this capacity. We have simultaneously performed core TPL services for the Medicaid agencies **and** medical support services for the child support enforcement agencies in Ohio, Connecticut, Colorado, and Maryland.

b. Maintain Continuous Liaison with MDCH and MFIA

To assure continuous liaison with MDCH and MFIA staff, the contractor shall establish and maintain an office in Lansing, Michigan. Expenses related to the maintenance of that office shall be the responsibility of the contractor. The contractor will have to assign one full-time project manager to manage both Project #1 and #2.

HMS affirms our willingness and ability to establish a Lansing-area office immediately upon contract award to ensure continuous liaison with MDCH and MFIA. Our plans for establishing this office—along with the capabilities and proposed functions of this location—are described, in detail, under Section C-2.7 (Lansing-Area Office) of this Tab. HMS understands and agrees that expenses related to maintaining this office will be HMS's responsibility.

HMS's proposed Project Management staffing exceeds the RFP requirement for one full-time Project Manager. Fran Coury will act as the Project Manager for this entire engagement, with a focus on the Medicaid Third Party Liability Recovery and Insurance Locate projects. In addition, we have proposed one full-time Project Manager—Linda Lemonds—who will be based in East Lansing and fully (100%) dedicated to serving as the Manager for Project 2 (Insurance Enrollment and NMSN Backlog Processing). These Project Managers will receive support from an experienced HMS/MAXIMUS project management team, including: Cynthia Jones (HMS Implementation Manager), Keith Reinold (HMS Senior Project Manager and Manager of Medical Support Enforcement), Donna Price (HMS Senior Vice President, Client Relations), Jeff Ball (MAXIMUS Partnership Manager), and Mary Ann Wellbank (MAXIMUS Project Consultant).

c. Meet with Contract Managers

In addition to continuous liaison with the contractor's project team, the MDCH and MFIA contract managers will meet quarterly, at a minimum, with the contractor's project manager. The meetings will be for the purpose of reviewing progress and providing guidance and direction to the contractor in

resolving problems and issues that arise.

HMS recognizes the value of regular meetings among project stakeholders. These meetings are a valuable forum—not only for reviewing progress, obtaining guidance, and resolving issues, but also for identifying potential issues and developing mutually agreeable plans for corrective action to avoid larger problems in the future.

Given our local presence in East Lansing—and the regular communication and interaction we anticipate this will enable—HMS agrees that quarterly meetings should be sufficient during the operations phase of this project. However, to ensure development of TPL and medical support programs that fully meet agency needs and state requirements, we suggest monthly meetings during the implementation phase. HMS operational staff will also attend these meetings frequently.

d. Provide Monthly Project Reports

The contractor will provide the MDCH and MFIA contract managers with written monthly project reports. The reports will summarize progress accomplished during the reporting period, work efforts to be accomplished during the subsequent reporting period, and issues or problems that should be brought to the attention of the MDCH and MFIA contract managers. The reports will also provide notification to the MDCH and MFIA contract managers of any significant deviation from previously agreed-upon work plans.

HMS will provide a written monthly project report to the MDCH and MFIA contract managers according to the format and content specified in RFP section II-D.1.d. This report will also include the required reports for Projects #1 and #2, as identified in RFP section II-D.2 (Reports), on pages 37 and 38. (See example in **Attachment 2**.)

e. Submit Work Plan

Within five (5) working days of the award of the contract, the contractor shall submit a work plan to the MDCH and MFIA contract managers for final approval. The final work plan must be in agreement with Section IV-C, subsection 2, as proposed by the contractor and accepted by the State of Michigan for contract. The final work plan shall include the following:

- (1) The contractor’s project organizational structure.
- (2) The contractor’s staffing table with the names and titles of personnel assigned to the project. The staffing table must be in agreement with the staffing presented in the contractor’s accepted project proposal. Necessary substitutions due to changes in employment status and other unforeseen circumstances may only be made with prior approval of the State of Michigan.

The project breakdown showing sub-projects, activities and tasks, and the resources required and allocated to each.

The time-phased plan in the form of a graphic display showing each event, task, and decision point in the work plan.

HMS affirms that—within five working days of contract award—we will submit a work plan to MDCH and MFIA contract managers for final approval. The final work plan will include each of the four components listed above.

With respect to item (2), HMS affirms that:

- The staffing table in HMS’s final work plan will be in agreement with the staffing presented in our accepted project proposal.
- We will seek prior approval from the State of Michigan before making necessary substitutions due to employment status and other unforeseen circumstances.

“Draft” versions of the four work plan components—subject to MDCH and MFIA approval—appear within this Proposal, as cross-referenced in **Exhibit C2-22**:

Exhibit C2-22: HMS Project Work Plan Components in Proposal Response to ITB 071I4001154

Work Plan Component	Proposal Cross-Reference
HMS project organization structure	Tab C4 (Staffing)
HMS staffing table, including names and titles of personnel assigned to project	Tab C4 (Staffing)
Project breakdown and resource allocations	Tab C2 (Technical Work Plans), Section C-2.2 (Person-Hours and Project Schedule)
Time-phased plan, in graphic display	Tab C2 (Technical Work Plans), Section C-2.2 (Person-Hours and Project Schedule)

C-2.1.e.ii Additional HMS-Proposed Project Control Tasks

In addition to tasks required by RFP section II-D.1, HMS offers the following project control features that will result in superior performance under this TPL/medical support contract:

- HMS Quality Control and Compliance Program
- Superior training program
- Established accounting protocols, in accordance with Generally Accepted Accounting Principles (GAAP)

C-2.1.e.ii.a HMS Quality Control and Compliance Program

Quality Assurance

For more than two decades, HMS has delivered high-quality revenue recovery services. HMS's **average client retention rate of 90%** proves that we “walk our talk.” We provide clients with high-quality revenue recovery services, and they consistently renew their contracts with us.

HMS understands that detailed, informed planning and scheduling are the primary vehicles that enable us to provide services that meet and exceed MDCH's/MFIA's needs. Timely and accurate revenue recovery results are chief among these needs.

To achieve strict quality control, HMS utilizes a complete and integrated Quality Control/Quality Assurance (QC/QA) contract management system under our present TPL contract in Michigan. This system combines routine management control techniques and computer-based analyses to guarantee that HMS deliverables meet industry standards and MDCH's needs. HMS's management control efforts comprise routine internal meetings, client meetings, and comprehensive internal reviews to ensure our services continue to meet HMS's strict standards of quality, accuracy, and optimal results. Our automated QC/QA process monitors and controls each activity (and its associated collection effort), ensuring 100% accountability.

HMS has gained national recognition for our ability to provide clients with the maximum number of accurate third party coverage updates and to generate maximum recovery yields.

Furthermore, HMS is actively working to ensure that our contract work complies with Health Insurance Portability and Accountability Act of 1996 (HIPAA) standards concerning transfer of data, billing submission and remittance formats (i.e., health identifiers), data confidentiality, and other requirements. HMS systems are compliant with the terms of the HIPAA Privacy Act as of April 14, 2003. We completed an Impact Analysis to ensure full compliance with the Act, which analyzed Physical Security, Data Center Security, Restricted Access to Public Health Information, and Infrastructure Security.

Quality Assurance Expertise

Two HMS staff members have primary responsibility for managing HMS's Quality Assurance initiatives:

- **Helene Garrick, Director of Compliance and Quality Assurance.** Ms. Garrick’s responsibilities address both Quality Assurance and Compliance, including HIPAA compliance.
- **Alexandra Holt, Training Director.** Ms. Holt oversees employee training, development of standard operating and quality control procedures, and technical documentation of processes.

By virtue of their longstanding experience with HMS and detailed understanding of TPL and related operations (10 years for Ms. Garrick and 20 years for Ms. Holt), they are ideally positioned to manage HMS’s comprehensive Quality Assurance program for MDCH and MFIA.

Statement of Requirements (SOR)

Following contract execution, the HMS and MAXIMUS Project Managers, working with the MDCH and MFIA contract liaisons and other project stakeholders, will coordinate creation of the SOR for the TPL and medical support projects. The SOR is a formalized document that provides detailed specifications covering a full range of project-related topics, including:

Report/file production and schedules

File/data exchange protocols

Contact names, addresses, and telephone numbers for the Medicare fiscal intermediaries and carriers

Contract specifics (e.g., start and end dates, renewal and/or extension options, and any amendments)

Payment processing protocols (e.g., lock-box contacts and procedures, reconciling lock-box deposits and other documentation, invoicing requirements)

Project-specific parameters

Overall file structures (key data elements on each state file and their positions on the source data files)

Client expectations and parameters for deliverables

Special eligibility match and billing protocols that the client requires, including procedures to ensure non-duplication

MDCH and MFIA contacts (technical and otherwise)

Benchmark data for the Medicaid program (e.g., the number of claims processed annually, the number of beneficiaries/recipients served)

Benchmark data for the medical support enforcement program

The SOR is a sophisticated and rigorous management and quality control document that enables HMS to ensure we meet every client’s exact needs. By providing detailed documentation of contract requirements and deliverables, the SOR serves as a foundation for our success.

We will routinely review and modify the SOR to address current contract requirements. We will provide a copy of the SOR to MDCH and MFIA and also post the SOR on HMS's corporate e-Center, where it will be available to HMS project team members, nationwide (password- and firewall-protected). HMS team members will use the SOR to develop specifications and processing systems to address each project requirement and to develop "benchmarks" for confirming the accuracy of our processing output.

Using the SOR as a guide we will institutionalize these requirements into our staff's daily activities by:

- Using the specifications to guide our cycle processing, billing, and invoicing protocols
- Monitoring requirements in our bi-weekly Project Development and Yield Management meetings. These meetings will discuss the on-going needs and requirements as they relate to new revenue collection projects and our follow-up, eligibility verification, and other operations activities that enhance recoveries.
- Scheduling meetings with subcontractors to ensure work is complete, accurate, and on-schedule
- Scheduling staff activities such as billing cycle development, programming, quality control activities, and data match activities based on SOR requirements
- Setting goals and performance expectations based on project requirements—ensuring that service delivery is precisely what MDCH and MFIA ordered
- Aligning corporate goals with customer goals to ensure we are aligning our resources and rewarding our team with the customer in mind, first

These are just a few of the ways HMS ensures we effectively manage our staff to deliver excellent service. Other ways we monitor our services are described below.

Quality Control Procedures

HMS established quality control procedures through review of contract requirements, project-level standards and benchmarks, and other protocols mutually determined with MDCH and MFIA. Additionally, our technical staff members use manual and automated quality control tools to ensure that we process files and produce deliverables correctly and timely. We will review protocols with MDCH and MFIA during implementation.

Routine Contract Compliance Review

HMS's project management staff members monitor contract requirements, thresholds, and projections to ensure compliance with the contract. When we identify issues during these reviews, we develop an action plan to resolve them quickly and efficiently. We review the action plan with state staff and then monitor the plan closely until we have resolved all outstanding issues. This ongoing review and feedback is also provided to the project team and executive management at HMS.

Supervisor and Account Management Review of All Deliverables

Operations personnel thoroughly review all data match, billing, provider recoupment, cost avoidance, invoicing, and reporting documents and files. We will ensure that these deliverables are complete, accurate, and meet MDCH and MFIA expectations. HMS uses quality control tools (both automated and manual) and cycle financial counters as methods to monitor the quality of deliverables. The HMS Project Manager—who is ultimately responsible for the

overall quality of all billings, recoupments, and client deliverables—performs a final quality control review.

Quality Assurance Team Review of All Deliverables

All client deliverables require quality assurance review and approval before release from HMS. These items include all direct billings to insurers, provider recoupments, cost avoidance, and mailings. HMS uses a series of Microsoft Access reports and mainframe reports to perform these quality assurance reviews. In addition, we summarize the results across contracts to measure our overall quality level and identify issues that recur across contracts and indicate a training need.

Standard Processing Methodologies

HMS employs written standard processing methodologies to provide step-by-step protocols for every mainframe and client-server processing job as well as for expediting recoveries from all payors. In addition, we have developed reliable solutions to typical, potential problems to ensure that these problems are identified early and addressed appropriately.

Contract Protocols Database

Once HMS and MDCH/MFIA agree to operational protocols, HMS will document these protocols in an online database, where they will be accessible to both HMS project staff and to designated state personnel via HMS's e-Center, which is firewall- and password-protected. This database will provide a dynamic environment through which we can define, monitor, and modify (as needed) operational protocols for this project.

Quality Incident Database

HMS uses an online database through which all HMS staff document and track any quality issues that may arise. HMS's Director of Compliance and Quality Assurance ensures that HMS resolves incidents and implements protocols to prevent the recurrence of such issues. HMS uses this database to track the results of our internal focus on quality and augment our continuous staff training. Results from our quality audits are shared with our Training Director to enhance job-specific skills and knowledge.

"Benchmark" Processing Routines

HMS's database processing system incorporates "benchmark" routines. These routines detect anomalous processing results that can occur when we add new third party coverage data to the existing Master File and/or when we match the Master File to other data files. HMS's review of such aberrant findings results in cleaner billings, better carrier and provider relations, higher and accurate recoveries, more reliable cost avoidance data, and correct deliverables to our clients.

Internal Review of Project Results

HMS will perform a comprehensive internal review of project results. If the results vary significantly from our expectations, we scrutinize our processing steps to verify they are functioning correctly. HMS will use this opportunity to review in detail and refine project approaches and processes without interruption in processing. In addition, state staff may review the project results, by provider and claim type, to ensure that HMS's processing generates accurate results.

Provider Involvement/Input as Enhancements Are Developed

HMS involves and informs providers and professional provider associations before implementing project enhancements and/or new projects that directly impact providers. Given ample warning of project changes and the opportunity to comment, providers are more willing to participate in the recovery process. HMS routinely discusses with providers, and their respective associations, ways to improve provider recoupment projects.

Corporate Compliance Ensures Quality

HMS's Compliance Expertise

HMS understands that our clients' revenue recovery programs must operate within the context of complex federal and state requirements. Accordingly, HMS has established a Corporate Compliance program that draws upon the resources of internal staff that have access to senior legal advisors.

For MDCH and MFIA, the HMS Compliance Team includes:

- **Richard Lang, Vice President of Corporate Compliance and Corporate Compliance Officer, HMS Holdings Corp.** Mr. Lang has ultimate responsibility for ensuring that the Compliance initiatives of HMS Holdings affiliates add up to a total Compliance Program that meets HIPAA and other federal and state laws.
- **Helene Garrick, Director of Compliance and Quality Assurance.** Ms. Garrick coordinates Compliance initiatives and efforts within HMS. She works closely with Mr. Lang to ensure that HMS's revenue recovery projects comply with HIPAA and other federal and state requirements addressing privacy, security, and data transactions.

To further provide the project depth of expertise in Medicaid, revenue recovery, and general Medicaid/Medicare policy matters, HMS uses a panel of senior legal advisors. These advisors, who have previous CMS (formerly HCFA) and Medicaid experience, include:

Mr. Galen Powers, Esq.—former General Counsel to CMS

- **Ms. Edith Marshall, Esq.**—former HHS and CMS senior attorney

HMS Compliance Program

As a processor of claims in the healthcare marketplace, HMS is committed to preventing, detecting, and resolving instances of conduct that do not conform to HIPAA and other federal and state laws and to the program requirements of commercial healthcare payors. Dedication to Corporate Compliance is an integral part of our routine operations. This vigilance helps to protect HMS and our clients from the risk of committing a fraudulent act and incurring possible government sanctions.

HMS's extensive Corporate Compliance Program fosters broad awareness of our high standards among employees and helps to prevent waste, fraud, and abuse in the healthcare system. It includes the following:

Written standards of conduct

Written policies and procedures that promote HMS's commitment to Compliance

The designation of a Chief Corporate Compliance Officer, who has responsibility for operating and monitoring the Compliance Program

Annual Compliance training programs for all employees, including the requirement that each employee undergo annual Compliance training, either on-line or face-to-face.

A process to report possible Compliance-related complaints and concerns through one of the following channels:

Lotus Notes Compliance Database (described in more detail below)

Call to the HMS Compliance Hotline (described in more detail below; this approach protects the anonymity of the complainant)

The investigation and correction of identified systemic problems

Policies addressing the non-employment of sanctioned individuals, partners, and vendors

Regular re-evaluation of Compliance Program requirements and components to ensure the Program's continued effectiveness

Monthly Corporate Compliance Team meetings

Lotus Notes Compliance Database

HMS has established a database to document and track any Compliance issues that arise. The HMS Quality and Compliance Officer and Corporate Compliance Officer will ensure that HMS resolves incidents and will implement protocols to prevent the recurrence of such issues.

Compliance Hotline

HMS recently reassessed our Compliance Program. We decided to change our Compliance Hotline from an internal to an external (outsourced) function. We made this change to encourage our employees' cooperation with and participation in HMS's Compliance Program by fully assuring caller anonymity. We have outsourced the hotline function to National Hotline Services (NHS), which serves over 250 companies having an aggregate of more than one million employees.

In the past, when HMS staff members became aware of a potential compliance issue, their options were to speak with an HMS Compliance Program Representative or to enter a Compliance Incident into our Lotus Notes Compliance Database. However, the new Compliance Hotline gives staff members the option to report a potential compliance incident anonymously. When HMS staff members call the hotline, they:

First, hear a brief recorded message informing them of their right to anonymity

Next, speak with an NHS professional, who records information the HMS employee supplies and reports the call to HMS's Compliance Officer, Dick Lang

When HMS employees call the hotline:

They are not obligated to provide their name.

NHS does not record the call, nor does NHS make any attempt to determine the location of any call.

HMS feels strongly that an active Compliance Program protects the best interests of our company and clients.

C-2.1.e.ii.b Training

HMS will continue to place a high priority on ensuring that all Team employees:

- Understand and adhere to requirements of the contractual relationship with the State of Michigan
- Follow applicable state and federal laws without exception
- Understand the responsibilities of their position within Michigan's TPL and/or medical support enforcement projects
- Are knowledgeable regarding operations of the Michigan Medicaid and medical support enforcement programs

To obtain these results, HMS has designed multiple training programs that include both new employee (corporate) training and job/project-specific training. HMS's training efforts comprise:

- Knowledge training
- Skills training and practice
- Testing to ensure skills/knowledge mastery
- Performance feedback

HMS's training program is dynamic and flexible:

- It is comprehensive, covering the broad information base a new employee requires.
- It is modular for rapid update and re-training of employees in cases where new policies are introduced and when policies change.

Training Resources

HMS has a dedicated Training Director, Alexandra Holt, who has 20 years' experience in third party recovery policy, procedures, and operations. The Training Director is responsible for developing and delivering training, and also ensures continuous coordination with our Quality Assurance program.

HMS places a premium on maintaining a tight relationship between knowledge dissemination, program and technical training, and quality of work produced. Therefore, we have implemented a variety of internal resources and processes. These are supplemented with external training, as requested.

- **The Training PowerPak.** HMS has a distributed database, available to all employees electronically, which is a repository of training and reference materials. The database contains materials covering a broad range of topics—from general HMS orientation, to Medicaid programs and TPL processing, [state-specific processes and procedures](#), and advanced materials on specific projects. Users can search the database using multiple modes. Any employee can use the database as a reference source, or complete self-study “modules” on various subjects. The database has links to external Web sites, as well as other operational databases within HMS. HMS also uses this database to create training curricula at the individual and group level, by job or subject type. HMS’s Training Director maintains and enhances the database monthly.
- **Training At Ten.** Each month, the Training Director delivers a two-week group classroom training, covering introductory and technical material. While the program is designed for the needs of new employees, any employee may attend. The curriculum is tailored each month for attending groups and their learning needs.
- **Technical Training.** Each month, subject matter experts deliver in-house technical training courses on HMS’s proprietary technical methodologies and processing protocols to HMS technical staff. There are also courses covering the structure and data components of client source files. In addition, courses in new technical tools are offered throughout the year.
- **Quality Review—Lessons Learned.** As the Training Director also serves as a Quality Review assessor, a monthly Lessons Learned session is held with internal staff groups. During these sessions, participants review any quality issues that may have arisen, receive additional training (if required), and review standard operating protocols.
- **Research Services.** The Training Director also provides a research and reference service for HMS—supplying information to all operating groups on specific topics, as requested. For example, this past year a state regulatory database was created to facilitate HMS staff access to federal and state-specific statutes and regulations regarding eligibility data matches and prompt claims payment.

New/Existing Employee Training

HMS provides training for all new employees. This training ensures that new employees understand basic concepts, terms, and processes that HMS uses. The program, which provides a structured foundation of knowledge, helps new employees:

- ◆ Acquire a conceptual understanding of technical processes (e.g., TPL, medical support) and their business unit
- ◆ Understand day-to-day tasks and responsibilities
- ◆ Master HMS’s technical infrastructure and environment
- ◆ Gain a fundamental understanding of revenue recovery product lines and marketplace imperatives
- Serve clients effectively

Employees routinely receive training upon hire, promotion, or transfer. HMS supervisors use the training curriculum to customize training schedules for each employee—based on the employee’s job requirements, background, and experience. All training programs provide a broad overview of HMS and include meetings with key staff from each department involved in revenue recovery operations. Furthermore, HMS assigns a “mentor” to each new employee. Mentors are experienced employees who work with staff through the first six months in a new position.

Training Specific to the MDCH/MFIA Projects

After introductory training is complete, employees will receive MDCH- and MFIA-specific training through a variety of modalities, including:

- Industry meetings, seminars, and conferences
- In-house training sessions on various topics relevant to MDCH and MFIA project operations, led by HMS’s resident experts
- Self-study using print, video, and electronic media
- Operations skills reviews
- Performance/quality feedback

HMS will continue to update our training curriculum continuously to meet changing needs. Anyone in any job may receive training in any subject they wish. Our training modules incorporate key concepts and information related to revenue recovery projects. Employee performance evaluations (at three months for new employees and annually for all other employees) assess attainment of objectives and mastery of revenue recovery principles. Objectives for the following year, including training and knowledge development, are included in each performance evaluation.

HMS develops additional training modules on an ongoing basis and will arrange for external training resources, as needed, to enhance our curriculum.

HIAA Training

HMS employees also participate in continuing education courses through the Health Insurance Association of America's Insurance Education Program. (All HMS Project Managers must earn at least one professional designation through HIAA.)

Participating employees take a combination of required and elective courses and complete rigorous examinations to earn the professional designation of their choice—each of which focuses on a key aspect of health insurance. Designations include:

- ◆ Health Insurance Associate (HIA®)
- ◆ Managed Healthcare Professional (MHP®)
- ◆ Healthcare Anti-Fraud Associate
- ◆ Long-Term Care Professional
- HIPAA Associate

Training Materials

Sample training materials are presented under **Attachment 4** of this Proposal.

C-2.1.e.ii.c Accounting Protocols

HMS already maintains and will continue to maintain our accounting practices according to generally accepted accounting principles (GAAP). HMS's practice is to maintain separate accounting and financial records for individual clients/contracts. Therefore, records related to Michigan's TPL and medical support projects will remain separate and independent from other HMS accounting records.

Furthermore, as a publicly traded corporation, HMS is subject to Securities and Exchange Commission (SEC) reporting requirements, which—by definition—are more stringent than reporting requirements for privately held companies. This is a significant issue when comparing vendors in a competitive procurement. HMS, due to its public company status, complies with full disclosure requirements that private companies may not. HMS's financial reports are directly accessible from our Internet home page (www.hmsy.com). These records are audited by KPMG, one of the world's largest accounting and audit firms.

C-2.1.e.iii Project Reports

C-2.e.iii.a Project #1: Medicaid Third Party Liability Recovery

HMS affirms that we will provide reports to the MDCH contract manager according to the RFP requirements (see **Exhibit C2-26**). We will provide these reports in the context of HMS's written monthly project report. (A sample appears under Proposal **Attachment 2**.)

Exhibit C2-26: Required Reports for Medicaid Third Party Liability Recovery

Report	Purpose/Description
Report by Carrier and Billing Cycle (Date)	Total claims and dollars billed Total claims and dollars paid (also cumulative amounts) Unduplicated number of recipients paid for (also cumulative amounts) Total claims and dollars denied (by the top five reasons for denial) Total claims and dollars pending
Report by Major Claim Type and Billing Cycle (Date)	Total claims and dollars billed Total claims and dollars paid (also cumulative amounts) Total claims and dollars denied (by the top five reasons for denial) Total claims and dollars pending

C-2.e.iii.b Project #2: Locate Commercial Health Insurance and Medical Support Enforcement

HMS/MAXIMUS affirms that we will provide reports to the OCS contract manager according to the RFP requirements (see **Exhibit C2-27**). We will provide these reports in the context of our written monthly project report. (A sample appears under Proposal **Attachment 2**.)

For Reports 2 and 3 below MAXIMUS will use MAXSTAR, which will generate the reports necessary to meet the contract requirements, and in addition, will produce specialized reports to meet internal metric goals and to review special initiatives. HMS will generate the reports in conjunction with information supplied by MAXIMUS through MAXSTAR.

HMS/MAXIMUS will work with OCS to ensure all the reports are available both electronically and in hard copy in an easy-to-read format.

Exhibit C2-27: Required Reports for Locate Commercial Health Insurance/Medical Support Enforcement

Report	Purpose/Description
Insurance Locate Report	<p>Summary of the Insurance Inquiry File records received from OCS</p> <p>The number of those records that were attempted to be matched at each insurer, sorted by insurer</p> <p>The number of records returned matched and unmatched</p> <p>A reconciliation of the Insurance Inquiry File records to those records included in the insurance response file</p>
Insurance Enrollment Report	<p>Summary of the insurance enrollment request file records received from OCS identified by date</p> <p>Summary of the balance of unprocessed NMSN at the beginning of the month, the number of NMSN received from employers and benefit administrators in the current month, and the balance unprocessed at the end of the month</p> <p>Summary of the insurance enrollment response records sent to the OCS including whether insurance was enrolled or not</p> <p>A reconciliation of the insurance enrollment request file records to those records included in the insurance enrollment response file</p>
Process Backlogged NMSN Report	<p>Summary of the NMSN received from OCS, identified by source and date</p> <p>Summary of the number of NMSN not yet processed at the beginning of the month (identified by date received from OCS), NMSN processed during the month (identified by date received from OCS), and those not yet processed (identified by date received)</p>

C-2.e.iii.c HMS Client e-Center

HMS has developed a Client e-Center that gives our clients the ability to better monitor our program activity. Through the Internet, clients will access—via secure log-on—a Web-based application that allows them to view both summary and detail information about every claim that HMS has billed. HMS clients report that the e-Center is easy to use and that it saves time with the ability to focus queries on the exact information needed.

Through the e-Center, clients are able to monitor, track, and analyze accounts receivables, payments, and denials (and HMS's posting of such).

Applications available through the e-Center include:

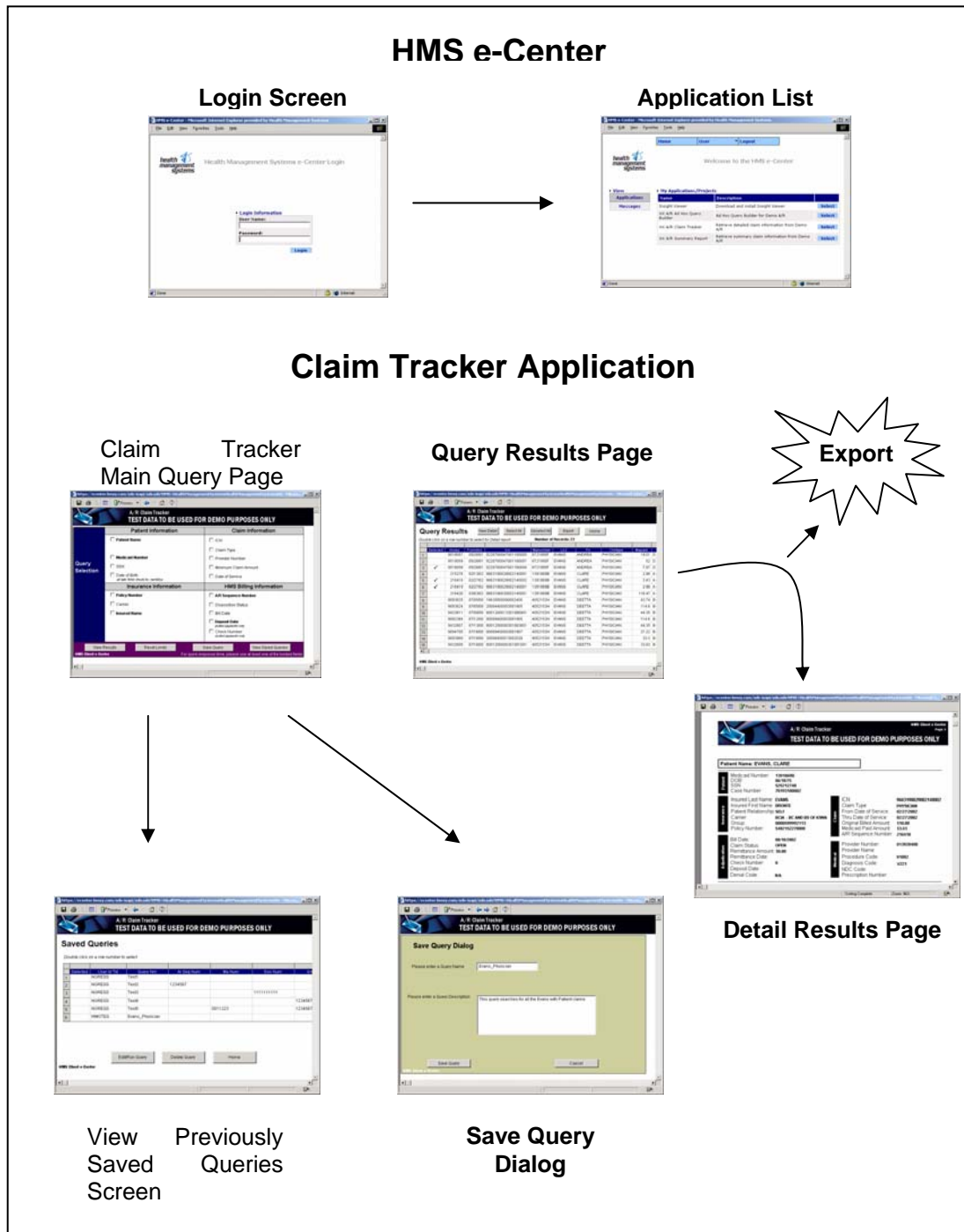
- **A/R Claim Tracker.** Allows clients to search individual HMS claims by Medicaid recipient and by carrier
- **A/R Summary Reports.** Summarizes the information in HMS's A/R aggregate database
- **Ad Hoc Query Builder.** Allows the creation of user-defined queries and reports against the A/R database

- **D/C Claim Tracker.** Allows clients to review recoupment projects

In addition, summary reports from ECARE, HMS's on-line eligibility verification system—are also available to clients and HMS management through the e-Center. These reports provide quick, analytic views on verification work in progress and also provide a summary-level audit trail. This function will be particularly useful to MFIA/OCS staff, who may wish to monitor HMS's progress on the commercial health insurance locate task.

Exhibit C2-28: Claim Tracker Overview provides an overview and screen shots of the e-Center's A/R Claim Tracker application. For a tour of our e-Center, please visit HMS's Web site (www.hmsy.com) and select "View an e-Center demo" from the global navigation bar at the bottom of the Homepage.

Exhibit C2-28: Claim Tracker Overview



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C-2.2 Technical Plan: Person-Hours and Project Schedule

Indicate the number of person-hours allocated each task and the estimated state resources necessary for each task. A MS Project schedule, time related, showing each event, task, and decision point in your work plan must also be provided.

Exhibit C2-29 presents the HMS Team's technical plan for accomplishing all aspects of the required work scope presented in RFP section II. This technical plan identifies tasks, the number of person-hours allocated each task, and the estimated state resources necessary for each task. The technical plan also meets the requirements for a time-related MS Project schedule and shows each event, task, and decision point associated with performing the required work scope.

HMS offers many in-place capabilities and interfaces that will ensure a smooth transition to the next contract term—including rapid implementation of the MSE project, minimal demands on state staff, and a secure and reliable revenue stream for MDCH's TPL project:

- **Uninterrupted operations of the MDCH TPL project**—HMS's established Medicaid TPL project in Michigan will enable us to meet the RFP requirements immediately.
- **No risk to the TPL revenue stream**—Our carrier network and eligibility database already include 15 of the state's top 20 carriers (approximately 90% of the insured population among these carriers), and our data mining capabilities ensure increased recoveries over the next 3-5 years.
- **No extraneous demands on state staff time**—We have established protocols, interfaces and relationships with MDCH staff and will rapidly establish similar relationships within MFIA.

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C-2.3 Capability to Perform Eligibility Matches

Demonstrate the ability to perform eligibility matches with the top twenty commercial health insurance carriers in the State of Michigan.

The following exhibits identify HMS's existing and in-process data exchange agreements with the top 20 health insurance carriers in Michigan:

- **Exhibit C2-2: Top 20 Carriers in Michigan for Medicaid TPL Data Matches (Excluding BCBSMI).** HMS's network includes 15 of the top 20 carriers in Michigan, including Aetna, Health Alliance Plan, CIGNA, and United Health Care. This network represents 75% of the top 20 carriers (and 88% of eligibility records among these carriers).
- **Exhibit C2-14: Top 20 Carriers in Michigan for Medical Support Enforcement Project (including BC/BS Michigan).** HMS's network includes 16 of the top 20 carriers in Michigan, including BC/BS Michigan, Aetna, Health Alliance Plan, CIGNA, and United Health Care. This network represents 80% of the top 20 carriers (and more than 90% of eligibility records among these carriers).

Detailed discussions about HMS's extensive carrier network appear in the following sections under this Tab:

- Section C-2.1.a.i: Eligibility Matching
- Section C-2.1.d.i: Insurance Locate Services

Provide a list of those active commercial health insurance carrier agreements for eligibility matches that your organization holds and a listing of the commercial health insurance carriers for eligibility matches that you are negotiating and the status of the negotiations including expected date of agreement execution.

HMS's proposal includes a list of carrier eligibility matches that HMS is presently negotiating, including the status of negotiations and anticipated date of agreement execution (**Exhibit C2-30**).

Exhibit C2-30: HMS Data Match Agreements Under Negotiation as of 4/26/04

Carrier	Status of Negotiations	Anticipated Date of Agreement ²²
M-Care, Inc.	Carrier's declination is under appeal	Unknown
Care Choices	In negotiation	5/31/04
SelectCare HMO	In negotiation	8/31/04
Physician Health Plan of Southern Michigan	In negotiation	8/31/04
OmniCare Health Plan	In negotiation	8/31/04

C-2.4 HIPAA-Compliant Medicare Claims

Provide evidence that your organization has achieved approval from Medicare to submit Health Insurance Portability and Accountability Act (HIPAA) compliant electronic claims.

HMS is currently billing ANSI 837 in production to **seven** Medicare Part B carriers: WPS (Michigan's Part B carrier), First Coast Services, Noridian, NHIC, Empire Medicare Services, Palmetto GBA, and HGSA.

CMS recently instructed its carriers and intermediaries to lengthen the payment cycle for providers submitting non-HIPAA compliant claims from 14 days to 28 days. The effective date of this new policy is July 1, 2004. The implementation date is July 6, 2004. HMS will be in a position to submit compliant claims for all of our contracts.

In Michigan, HMS submits electronic claims to WPS, the Medicare Part B Carrier. We encourage MDCH to contact Tammy Geary of WPS (telephone: 1.877.908.4067, extension 85157) and verify our approval to submit HIPAA-compliant electronic claims to this carrier.

Exhibit C2-31 and **Exhibit C2-32** are letters providing evidence that HMS has approval to submit HIPAA-compliant electronic claims to Medicare Part B carriers.

C-2.4.a Additional Information about HMS and HIPAA Compliance

HMS and MAXIMUS will ensure that all services we perform under this contract will continue to meet HIPAA standards. We will comply with all HIPAA regulations concerning the electronic transfer of covered transactions, privacy, and security.

HIPAA Requirements

²² Agreement dates are estimated—based on HMS's experience negotiating similar agreements with other network carriers—and are also contingent upon each carrier's willingness to participate in data matches. Michigan presently does not have a statute requiring carriers to participate in eligibility matches, and carriers are free to decline participation requests.

Enacted in August 1996, HIPAA amends Title XI of the Social Security Act by adding Part C, which addresses Administrative Simplification. HIPAA:

- Mandates the use of standards for electronic exchange of healthcare data
- Specifies the medical and administrative code sets that Covered Entities (CEs) must use within those standards
- Specifies the types of measures that CEs must use to protect the security and privacy of patient information
- Requires the use of national identification systems for healthcare patients, providers, plans, and employers

The following entities are subject to HIPAA if they receive or transmit any covered transactions:

- ◆ Healthcare providers
- ◆ Health plans
- Healthcare clearinghouses (HMS is in this category)

Exhibit C2-33: HIPAA Standards and Compliance Dates shows a current timetable for HIPAA implementation, in terms of final rule publication and associated compliance dates for CEs.

Exhibit C2-33: HIPAA Standards and Compliance Dates

Privacy Requirements

HIPAA privacy requirements pertain to Protected Health Information (PHI), which HIPAA defines as individually identifiable health information that CEs:

- Maintain in any medium that the HIPAA Transaction Set Final Rule describes as “electronic” (e.g., Internet, Extranet, any kind of transmission lines, magnetic tape, compact disk)
- Transmit or maintain in any other form or medium

In other words, PHI is virtually any kind of individually identifiable health information that a CE is likely to receive, maintain, or transmit. PHI data elements encompass a broad range of unique identifying numbers, characteristics, and codes—both in and outside of the public domain—such as:

- ◆ Name
- ◆ Address (including more than three Zip Code digits)
- ◆ Date of birth
- ◆ Phone number
- ◆ Social Security Number
- ◆ Medical record number
- ◆ Health plan policy number
- ◆ Names of relatives
- ◆ Names of employers
- ◆ Facsimile number
- ◆ E-mail addresses
- ◆ Certificate/license numbers

- ◆ Any vehicle or device serial number
- ◆ Web URL
- ◆ Internet Protocol (IP) address
- ◆ Finger or voice prints
- Photographic images

There are limited circumstances under which CEs may disclose PHI, specifically:

- ◆ If the individual receiving healthcare requests disclosure
- ◆ For healthcare treatment, payment, or operations (TPO)
- In connection with national policy activities (e.g., public health activities)

In summary, HIPAA establishes stringent requirements to guard against unwarranted disclosure of PHI.

Security Requirements

To ensure data privacy and security, HIPAA specifies administrative procedures, physical safeguards, technical security services and mechanisms, management controls, training, and mandatory documentation that each CE must have and/or provide.

HMS believes that our already-established data security practices provide a solid foundation that will facilitate our compliance with all final HIPAA standards. For example, HMS has taken the following steps:

- HMS meets all of the security standards of the Statement of Auditing Standards No. 70 Processing of Transactions by Service Organizations (SAS 70). HMS will apply the knowledge of security learned in meeting the SAS 70 requirements to ensure that HMS complies with HIPAA security requirements.
- HMS meets the requirements specified in the Department of Health and Human Services' OIG Compliance Guidelines for Third Party Medical Billing Companies. These guidelines require that affected companies perform biennial assessments to review their compliance with a broad range of areas pertinent to healthcare billing services, including: data processing system integrity, data confidentiality protocols, and proper billing protocols (e.g., provisions to prevent duplicate billings).

To ensure that HMS is in compliance with the final security rule, we will:

- Undertake a formal risk analysis of our present data processing safeguards and implement any corrective measures that will improve HMS's data security protocols
- Cultivate a heightened sensitivity to privacy among our employees and business partners
- Continue to monitor "boundaries"—or points of internal/external data transmission—that can compromise data security (e.g., fax transmissions) and adapt our practices, as needed, to ensure maximum security

MAXIMUS Security Protocols

MAXIMUS fully understands that a fundamental tenet of child support operations is the safeguarding and security of personal information collected about applicants for child support services as well as information about participants. The company is committed to maintaining a high-level of confidentiality for all information received or collected under this contract. MAXIMUS goes to great lengths to safeguard the personal information it possesses—for custodial parents, NCPs, and children.

MAXIMUS routinely conducts background checks on all new employees, as this is a valuable tool in determining the trustworthiness of potential MAXIMUS employees. Background checks include searching for restraining orders, violent crimes against persons, burglary, and theft.

MAXIMUS employees receive extensive training on the importance of maintaining the confidentiality of customer information. This confidentiality training focuses on the provisions of federal laws and regulations, including HIPAA and Title IV-D of the Social Security Act. Additionally, any Michigan data security and confidentiality requirements will be taught and made part of the MAXIMUS quality assurance review. The company's management team will have responsibility for ensuring data are safeguarded at all times.

A confidentiality agreement—which protects the information provided, captured, and recorded during the day-to-day operation of MAXIMUS projects—is read and signed by each project employee at the beginning of every child support project. This is part of the company's standard operating procedures. These agreements are executed as part of the new employee orientation and training. MAXIMUS will require project staff to read, understand, and sign the confidentiality agreements and statements.

MAXIMUS understands that personal information about its customers may only be released to the subject of the information and should be protected, pursuant to provisions of the applicable federal or state law. During the transition, MAXIMUS systems experts will ensure that safeguards are in-place to ensure data remain secure.

During and after business hours, MAXIMUS maintains secure areas for storing case files and other documents. An electronic security system protects the entrance to work areas, and the building is equipped with fire alarms, extinguishers, and a central sprinkler system for fire suppression. The employee entrance also is secured to prevent unauthorized entry.

MAXIMUS provides a secure file space within the office to house the physical case files for that office. This space is separate from any space used as storage and from the general office work areas. The file area is accessible only to the MAXIMUS staff performing tasks related to the contract.

Access to MiCSES cannot be abused, and MAXIMUS will make sure that regular file transfers and any other interfacing with MiCSES data are done securely and confidentially, free of third-party intrusion or interception. MAXIMUS will review its security plans with MFIA/OCS during the transition to ensure that MFIA/OCS has absolute confidence in the company's ability to keep data secure and confidential.

MAXIMUS has more than two decades of experience in providing child support services and therefore has a proven record of understanding and complying with federal IV-D requirements as well as MFIA/OCS policies and procedures as contained in manuals and written directives. From its long experience with child support, MAXIMUS understands that the IV-D program is dynamic, and MAXIMUS commits to full compliance with all applicable laws, regulations, and policies as they are enacted, amended, or changed during the contract.

Requirements Pertaining to National Provider Identifier

CMS announced the adoption of the National Provider Identifier (NPI) in late January 2004. HMS will adapt our protocols, as needed, to comply with the final rule by the required deadline.

HMS Will Continue to Ensure HIPAA Compliance

HMS is pursuing a number of initiatives to ensure that we are ready to receive and transmit HIPAA-compliant data according to the federal timetable:

- HMS has entered into discussions with legal counsel, clients, and directly with the Centers for Medicare and Medicaid Services (CMS). The purpose of these discussions is to clarify the interpretation and implementation of certain HIPAA regulations (e.g., identifiers, data confidentiality, covered entities, and release of data match information from and to third party insurers) with regard to Medicaid TPL.

Through Claredi we have independent verification that HMS has the capability of sending and receiving specific transactions in compliance with the HIPAA Implementation Guides. For the most current status of HMS's Claredi certification, please visit our Web site at www.hmsy.com and click on the Claredi Seal in the bottom left corner of our Homepage.

- HMS already receives and processes transactions that are American National Standards Institute (ANSI)-835 compliant for some Medicare B carriers, BC/BS plans, and for commercial insurers that we bill through WebMD.
- HMS has been certified in several HIPAA transactions through Claredi. We believe that obtaining certification on the standard 837 transactions facilitates testing and approval on the reclamation claim transaction once it is finalized by the ASC X12N committee and made law. In addition, we have determined that we can use the standard 837 medical format to submit TPL claims to Medicare Part B. Currently, we have obtained Claredi certification to submit the following transactions:
 - ◆ 270 Eligibility Inquiry
 - ◆ 276 Claim Status Request
 - ◆ 837 Institutional Claim (v4010 and v4010A)
 - 837 Professional Claim (v4010 and v4010A)
- Although HIPAA does not yet cover reclamation claim formats for billing commercial insurers, HMS believes that HIPAA requirements will apply to these claims. Hence, we are preparing for this anticipated requirement by participating in related industry workgroups and by monitoring the development of rules and processes related to Medicaid subrogation layouts:
 - Robert Dickerson, HMS's Director of Carrier Relations, participates in NCPDP's Governmental Workgroup. In this capacity, he is helping to develop the NCPDP Medicaid Subrogation v5.1 claims layout.²³
 - HMS has successfully tested NCPDP v5.1 with Medco Health. Soon Medco Health will move us into production. We are not only the first vendor to test this transaction with MedcoHealth, but we are also the first to obtain approval. With respect to remits, Medco Health has converted us to the ANSI 835 format which we use to post all payments and denials. In addition, we have begun testing NCPDP v5.1 with other PBMs like Argus, Express Scripts, and Prescription Solutions.
 - HMS is monitoring the development of the ASC X12N Health Care Coordination of Benefits Request and Response Implementation Guide, for which the first public comment period closed in early January 2003. Still in draft format, this guide outlines the processes for: (i) requesting verification of a primary payor payment by a secondary payor; and (ii) providing positive or negative verification of a primary payor payment to a secondary payor.
 -
- HMS is currently testing the ANSI 270/271 transaction with WebMD in order to submit eligibility status requests to Aetna US Healthcare. We will continue the same process for all of the other major carriers that participate with WebMD. We are also testing with TRICARE to obtain DEERS eligibility. We also plan to begin testing this transaction with Medunite to send requests to the carriers that participate with this vendor. Additionally, some insurance carriers have approached HMS and asked us to use the 270 transaction to obtain eligibility information, and we are testing directly with the carriers.

²³ This claims layout is the subrogation corollary to the NCPDP Telecommunication Standard Format, Version 5.1. HIPAA final standards for electronic healthcare transactions and code sets have adopted this format and the NCPDP Batch Standard Version 1 Release 1 for pharmacy claims. Health plans, health clearinghouses, and healthcare providers who use electronic transactions must use these standards beginning October 2003.

- HMS is currently working with United Healthcare (UHC) on using their B2B product. This product includes an ANSI 270/271 component that will allow HMS to send the ANSI 270 transaction directly to UHC as opposed to going through a clearinghouse such as WebMD. It will also allow for real time eligibility responses.
- HMS is a corporate member of the ASC X12 organization. Renee Gundersen, Manager of EDI Development, and several HMS project managers regularly attend ASC X12 quarterly meetings. HMS actively participates with X12N (insurance) Work Group 2 (healthcare).
- HMS attends CMS’s annual National HIPAA Summits. Through our participation in these meetings, we exchange information with key players in the industry. Because HMS independently invests in doing our own HIPAA research and ensuring that our knowledge is current, we are able to serve our clients effectively—without making unnecessary demands on their staff/knowledge resources.

In addition, HMS believes it is fully compliant with the HIPAA Privacy Rule, compliance with which was required by April 14, 2003. Some of the major steps HMS has taken to achieve compliance include:

- HMS has executed Business Associate Agreements (BAAs) with all clients and vendors for whom BAAs were required by April 14, 2003, and will execute additional BAAs with other clients and vendors by the required deadline (whenever the contract with the client or vendor is next modified or by April 14, 2004, whichever comes first).
- Although not required by HIPAA, HMS has implemented a policy to further safeguard PHI in all of our office locations. Any visitor that may have incidental access to confidential health information must sign a Confidentiality Agreement with HMS. For example, employees from cleaning companies, Xerox repair services, and coffee suppliers that support HMS must sign this agreement.
- HMS has developed a set of written Privacy Policies and Procedures and, through an Internet-based delivery vehicle, trained all employees in the Policies and Procedures and documented such training. All new employees must receive this training before they can work with Protected Health Information.
- HMS has reviewed the physical security of our offices and made security improvements where deemed appropriate.

C-2.5 Electronic Claiming Capabilities

Provide evidence that your organization submits electronic claims to commercial health insurance carriers.

HMS’s electronic claiming capabilities will ensure that we continue to prepare and submit Medicaid TPL claims to liable third parties, on behalf of MDCH, within federally mandated timeframes (Code of Federal Regulations, Title 42, Section 433.139). This regulation requires state Medicaid agencies to seek recovery of third party reimbursement within 60 days after the end of the month in which the agency learns of the third party coverage.

HMS submits claims through various electronic paths—including directly to carriers (through custom platforms/interfaces that HMS develops with these carriers), and through WebMD Transaction Services. [Per RFP requirements, HMS has provided proof of our electronic claiming capabilities in the form of the following letters:](#)

Section C-2.1.a.ii (Commercial Health Insurance Recovery) under this Tab provides detailed information about HMS's electronic claiming capabilities and protocols.

C-2.6 Ability to Interface with MDCH and MFIA Systems

Provide evidence that your organization has the capability to interface with the MDCH and MFIA computer systems.

Interface with MDCH MMIS System

HMS will continue to meet and exceed the interface needs and requirements of MDCH's MMIS. We will continue to maintain the interfaces required to update the state's TPL file, obtain information on potential third party liability, and obtain claims data to pursue pay-and-chase claims.

Since initiating third party recovery services for clients in 1984 and Michigan in 1994, HMS has worked with the Medicaid Management Information Systems of 30 Medicaid agencies—proving our ability to aggregate, purify, and enhance volumes of data from any source. We have developed effective and highly efficient interfaces with a variety of operating systems and hardware, ranging from Honeywell and DEC to over a half-dozen IBM configurations and processing platforms. Because of this experience, we can read and interpret virtually all data structures, data dictionaries, and related systems documentation and processing protocols that Medicaid and other healthcare payors currently use.

Hence, HMS has demonstrated the ability to work effectively with the data file structures and layouts needed to continue performing accurate and timely Medicaid TPL services for MDCH. MDCH will not need to allocate staff resources to reformat or reprogram data files for HMS.

HMS has also developed an effective relationship with Don Vanden Heuvel, our MDCH data file contact. Our operations team works in collaboration with Mr. Vanden Heuvel to immediately resolve data issues as they arise.

HMS Has Superior Data Processing Expertise

HMS excels in performing three basic data processing tasks that are key aspects of all revenue collection projects:

HMS can accept MMIS files without any reformatting or reprogramming and use them to perform successful revenue collection projects. We work with a broad range of files, including:

- ◆ Eligibility Files
- ◆ Paid Claims Files
- ◆ TPL Coverage File and Other COB Data Files
- ◆ Provider Files
- ◆ Carrier Files

HMS can transmit TPL cost avoidance data via tape, batch CPU-to-CPU transmission (NDM), or FTP directly to the MMIS system. At the request of MDCH, HMS will also provide hard copy listings of these updates.

HMS can transmit updated TPL paid claims data via tape, batch CPU-to-CPU transmission (NDM), or FTP directly to the MMIS system.

Furthermore, HMS owns and operates a sophisticated data processing center in our New York City offices, where we perform all data extraction and reformatting. HMS's processing hardware and operating system is compatible with most state MMIS as well as systems of other healthcare payors. Specifically, the HMS system:

- ◆ Reads or receives EBCDIC tapes in either 9-track 1600 or 6250 bpi or 18-track cartridges (via compressed IDRC or non-compressed)
- ◆ Reads or receives ASCII data on any media
- ◆ Operates hardware using MVS operating system software
- ◆ Has bulk file transfer capability
- Can produce output cartridges that are 100% compatible with a client's configuration and software

In short, we have developed complete functional compatibility to receive and process revenue recovery-related files from healthcare payors and to generate tape and/or hard copy listings for MMIS file updates.

As we are data processing experts with direct knowledge of the Michigan Medicaid and TPL environment, our services will continue to deliver value for the state while, at the same time, placing minimal burden on MDCH and its MMIS operations.

Interface with MFIA's MiCSES System

The HMS Team also brings experience with the MiCSES system. Our proposed subcontractor, MAXIMUS, is well-acquainted with MiCSES, having served as a subcontractor during its development and as a user on the SDU QA project. Also MAXIMUS sends files routinely to the state on Oracle-based systems similar to MiCSES.

For insurance locate functions, HMS will provide an electronic Insurance Response File, formatted according to OCS requirements—including the RFP-specified eight record types, ordered by subscriber. HMS has experience providing verified third party coverage data in state-system-compatible formats for child support enforcement agencies in Ohio, Connecticut, Colorado, and Maryland.

For insurance enrollment functions (including the NMSN backlog task), the MAXIMUS MAXSTAR automated networked system—which has its own server on-site for internal work—will generate compatible files with MiCSES and offer seamless service without adding dozens more MiCSES terminals. During implementation, several MAXIMUS staff will assist new staff on MiCSES from a macro and micro perspective—to ensure that project staff members understand the system and its interface requirements. All electronic files daily transferred will be done through MAXSTAR using a T-1 line, in the state-specified, MiCSES-compatible format. We will generate the Insurance Enrollment Response File and send it to OCS via MiCSES using the 10 records OCS prescribes in the RFP and in a compatible file format.

C-2.7 Lansing-Area Office

Provide evidence that your organization has a Lansing office or the plans to establish a Lansing office.

As required, HMS will use a metropolitan Lansing area office to serve MDCH's/MFIA's projects effectively. We plan to establish this office at:

2651 North Coolidge
Suite 200
East Lansing, MI 48823

HMS's proposed MSE subcontractor—MAXIMUS—presently occupies this location, from which it provides call center services under the Michigan MICHild/Medicaid Enrollment project. This office contains advanced telephony, state-of-the-art computer systems, and floor space and other resources more than adequate to support the on-site staff who will serve the new TPL/MSE contract.

HMS's proposed East Lansing location will support selected Medicaid TPL functions, such as claims follow up and insurance verification. In addition, this office will house most of the functions associated with Project #2 (Locate Commercial Health Insurance and Medical Support Enforcement), such as insurance coverage verification, insurance enrollment, and NMSN backlog processing.

Our East Lansing location will provide:

- Close proximity to both MDCH and MFIA/OCS. Our East Lansing location is fewer than five miles—less than a 15-minute drive—from both the MDCH and MFIA offices, and our staff members will be available for meetings daily.
- Regular communications, including face-to-face meetings, with the entities this recovery project affects (e.g., the client agencies, healthcare providers, fiscal intermediaries, the Medicaid fiscal agent, and other TPL and child medical support enforcement stakeholders)
- A local base from which to operate the citizen-sensitive MSE program
- Ready access to all project-related materials and/or systems to facilitate any federal and/or state audits

HMS's Project Manager will be available to meet with MDCH/OCS and other project stakeholders with only minimal notice. In brief, HMS's local presence will ensure that we perform this project effectively and to the state's benefit.

HMS's East Lansing office will have full access to the resources and expertise of HMS offices and staff nationwide.

C-2.8 HMS Data Processing Resources

HMS believes that our data processing resources have no equal in the third party coverage identification and verification arena. We offer our clients a data processing environment that:

- **Is fully (100%) dedicated** to supporting HMS revenue recovery projects

- Consistently meets our 99.99996% availability goal
- Effectively connects and supports HMS’s nationwide network of clients, employees, and data processing centers

Data Processing Resources Dedicated to HMS Projects

HMS directly manages the full array of computer processing platforms and systems resources that we use to perform our revenue recovery services. As such, we can ensure timely responsiveness to MDCH’s/MFIA’s project requirements. HMS’s data processing protocols differ from those of other vendors, who use subcontract-source data processing. Having direct control over our data processing systems, HMS can allocate adequate data processing resources to meet individual project needs and comply with the most stringent project and data security requirements.

HMS’s data processing resources reside at our headquarters. [These resources presently process over 170 million client and insurance eligibility records each quarter.](#) The number of records that we process varies by client—according to the size of each state agency program—and has reached up to 28 million records per month for our largest client, the State of California.

Exhibit C2-38 summarizes HMS’s state-of-the-art data processing capabilities. HMS runs traditional IBM mainframe processing, UNIX, and NT on multiple platforms. In addition, we use Web-enabled applications and other tools to support data integration. These tools include:

- ◆ The Rational product suite (systems development and project management)
- ◆ Informatica (extraction, transformation, and loading)
- ◆ BEA/WebLogic (system software)
- ◆ SAS (decision support/query and analysis)
- DB2/UDB and SQL Server (database technology)
- BRIO (report writing)

Dedicated Experience with Medicaid Data Processing Systems

HMS has developed customized interfaces for states that don’t rely on intermediaries and instead operate their own MMIS systems, including Michigan, Ohio, Maryland, and Pennsylvania. In addition, we have experience exchanging data through system interfaces with the MMIS systems of all major fiscal intermediaries, including Palmetto GBA, EDS, ACS, First Health, and Unisys. This experience translates to rapid implementation—including early return of coverage verifications and recoveries.

Demonstrated Ability to Consistently Meet Service Level Commitments

To ensure that HMS can meet all service requirements, we have recruited a technical staff with unparalleled knowledge of large-scale data processing systems, data integration, and database construction. [HMS has consistently met service level commitments \(>99.9% availability of services and/or resources\).](#)

Fully Networked Data Processing Environment

As a nationwide company, HMS has processing centers, remote employees, and clients located throughout the U.S.A. We use several approaches to link this HMS community:

- Virtual Private Network (VPN) technology facilitates connections between HMS and its remote employees/sites and clients.
- A Local Area Network/Wide Area Network (LAN/WAN) connection directly supports over 200 users at HMS's New York City corporate headquarters.
- A Frame Relay WAN connects our main office with over 250 additional users at HMS field offices nationwide.

Processing Environment

HMS maintains and operates a state-of-the-art-processing center that operates within the IBM OS/390 environment. We run traditional mainframe processing, UNIX, and NT on multiple platforms to meet the large-scale data processing requirements of public sector revenue enhancement projects.

HMS has online storage greater than 10 TB to accommodate the many technological enhancements that we are implementing (see our "Expanding Base of Information Technology Resources" Section of our Proposal). This storage expansion has enabled HMS to move data from tape to online storage, thereby streamlining production by improving HMS staff access to the data.

In addition, our data center supports compressed or non-compressed File Transfer Protocol (FTP) transmissions, Internet applications accessing database information, and mail services. Through our processing technology, we can also accept and provide data files in virtually any format—magnetic tape, cartridge, diskette, CPU-to-CPU transmission, or hard copy.

Exhibit C2-38: Summary of HMS's Data Processing Capabilities

Facilities

Large Data Center ((HMS New York):
24/7 processing
24/7 security personnel

Processing Environment

IBM 9672 Model R24
EMC²DASD online storage (10 terabytes)
SUN 420/220 servers
SUN online storage (2 terabytes)
Compaq/IBM servers

Magnetic Tape Storage

Standard 9 track, 1600/6250 BPI tape drives
18 track, 38,000 BPI cartridge drives
36 track, HDS 2.4GB cartridge drives
256 track IBM 3590 20/40GB cartridge drives

Printing

High speed 2000 LPM line printers
IBM 4245 high speed line printers
Xerox 4635 laser printer system
Xerox 4090 laser printer system

Telecommunications

IBM 3745 front end communication controllers
SNA and TCP/IP networks
Access via:
VPN
Frame Relay WAN
Dial-up communications

Teleprocessing Control/Monitor

NCP
GENTRAN
NETVIEW
TSO
FTP
Network Data Mover (NDM)

System Software

SUN Solaris
BEA/WebLogic
OS/390
ACF/VTAM
VSAM Optimizers
TCP/IP
OPC/ESA
DF/SORT
Changeman
Panvalet
CICS Transaction Server
Security Server
VIEW-DELIVER
DITTO
ZELA
FASTGENR
NT, WIN/2000
Novell Netware
Novell SAA Gateway

Programming Languages

SUN ONE
JAVA
DYL260/280
SAS
PC-SAS
COBOL LE
C/C++
Visual Basic
MS/Access

Decision Support Systems

SAS/FSP, SAS/SHARE, SAS/AF,
SAS/DB2
SAS/FSP
SAS/ETS
SAS/GRAPH
Clear Access

Networking

Token Ring
FDDI
GB Ethernet

Performance Analysis/System Measurement

InTUNE
DB2PM
HP OpenView
Veritas
Quest Central

Communications

Extra!
WS FTP Pro

System Utilities

McAfee Anti Virus
ArcServe
Norton Utilities

Database Technology

DB2/UDB
SQLServer

Debugging Aids

File-Aid
Xpediter

Analysis/Reporting Tools

Brio

Extraction, Transformation, and Loading (ETL)

Informatica

Desktop Configuration

Compaq/IBM workstations
LAN/printer connections
Lotus Notes
MS Office Suite
MS Project Manager

Desktop Technology

HMS's microcomputer environment consists primarily of Compaq and IBM PCs having an average of 256 megabytes of RAM. Our standard desktop operating system is Windows 2000, and each desktop is linked via LAN to other HMS desktops and to one or more printers. The LAN also provides a communication gateway to HMS's processing systems. For network and/or client-server application services, we use Windows 2003, Windows 2000, Windows NT, and Solaris systems, which are similarly interconnected.

Staff use a variety of productivity software, including Microsoft Office (i.e., Word, Excel, PowerPoint, Access), project management software (e.g., Microsoft Project), decision support system tools (e.g., SAS), and telecommunication packages (e.g., Extra!, WS FTP Pro).

HMS has sufficient computer capacity to support virtually unlimited data processing demand and remote communication needs. In addition, the HMS system architecture can accommodate virtually any input and output requirements.

To ensure access of client information is secure and protected, our remote staff members may only access the HMS processing environment using HMS's VPN.

Telecommunications Connectivity

HMS offers the following telecommunications connectivity capabilities:

- HMS supports FTP transmissions through the Internet. HMS can connect to a state FTP server, or the state can connect to one of several HMS FTP servers.
- HMS supports transmissions through value-added networks, such as AT&T Global Network Services (formerly Advantis, using Sterling Commerce's Connect Direct file transfer software).
- HMS can support FTP or Connect Direct transmissions across dedicated communication circuits between HMS and the state, with speeds typically between 56 kbps and full T1 throughput.
- HMS can support transmissions using Network Data Mover (NDM).
- For smaller files, HMS can support dial-up transmissions via PC using popular PC transmission protocols, such as ZMODEM or XMODEM. To process compressed files, we use PKWare's PKZIP product.

Expanding Base of Information Technology Resources

HMS invested more than \$5.5 million in information technology development during 2002, including \$3.5 million in new systems development for insurance identification and an additional \$2.0 million for enhanced technologies for product development (e.g., data warehousing and enhanced automated processing). This financial outlay demonstrates HMS's commitment to ongoing reinvestment in the science of TPL and revenue enhancement. HMS will apply other new technologies under the new Michigan TPL/MSE contract as we develop and implement them.

Recent technological enhancements include:

- **Implemented Informatica software products.** These products facilitate building and management of enterprise data warehouses and data marts. HMS uses these tools to augment existing decision support and data mining capabilities and to incorporate source data into our production environment more efficiently to reduce the development cycle for new clients.

- **Providing enhanced system access for remote users.** HMS offsite employees are now able to gain access to our corporate data system over the Internet, using HMS's VPN
- **Deploying and using application servers** (e.g., BEA/WebLogic) to provide Web-based applications
- **Expanding our use of data warehousing and data marts and using tools** such as Brio to provide Web-enabled access to data, including drill-down capabilities and "what if" scenarios
- **Implemented HMS e-Center.** HMS has developed a Client e-Center that gives our clients the ability to better monitor our TPL program activity. Through the Internet, client staff access—via secure log-on—a Web-based application that allows them to view both summary and detail information about every claim billed by HMS. HMS clients report that the e-Center is easy to use and that it saves time with the ability to focus queries on the exact information needed.

HMS Has Data Warehousing Capabilities

MDCH/MFIA will benefit from HMS's unique capability to capture, warehouse, and analyze extremely large volumes of healthcare data from the Michigan's Medicaid and child/medical support source data files.

The value of this data warehouse will prove very significant over time:

- Because our data warehouse will store **all** data, HMS will not burden MDCH/MFIA with iterations of data requests as new project requirements emerge.
- The full data set offers far greater insight to HMS than that available from the reporting features of individual payor adjudication systems.
- MDCH/MFIA can leverage this data warehouse for other types of projects to optimize reimbursement and maximize efficiency.
- HMS's processing environment has the advanced capabilities required to handle statewide projects of great magnitude because of the following features:
 - IBM9672 Model R24
 - EMC²DASD online storage (10 terabytes)
 - SUN 420/220 servers
 - SUN online storage (2 terabytes)
 - Compaq/IBM servers

HMS welcomes the opportunity to apply our 29+ years of expertise, knowledge, and state-of-the-art technology to create a valuable data warehouse to provide MDCH/MFIA with the proposed revenue recovery services, as well as additional projects resulting from our data analysis efforts.

Data Security and Confidentiality

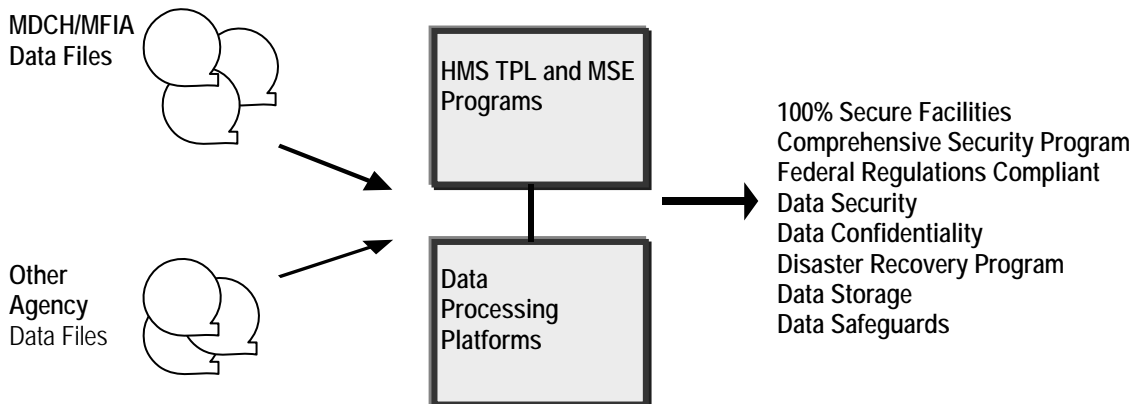
As an industry leader in the healthcare information services field, HMS recognizes our clients' need for the highest level of data/system integrity and security. We offer full protection against physical damage and prevent unauthorized access to data and systems through use of a multi-level security system.

HMS's policy is to meet or exceed all applicable state and federal statutes concerning data security and confidentiality, including any client-specific requirements pertaining to data security, in general, and patient/clinical data, in particular. Where necessary, we modify our approach to satisfy the particular needs of each client. HMS will ensure that our subcontractors meet the same stringent requirements.

Furthermore, HMS is actively working to ensure that our contract work complies with Health Insurance Portability and Accountability Act of 1996 (HIPAA) standards concerning transfer of data, billing submission and remittance formats (i.e., health identifiers), data confidentiality, and other requirements. HMS systems are compliant with the terms of the HIPAA Privacy Act as of April 14, 2003. We completed an Impact Analysis to ensure full compliance with the Act, which analyzed Physical Security, Data Center Security, Restricted Access to Public Health Information, and Infrastructure Security.

Exhibit C2-39 provides an overview of HMS's data security and confidentiality processes.

Exhibit C2-39 — Summary of HMS's Data Security and Confidentiality Protocols



Data Security

HMS's comprehensive data security program includes data management and storage procedures that will safeguard all information in whatever format we receive it (i.e., transmission, tape, cartridge, CD, or hard copy). When HMS receives client data, we identify, log, and route it to the access-controlled library appropriate for the data's storage medium. HMS staff will access these data only for processing activities under the client's contract. Project staff access the related data files using an internal multi-level password-protected data interface.

Online System Security Controls

HMS manages appropriate access to project-specific, online data through a series of security controls and multi-level passwords. For example, security controls for a current client include the following:

- A pyramid of security clearances based on employee function, which allows each employee to use data that are appropriate and necessary to his/her work only
- Secure identification codes for each user; these codes change every six months

Procedures for Data Management and Backup

HMS has detailed data management procedures. These protocols address both data files and tapes that clients entrust to us and files that we create while manipulating client data to perform revenue recovery tasks.

Data Storage and Management

When HMS receives a client data file/tape (or creates a file), we identify the data and associated client and determine:

- ◆ How HMS will use the data
- ◆ Which HMS employees will have access rights to the data
- ◆ The identity of HMS employees who need to know if there are problems with the data
- When and how to return client data

HMS uses a Lotus Notes database to track all data and associated details (as identified above). This management system enables HMS to handle large volumes of data securely—with constant control of all input and output.

When we first receive client data (whether tape or electronic files), these data are external to HMS's secure processing environment. To ensure security, HMS copies the data into our library, where we can manage, control, and audit the data.

Data Backup

HMS backs up our mainframe environment (including all production DBL databases) through:

- ◆ Incremental backups (daily), which include any changes to our system and control files
- Full system backups (weekly), which include programs, operating systems, and control files

For any systems that run in a database, HMS:

- ◆ Logs all transactions
- ◆ Performs incremental backups daily
- Performs full system backups weekly

With respect to system data, HMS retains a copy of all processing outputs (e.g., billing files) for an average of three to five years, depending on individual client requirements for maintaining data.

Data Confidentiality

HMS vigorously guards the confidentiality of data we obtain and process when performing our services. As an established service provider for many public sector clients, we assure MDCH/MFIA of our ability to maintain the security and confidentiality of all project-related data, files, and records in accordance with federal, state, and agency requirements, including:

- *Federal Regulation Code 42, Chapter IV, Subpart F*, regarding the confidential nature of all information concerning Medicaid clients
- *Computer Security Act of 1987*, providing for a Federal Computer Standards Program, government-wide computer security, and training in computer security
- Privacy Act of 1974, Public Law 93-579 (4 U.S.C. 552a), regarding the design, development, and operation of a system of records on individuals to accomplish an agency function
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

To meet the demanding standards and considerable sensitivities of federal, state, and local entities, HMS has developed the most sophisticated measures to guarantee confidentiality. We protect the confidentiality of all personal, financial, clinical, and employment information pertaining to our clients and our clients' clients (their recipients).

Disaster Recovery Procedures

If a disaster renders our New York headquarters inoperable, HMS can fully reproduce our data processing environment at an off-site facility. SunGard Disaster Recovery Services—the nation's leading third party disaster recovery system vendor—manages this facility, which features over 200,000 square feet of state-of-the-art mainframe, microcomputer, and telecommunication resources.

HMS also has a business arrangement with an off-site records management company. We maintain copies of our data files at an off-site location that uses state-of-the-art approaches to inventory, secure, and control all types of data, including paper and magnetic media. Each morning, the records management company picks up backup tapes from HMS New York and transports these tapes to long-term storage in an off-site data vault.

If a disaster occurs, HMS would retrieve data files and systems backups from the off-site storage location and transport them to the SunGard facility in Philadelphia. At SunGard/Philadelphia HMS software systems would operate using hardware that fully replicates our own mainframe data processing environment. Additionally, another SunGard facility in Jersey City, New Jersey would provide LAN hardware and serve as a site that HMS personnel could occupy. A telecommunications network would link the Jersey City and Philadelphia facilities.

APPENDIX B

CONTRACTOR'S PRICING

See Section

II-E PRICE