April 4, 2003

Mr. Lee Wallace, Issuing Officer
Vermont Purchasing and Contract Administration Division
128 State Street, Drawer 33
Montpelier, Vermont 05633-7501

Dear Mr. Wallace:

EDS is pleased to submit our proposal to the Vermont Department of PATH in response to the Request for Proposal (RFP) for MMIS Core Claims Processing Takeover.

Our submission includes one original, three paper copies, and six CD-ROM copies of our proposal response. Each proposal set includes two binders for Volume 1, Narrative Proposal, and one binder for Volume 2, Price Proposal. As requested in the RFP, we have packaged the Narrative Proposal separately from the Price Proposal and marked each box appropriately. Our submission also includes six electronic copies on CD-ROM of Volume 1, Narrative Proposal, and six copies of a separate CD-ROM with Volume 2, Price Proposal. Each CD-ROM sleeve is marked accordingly.

We welcome the opportunity to build upon our solid history of outstanding service to meet Vermont's business need and achieve your future vision. As the state's fiscal agent and MMIS provider for more than 21 years, we are fully aware of the many facets of Vermont's program and remain confident that we are well positioned to achieve the state's vision.

We believe EDS is the best choice for a partner to help achieve Vermont's objectives:

- Maintain an MMIS that meets the current needs—A ground-up development effort between Vermont and EDS has created a revolutionary MMIS—one that serves as the parent for nine other states. Leveraging this mutual investment provides the opportunity for us to build upon this foundation of success and create an environment that achieves your vision to "connect consumers to programs."
- Provide claims processing, financial management and provider services—Our experience ensures there will be no disruption of service to the citizens of Vermont, a continued compliance with program policies, and no delay in moving forward with future improvements.

- Institute business process and technical innovations—We have demonstrated a history of innovation in Vermont, including the first fully client/server Medicaid system in the nation. During certification, a member of the HCFA Certification Team said, "The technology being employed here is the way of the future. The flexibility you all have with this system is what will be necessary to meet the challenges in the years to come." We look forward to continuing this innovative partnership.
- Propose cost-containment ideas—As a long-term partner in Vermont and 16 other states, we are excited about the opportunity presented by this procurement to propose additional cost-containment ideas to increase the state's control over fiscal agent and program expenditures.

We are committed to improving our services to the citizens of Vermont and will leverage advancements in technology to catapult Vermont toward your vision of a "digital state." We look forward to continuing this focus by working with the Department to support the new proposed national MMIS business model defined by the MMIS Definition Workgroup.

Following this Transmittal Letter, we include certification by Fred Geldon, EDS' Assistant Secretary. This certification confirms that the signatory of this letter, Kevin J. Durkin, has the authority to obligate the company.

We confirm that:

a. EDS does not discriminate in its employment practices with regard to race color, religion, age (except as provided by law), gender, marital status, sexual orientation, political affiliation, national origin, or disability.
b. No cost pr pricing information has been included in the Transmittal Letter or the Narrative Proposal.
c. EDS certifies that the bid price was arrived at without any conflict of interest, and that it is firm and binding for six calendar months from the April 4, 2003, proposal due date.
d. EDS has received and reviewed the following amendments: (1) Response to Bidder Questions, dated March 7, 2003, and (2) Amendment 1.
e. EDS agrees to adhere to all requirements set forth in this RFP with the understanding that the state will consider proposed modifications as indicated in the response to Bidder Question 23.
f. Subject to the state's response to Bidder Question 23, allowing the successful bidder the ability to discuss changes and modifications, EDS has read, understands, and unconditionally accepts all requirements, responsibilities, and terms and conditions in this RFP.
g. EDS agrees that payments to us will be reduced by the amount of any lost or reduced federal financial participation (FFP), resulting from our deviation from specifications and requirements.

For the Operational Phase of the MMIS Core Claims Processing Takeover project, EDS proposes Health Management Systems (HMS) as a subcontractor. As the leader in third-

party recoveries, HMS will work to increase the state's revenue by providing TPL data matching services. Our partnership with HMS allows the state the opportunity to expand the depth of the optional TPL enhancements. HMS is a feature of EDS' approach to Optional Enhancement 2.8.3.3, TPL Responsibility Reorganization and Subsystem Upgrade.

For questions or further discussion regarding the content of our proposal, please contact Mary Simpson, the EDS client sales executive for the Vermont MMIS project. Mary can be reached at (317) 488-5110 or mary.e.simpson@eds.com.

Please accept my sincere thanks for the opportunity to participate in this procurement. We look forward to another opportunity to serve as the Medicaid fiscal agent and working with PATH and the state of Vermont in the years to come.

Sincerely,

Kevin J. Durkin
Senior Vice President,
U.S. Government Solutions, Sales and Marketing

13600 EDS Drive
Herndon, Virginia 20171

EDS

April 4, 2003

Mr. Lee Wallace, Issuing Officer
Vermont Purchasing and Contract Administration Division
128 State Street, Drawer 33
Montpelier, Vermont 05633-7501

Subject: Request for Proposal; Vermont Core MMIS Proposal 2003

Dear Mr. Wallace:

By signing the page below, I confirm that Kevin J. Durkin, Senior Vice President US Government Solutions, Sales and Marketing, has the authority to obligate and bind the corporation to the proposal's terms, conditions and provisions.

Certifying Official: Fred Geldon

Signature

Fred Geldon, Assistant Secretary

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C. Bidder Information Sheet

RFP Reference: 3.2.2.3, p. 3-6

a. Name of Company	Electronic Data Systems Corporation
b. Mailing Address	13600 EDS Drive, MS A6N-B29 Herndon, Virginia 20171
c. Street Address	13600 EDS Drive, MS A6N-B29 Herndon, Virginia 20171
d. Company Federal ID Number	75-2548221
e. Vermont Department of Taxes Business Account/ID Number	03-6000-264
f. Identification of the Corporation	Electronic Data Systems Corporation
g. Contract Signer	Kevin J. Durkin Senior Vice President U.S. Government Solutions, Sales and Marketing (703) 742-1798 E-mail: kevin.durkin@eds.com
h. and i. Evaluation Period Contact	Barbara Davis EDS 312 Hurricane Lane Williston, VT 05495 Direct Phone: (802) 978-4450 Fax: (802) 878-3440 E-mail: barbara.h.davis@eds.com

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D. EXECUTIVE SUMMARY

RFP Reference: 3.2.2.4, p. 3-6

Imagine the future with a contractor … who brings a wealth of Vermont experience to help you meet your current objectives while also providing a solid foundation for the program's continued evolution.

The adage that nothing remains the same defines Medicaid. Federal and state regulations and advances in health care contribute to this ever-changing landscape. Despite the myriad of changes in recent years—new regulations, expanding benefits, growing beneficiary rolls, rapidly evolving technology—EDS' commitment to Vermont and its Medicaid program has been a constant. As we look to the next contract period, we remain focused on the vision of the Department of Prevention, Assistance, Transition, and Health Access (PATH) to provide the people, processes, and technologies that serve the health care needs of Vermont citizens. Recently, Commissioner Pat House spoke to the Vermont Legislature about her vision for PATH. That vision requires the Department to be ***nimble, connected, and adept***. By selecting EDS for the MMIS Core Claims Processing Takeover, you will select a nimble, connected, and adept partner with whom you share a history of camaraderie, a partner who can provide the services necessary to attain the success Commissioner House describes.

Nimble—EDS offers an experienced staff and a flexible operational environment to meet PATH's business and program needs. Information technology gives you access to critical program information to readily monitor the quality of health care services.

> "EDS is really a model for how government can and should partner with the state in ways that save money and increase productivity."
>
> --Senator Leddy, Health and Welfare Committee Chairman

Connected—A shared vision between PATH and EDS offers expanded avenues of digital communication to connect beneficiaries with programs and make Vermont a "digital state."

Adept—Together, we have created an infrastructure that aligns with the national Medicaid Management Information System (MMIS) business model, supports PATH's goal of high-quality, efficient health care delivery, improves beneficiary outcomes, and facilitates the flow of critical information between PATH and the many programs that serve the same populations.

Over the course of nearly 22 years, we have worked to construct a revolutionary MMIS environment. The flexibility and adaptability of our respective organizations have allowed us to successfully implement more than two decades of key program initiatives. Since 1981, the scope of services and the population served by the Office of Vermont Health Access (OVHA) have expanded. We are grateful for the opportunity to have worked with PATH as these initiatives evolved. Together, we transitioned from a legacy MMIS to the most advanced MMIS in the nation—VermontAIM. This evolution offered PATH an unprecedented level of processing capabilities, combining operational and technical practices that resulted in improved service to

program stakeholders. The VermontAIM design made the integration of other health care programs within the Vermont MMIS infrastructure possible. It allowed the MMIS to serve as the nucleus to support program administration services to the General Assistance Program, Department of Corrections Program, the State Children's Health Insurance Program (SCHIP), and the PC*Plus* managed care program. Integrating these programs into a single processing environment created an opportunity for Vermont to maximize federal funding and reduce the administrative expense for these programs.

This successful evolution will continue to serve as the foundation for our entire organization throughout the term of this contract. We are as enthusiastic today as we were in 1981, when we started to serve Vermont, or in 1993, when we implemented the new VermontAIM, or every day since. We are very excited about the mandatory and optional enhancements and cost containment measures that will continue Vermont's legacy as a leader in Medicaid administration.

Because of the dynamic nature of Medicaid administration, we regard this procurement as an opportunity to examine Medicaid program advances and offer the state the best people, processes, and technologies to meet or exceed the RFP requirements. Our Vermont-based team, supported by corporate resources and prepared by two decades of Vermont Medicaid experience, eliminates the risk associated with a change in contractors. The benefits to the state are evident in the Takeover, Operations, and Enhancements/Modifications Phases of this contract.

Takeover Phase

Approach: Our approach to the Takeover Phase is simple. With EDS, takeover is complete on the first day of the contract (September 1, 2003). **As the incumbent with operations and staff established in Williston, we are the only bidder who can offer a 100 percent risk-free, disruption-free takeover.** With its own facility and staff, the project is already fully integrated into existing EDS obligations and workloads.

With staff that brings more than 410 years of Vermont Medicaid experience, we are also positioned to guarantee PATH a high-value solution. Our solid foundation of experience, knowledge, commitment, and history of service excellence ensures continued compliance with federal and state mandates (including HIPAA), uninterrupted service to all program stakeholders, and the essential momentum necessary to achieve your future endeavors.

As we have done without fail for the past 21 years, we will:

- Continue to pay claims efficiently and accurately without any interruption of service
- Work with PATH to build on our infrastructure to implement enhancements
- Preserve our open, honest relationship based on mutual respect and effective program management

Staffing and Schedule: If the state wishes, EDS is ready to begin work on the mandatory and optional enhancements, as well as the cost containment mechanisms, during the Takeover Phase. This strategy positions PATH to realize the benefits associated with these initiatives more quickly than you would with a new fiscal agent. We are acutely aware that containing program

costs is vital to the state's fiscal health. **With EDS, the financial investment, activities, and risks associated with a new contractor during a takeover are negated.** In this time of budget deficits, both PATH and EDS can focus their energies on the program enhancements and alternative cost containment initiatives that expedite financial returns. **Our strategy turns this "window of time" into a "window of opportunity,"** during which your Vermont team stands ready to reach the fiscal and programmatic milestones that offer quantifiable benefits to all program stakeholders.

Operations Phase

Approach: Our approach to the Operations Phase of this procurement is to expand upon our proven ability to provide monetary and productivity improvements for Vermont Medicaid to further enhance health care services for all Vermonters. We can focus on and direct our energy toward improvements because the project is fully staffed and integrated into our daily Medicaid operations today.

The combination of our people, infrastructure, and expansive relationships create the optimal operational environment for continued support of the following operational tasks:

- Claims processing and administration
- Provider services
- Financial management
- MMIS maintenance
- Technical services and support
- Program documentation creation and maintenance
- Federal and state regulatory compliance
- Business continuity and disaster recovery
- HIPAA privacy/security compliance
- Planning regulations

EDS' approach to the system changes required to comply with the new HIPAA regulations exemplifies our ability to maximize resources to benefit our clients. Collaborative efforts among New Hampshire, Rhode Island, Connecticut, and Vermont led to a consortium of New England states that share in the developmental efforts required for HIPAA compliance. In the end, everyone benefited. According to initial remediation estimates, Vermont saved $4 million to $6 million. Technically, this approach offered Vermont and the other New England states a mechanism to maximize resources, hardware, software, and telecommunications links. We will continue to support this collaboration as well as all responsibilities related to the MMIS core claims processing procurement with innovative solutions throughout the contract term.

Staffing and Schedule: We feel strongly that our people are the number one asset we offer the state. Our current team, under the leadership of Client Delivery Executive Barbara Davis, will remain at our Williston facility ready to begin fulfilling contract obligations on Day One. Her local presence, leadership skills, and program expertise provide the stature necessary to successfully manage this high-profile project. Barbara's Vermont Medicaid experience spans nearly 27 years. Her career path is an example of the opportunities afforded to employees. In 1981, Barbara transitioned from the previous fiscal agent (Blue Cross/Blue Shield) to EDS as the

claims manager. Her entire career has been devoted to supporting the state's goals, and her devotion to your success led to her current role. Her Medicaid expertise and leadership experience guides our staff of more than 70 employees to meet contract requirements and achieve future program goals.

The commitment of the entire team remains steadfast and is exemplified by the contributions of two of our employees. When Commissioner House awarded Louise Brooks the "2002 OVHA Speed of Light Award," she recognized Louise's many contributions:

> Over the past 21-plus years your job has changed tremendously, and you have become an irreplaceable asset for the Department. Your ability to live in two worlds—EDS and the Department of PATH—is remarkable…. Your ability to educate, to synthesize, and to move at the speed of light is appreciated by all of us…. Just as important is your patience and professionalism.

When Chrissie Racicot received the "2002 OVHA Distinguished Performer Award," Commissioner House pointed to her responsiveness and flexibility:

> You are the one we count on to be there … applying the detail that makes a change—or a Commissioner's vision—come to life…. Your ability to work with just about anybody and the clarity of your thinking is much appreciated.

The skills and contributions of these two women are representative of the entire Vermont team. Our experienced staff will continue to provide the support to meet all operational requirements.

Enhancements/Modifications Phase

Approach: Concurrent with the first year of the Operations Phase, the RFP and Amendment 1 outline mandatory and optional enhancements/modifications that must be completed between January 1, 2004, and December 31, 2004. These enhancements are the first step toward the "MMIS of the Future." We share your goal of digitally connecting consumers to available services, interfacing with outside entities to exchange valuable program data, and providing an operational design that allows uninterrupted service to program stakeholders. The approaches we have defined for the enhancements and modifications bring characteristics of the "MMIS of the Future" to VermontAIM *today*.

Staffing and Schedule: The acumen of our Vermont team combined with proven business processes, technology advancements, and corporate resources best positions PATH to reap the rewards associated with these enhancements while virtually eliminating the risks associated with a large-scale project. Recognizing the importance of dedicated resources to maintain our current level of outstanding service, we have created a distinct team of experienced technical resources dedicated to seamlessly integrating the optional and mandatory enhancements. The Vermont-based operations team will assist the Enhancements/Modifications team by providing its expertise, and Barbara Davis will continue to serve as the single point of accountability. The work plan presented in this proposal shows work occurring in 2004. However, with the state's approval, the Enhancements/Modifications team stands ready to begin addressing the state's enhancements needs immediately upon award of the contract.

Our proposed Enhancements/Modifications Manager Sean Daly is uniquely qualified to serve in this role and exemplifies our commitment to providing the highest caliber support staff. During his 13-year career with EDS, Sean has designed, led, and implemented multiple client/server systems. He has supported systems architecture design, development, deployment, and operation for multiple Medicaid and EDS clients.

Sean leads a dedicated team that brings an unprecedented concentration of technical, Medicaid, and client/server MMIS expertise. Our proposed team will fuse this expertise with proven project management methodologies to offer the dynamics essential for a structured approach and quality processes that generate proven results. In fact, our proposed team has previously implemented more than 75 percent of the mandatory enhancements for other clients; they bring experience Vermont stakeholders will recognize as invaluable.

Cost Containment Mechanisms

Harsh budget realities have negatively affected nearly all 50 states, and as Vermont's expenditures continue to escalate, we welcome the opportunity to recommend cost containment mechanisms. As a Medicaid thought leader, we proactively research and identify emerging trends that create an opportunity to develop solutions aimed at reducing program expenditures. Our research encompasses both technological advancements and potential partners that offer Vermont a wealth of specialty services designed to reduce or contain benefit expenditures. The cost containment mechanisms described in this proposal are the result of this research.

The cost containment partners we recommend in this proposal provide the tools and expertise for improved access to program data and clinical services and offer enhanced program management and cost containment support without sacrificing the health care needs of Vermont's beneficiary community. We are excited about the opportunity to bring Vermont the clinical management services and pharmacy auditing services of Heritage Information Systems and the disease management services of TrestleTree. We will work with PATH to coordinate the activities necessary to integrate and provide ongoing support of these services. Like PATH and EDS, our partners are committed to innovative solutions that support your goal for continued access to service, quality, and cost control. Our approach to ClaimCheck and ClaimReview and TPL enhancements should be considered as additional features of the cost containment suite.

Why Vermont Should Select EDS

Vermont deserves a partner with strategic insight into health care, information technology, digital communications, and administrative services. As the premier provider of these services, EDS is eager to expand our contributions and support for Vermont. The long-term alliance between PATH and EDS has created a unique union of people, processes, and technologies that provide a foundation that makes the realization of our shared vision possible. We consider our relationship with the state of Vermont an invaluable asset. **Our goal is to be afforded the opportunity to extend this valued relationship and embark on a new era of excellence, performance, service, and capability built upon trust, respect, and commitment.**

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E. Corporate Capability

RFP Reference: 3.2.2.5, p. 3-7

The Vermont Department of Prevention, Assistance, Transition, and Health Access (PATH) guides Vermont's Medicaid and other health care programs, and since 1981, has chosen EDS as its partner in defining, evaluating, and implementing business process improvements and new technology. As your Medicaid program has evolved, we have teamed with you to determine the most effective way to implement the necessary changes.

We are pleased to have the opportunity to continue to partner with you in fostering the positive evolution of the Vermont program. **We understand your vision of having an MMIS driven by business needs and have worked with this goal in mind for more than 21 years**. Our experience provides a solid foundation for the program's ongoing evolution.

Health Management Systems, Inc., (HMS) will be our subcontractor if the state selects the third-party liability (TPL) optional enhancement. We have included the requested subcontractor information for HMS in the event that you select this enhancement.

Proven Performance

"Working together with the state for more than 21 years, Barbara Davis and our Vermont team have dedicated themselves to building a solid foundation focused on transforming health care for all Vermont citizens. The VermontAIM system fully supports Medicaid and other cross-agency programs and also positions the state at the leading edge for driving the evolution of the MMIS."

--Kevin McFarling,
EDS Regional Director

We will leverage our more than 21 years of experience with the Department of PATH and the VermontAIM as we continue to provide the teamwork, expertise, and professionalism you have grown to expect from us. We are the **only** company to offer the following:

- Extensive knowledge of the Vermont Medicaid Program and its intricacies, the political environment, the requirements of various stakeholders, and the historical perspective and vision of your Medicaid program
- Fundamental, detailed knowledge of the VermontAIM gained from designing, maintaining, modifying, and enhancing this system to accommodate new state and federal programs and regulatory requirements
- Extensive system and program knowledge and historical perspective, which translates into being able to handle a seamless takeover and immediately focus on enhancement activities
- No risk and no disruption during the Takeover Phase

No other vendor can make the following statement: Our team is an integral part of the history and vision of Vermont's Medicaid Program. We assisted the state in creating, building, and shaping it.

We believe that our relationship with Vermont's Department of PATH and the VermontAIM provides a solid foundation for growth as we work together to build the MMIS of the future that is necessary to serve the digital state. We want to continue to partner with you to transform your vision into Vermont's reality.

We describe our unique strengths and abilities in the following sections:

- A Legacy of Partnership, Teamwork, and Knowledge
- For EDS—Service Comes First
- VermontAIM: A Unique, First-of-Its-Kind System
- Built-In Flexibility to Support Vermont Program Growth

A Legacy of Partnership, Teamwork, and Knowledge

EDS is the best value for the Vermont Medicaid expense dollar because we know the Vermont Medicaid Program and its environment. Our experienced staff built Vermont's MMIS while learning many valuable lessons in the process. We will combine our knowledge and the lessons learned as we go forward, which will benefit all program stakeholders.

Proven Team Work and Partnership

"EDS has worked closely with the legislature and throughout has had good and open communications. They are a true partner in working to serve the citizens of Vermont."

--Speaker of the House
Walter Freed

No other vendor has this legacy of Vermont-specific experience and knowledge. As a result of the expertise we have gained over the years as your fiscal agent, we can ensure uninterrupted service while focusing on the enhancements you have identified rather than having to address issues specific to the system takeover and program turnover.

We have built strong relationships with critical stakeholders, including the Department of PATH, provider associations, and the provider community. We have proven our responsiveness by quickly implementing critical new enhancements, such as the complete system refresh in 2000, the addition of Department of Corrections claims, the upgrade of the ad hoc system to a DB2 platform (2002), and the IBM Content Manager OnDemand digital archival system for reports.

In addition, we have worked closely with the Department of PATH staff to ensure that we implement annual legislative changes in a timely fashion to provide the intended benefits and budget adjustments. We implemented these changes on time and within budget.

Our people are our greatest asset. They have the expertise and knowledge that makes Vermont Medicaid one of the premier Medicaid programs in the country. The stability of our staff is key to providing service continuity and improvement. Several members of our team have been here since the beginning of our relationship in October 1981. Our current team brings more than 410 years of combined Vermont Medicaid knowledge. This perspective of the Vermont Medicaid Program provides a source of institutional memory that covers more than two decades of program history.

For EDS—Service Comes First

It is our service to the various Medicaid stakeholders that makes the critical difference in your success, the Program's success, and our success. Our efforts have resulted in **continuous on-time payments to providers and wider access to health care for beneficiaries**. Of primary importance, we never lose sight of the need to manage Medicaid program dollars effectively so that the end result is the best possible value for Vermont beneficiaries. We view our relationship with the state as that of "a single team," whose goal is the maintenance and continual evolution of an exemplary Medicaid program.

Proven Quality Work

"As chair of the Health and Welfare Committee, I naturally asked questions of EDS. I was impressed with the quality, detail, and thoroughness of the responses I received. I am absolutely convinced of the quality of EDS' work."

--Former Senator
Nancy I. Chard

We recognize that the success of the Vermont Medicaid Program is based in a large part on the provider community and the service we provide to this community. Our commitment to provider service can be seen as far back as 1981, when we implemented a new MMIS. We focused on making the transition easier for the provider community by adopting the previous vendor's claim forms, provider numbers, and procedure codes. Over the years, we have created a wide array of user-friendly training for the provider community as we have worked with you to successfully implement several new state and federal programs. We also implemented a point-of-sale (POS) eligibility system and an automated voice response system (AVRS) in support of your providers.

Based on provider input and Vermont's desire to evolve the VermontAIM into a state-of-the-art system, we have partnered with you to make continual program improvements to your system. Our **vision is to continue this ongoing evolution to achieve major enhancements** during the new contract and beyond.

Timely payments are a very visible measure of our performance. They are critical to the provider community and to promoting health care access for beneficiaries. In fact, since we generated our first weekly claims cycle in October of 1981, we have **never missed a weekly claims payment cycle.** Using the current VermontAIM, which became active in November 1993, we have generated more than 475 consecutive payment cycles on behalf of Vermont's providers without any disruptions. Our most recent annual survey, completed in December 2002, reflected the highest marks we have ever received for our provider services area. This positive feedback is a further validation of our continued striving to provide the best possible service.

We balance this long-term consistent, quality performance with constantly improving and expanding the system. We consistently respond to diverse program needs without risk or disruption.

EDS is often the face of the Vermont Medicaid Program to the provider community, and we take this responsibility seriously. We are your program ambassadors. Every interaction is an opportunity for us to exceed provider expectations with our knowledge and responsiveness to their needs.

VermontAIM: A Unique, First-of-Its Kind System

At the time of the 1992 contract renewal, we proposed to design and implement the first client/server MMIS, the VermontAIM. It was the first-of-its-kind in the industry, providing an open system, client/server architecture that supported a paperless environment, and providing desktop access to MMIS information as well as real-time claims processing and updating capabilities. This system began EDS' client/server MMIS legacy and has remained current as technology advances were incorporated.

The VermontAIM's scalability and flexibility has allowed it to handle program growth and reform. We can implement new enhancements that result from your thought leadership and visionary thinking. **We remain the first and only vendor to provide this advanced system**.

Visionary Technology

"The technology being employed here is the way of the future. The flexibility you have with this system is what will be necessary to meet the challenges of the future."

--HCFA

The VermontAIM is table-driven and rules-based. Its flexibility has allowed it to support additional programs, such as Managed Care in 1996, PCPlus in 1999, State Children's Health Insurance Plan (SCHIP) in 1999, and Breast and Cervical Cancer Treatment (BCCT) and General Assistance in 2001.

We added run-time improvement and enhanced search and reporting capabilities as a result of the BusinessObjects implementation conducted in 1998 and the platform upgrade to DB2 completed in 2002. By adding these capabilities, we offered users the ability to perform research from their desktops. The increased disk space capacity, new server, and Web browser reflect changes to this system that better serve the state.

Our long-term, in-depth knowledge of the VermontAIM means we fully understand the impact of the ongoing operations and the requested enhancements to this system. We are able to focus our attention on the design, incorporating the enhancements in a seamless, rapid manner due to our expertise. Other vendors must first focus on learning the unique complexities of the VermontAIM and the Vermont Medicaid Program. Then, they must gain an understanding of the enhancements and their specific requirements. Finally, any other vendor must try to determine how to bring all these factors together to best serve the state. Any misinterpretation by the vendor could result in wasted or lost time, additional costs, and unnecessary work or rework.

Built-In Flexibility to Support Vermont Program Growth

We have a track record of more than 21 years of providing excellent performance. Today, we process claims through the MMIS for Dr. Dynasaur, a state-funded program for children under the age of 18 and pregnant women. The flexibility and scalability of the VermontAIM allowed us to easily modify it to recognize program beneficiaries based on aid category and to produce separate management, utilization, and financial reports. Also in 1999, we created a primary care case management program (PCCM) in less than four months at your request when Kaiser Permanente and Blue Cross/Blue Shield of Vermont withdrew from the program. We tapped into the extensive knowledge of our other Medicaid accounts to avoid foreseeable issues and to ensure we deployed the best practices, including interactive television training.

We have the ability to easily, quickly, and seamlessly add programs, such as Dr. Dynasaur, and to react quickly, efficiently, and professionally to unforeseen circumstances. This ability demonstrates the flexibility of the system and our team, which is a necessity for future growth.

Comprehensive Third-Party Recovery and Revenue Recovery Services

Should the state decide to purchase the TPL optional enhancement, we will add HMS' nationally recognized TPL recovery services to our offering. HMS is the strategic source for innovative revenue enhancement and recovery services to programs and payors serving public health care. HMS applies state-of-the-art information management and processing technology to enhance its clients' revenues and reduce their program and administrative costs, thereby supporting efficient, appropriate use of public health care funds.

HMS has performed Medicaid third-party recovery (TPR) and revenue recovery services in 30 states, recovering more than $1.7 billion for its clients. **HMS' expertise—in terms of clients served and monies recovered—exceeds that of any other TPR services vendor.**

HMS is currently a subcontractor to EDS for three of our MMIS accounts: Delaware, Indiana, and Kansas. While performing TPR services as a direct contractor with the state, HMS has also worked closely with us in Connecticut, Pennsylvania, California, Oklahoma, Georgia, and Arkansas.

HMS will perform the following TPR and revenue recovery services for the Vermont Medicaid Program:

- Perform data matches to identify third-party coverage
- Perform recovery from a range of third-party resources, including commercial insurance, Medicare Parts A and B, Blue Cross/Blue Shield, and TRICARE/CHAMPUS
- Provide potential third-party coverage updates
- Identify other areas for the state to reduce costs and increase revenue

HMS' services are scalable. HMS will work closely with EDS, as a subcontractor, and the Department of PATH to ensure that recovery services fully meet project requirements and state needs.

As a testimony to EDS' work in Vermont, we include the following letters from Vermont providers:

- Helen Riehle, Executive Director of the Vermont Program for Quality in Health Care
- Robert Bycer, Primary Care Health Partners
- Alecia Armstrong, President Vermont Mental Health Counselors Association
- Richard Tobin, Keene Medical Products, Inc.
- Karin Seidel, Doctor of Optometry

March 28, 2003

Ms Barbara Davis
Executive Director
EDS-Williston
P.O. Box 888
312 Hurricane Lane, Suite 101
Williston, VT 05495

Dear Barb,

The Vermont Program for Quality in Health Care, Inc. has had the pleasure of working directly with EDS-Williston for the past year and a half. Through two contracts with the Vermont Agency of Human Services, VPQHC has undertaken analysis of the Medicaid claims data for Vermont and worked closely with the personnel at EDS-Williston to translate the data into formats useful for understanding the quality of care received by various subpopulations of Medicaid caseload.

EDS-Williston has been extraordinarily helpful and responsive to the questions and challenges for VPQHC as we have developed an understanding and ability to perform the translation work. Cherie Bergeron, Cindy Littlefield and Louise Brooks have gone out of their way to assist us, promptly answering phone calls and personally coming to the office in Montpelier. The outreach was particularly important after we were faced with a significant and unexpected personnel change at VPQHC. The extra effort has served this organization and the State of Vermont well.

We look forward to a continuation the productive relationship with your organization.

Sincerely,

Helen Riehle
Executive Director

primarycare
HEALTH PARTNERS

January 24, 2003

Barbara Davis
Account Manager
EDS
PO Box 888
Williston, VT 05495-0888

Dear Ms. Davis:

I am sending this letter in support of EDS retaining the contract as the fiscal agent for Vermont Medicaid. Primary Care Health Partners (PCHP) has enjoyed a positive working relationship with EDS and its employees. EDS has assisted PCHP staff with many special projects and requests and been responsive to our questions and inquiries. EDS has also cooperated with providing in-service education for our business office and health center staff. We have enjoyed and learned much from our working relationship with EDS. I trust EDS will be successful in renewing its contract as Vermont Medicaid's fiscal agent.

Please feel free to call me with any questions.

Sincerely,

Robert E. Bycer
Chief Operating Officer

Management Services Organization
145 Pine Haven Shore Road, Suite 2161 Shelburne, VT 05482
Phone: 802-860-1145, Fax: 802-846-3097

PCHP is a regional association of community-based primary care health centers throughout Vermont and upstate New York

Haskins, Chris

To: alecia armstrong
Subject: RE: Letter of recommendation

-----Original Message-----
From: alecia armstrong [mailto:aleciaarmstrong@yahoo.com]
Sent: Saturday, November 09, 2002 9:13 AM
To: Haskins, Chris
Subject: Letter of recommendation

November 11, 2002

To Whom It May Concern,

I am writing on behalf of EDS which is the Fiscal Agent for the Office of Vermont Health Access.

EDS is quickly becoming a model fiscal agent for timely payments and quick resolutions. While there have been problems in the past, they tend to be traced back to non-compliance by providers due to a lack of understanding of procedures.

I have been in contact with Christine Haskins RE: support and education to providers to help resolve such problems. EDS is now offering workshops on billing procedures and has been increasingly responsive to individual providers to help resolve such difficulties.

The free billing software which EDS provides to providers is second to none. It beats NDCassist and Cigna's programs hands down. There would be very few problems with billing if all providers could use this software.

Please feel free to contact me for further comment.

Sincerely,
Alecia Armstrong, MA LCMHC
President Vermont Mental Health Counselors Association

KEENE MEDICAL PRODUCTS, INC.

P.O. Box 439, 240 Meriden Road
Lebanon, NH 03766-0439
(603) 448-5290

" home care is our business "

December 27, 2002

EDS
Attention: Barbara Davis
P.O. Box 888
Williston, VT 05495

Dear Barbara,

Keene Medical Products, Inc., has enjoyed our relationship with EDS of Vermont. Christine Haskins has been instrumental in helping us get claims processed through EDS and OVHA. If it was not for Christine, Barb, and other members of EDS of Vermont, our communication with OVHA and EDS probably would not be as good as it is today.

I feel that EDS does go out of its way to help the provider to the best of their ability. EDS works very hard for their providers and I hope this letter will help in your decision process for processing claims.

We look forward to working with Christine in the future.

Sincerely,

Richard Tobin
Comptroller

Karin M. Seidel, O.D.
833 Brooklyn St. Apt 1
Morrisville, VT 05661
Ph: 802-888-5272 FAX: 802-888-5870

EDS
Barb Davis, Account Manager
213 Hurricane Lane Ste 101
PO box 888
Williston, VT 05495

Dear Barb:

This letter is written expressly to sing the praises of my wonderful provider relations representative, Barbara Jackson and to compliment EDS on the wonderful job they do with a very difficult task.
I have been a vision provider for Medicaid in Vermont for many years and have generally had a good working relationship with EDS. I cannot deny that we have had our rocky times but with rare exception, I have found the phone representatives co-operative and truly wonderful to work with. However EDS' greatest gift to me was Barbara Jackson.
Barbara has spectacular working knowledge of the nuances of the Medicaid System and is consistently pleasant, accurate, willing and responsive to my questions and requests. I sense that she is genuinely concerned about my situation and can honestly tell you that she has made my journey through the persistently changing rules, a smooth and easy one. Aside from the high degree of professionalism she demonstrates daily, she is just plain fabulous on a personal level. She is never ending patience and kindness and epitomizes the professional relations liaison I would wish for with every company. As you can see, there simply are not enough words to say how much I appreciate her and her efforts on my behalf. She is a jewel in your organization and I truly hope that EDS has the wisdom to keep her. She is just " a peach".
In support of EDS, I have to say that you do a wonderful job for me, personally. Knowing that the vision care alone is merely a ripple in the vastness of cosmic third party care, I understand that you are called upon daily to be accurate about an encyclopedic amount of rules and regulations. Clearly there are places for improvement in the system, but generally speaking, EDS does quite a good job of what it is called upon to do. The billing program is fabulous. It's fast, user-friendly and the turn around time is great. Again, I wish that all my billing could be as simple. Hopefully, time will bring changes in the system that will further expedite the processing of other codes and information.
Therefore, in closing, I'd like to say thank you. I appreciate your efforts on my behalf and ask that you pass my appreciation on to the many wonderful people in your organization who assist me daily. And thank you for assisting me with HIPAA compliance. That alone, is worth its weight in gold!

Sincerely,

Karin Seidel

Karin M. Seidel, O.D. 0006605

BACKGROUND

RFP Reference: 3.2.2.5.1, p 3-7

We are pleased to provide the requested corporate capabilities information for both EDS and our proposed subcontractor, Health Management Systems (HMS). We are using a table format to respond to items a through h. The performance history and reputation (item i) and goals that are relevant, closely related, or will complement this project (item j) are then discussed in a longer, narrative format. We also provide a listing of EDS subsidiaries.

EDS Capabilities

By selecting EDS, the Department of PATH partners with a technology leader with proven operational experience in supporting all areas of Medicaid programs. Our goal is simple—to ensure Vermont Medicaid's success now and in the future. We discuss our capabilities in the following subsections:

- EDS Performance History and Reputation
- EDS Goals That Are Relevant, Closely Related, or Will Complement This Project

The following table provides background about the company.

Details of EDS Background

RFP Requirement	Response
Date established	1962
Location of principal place of business	5400 Legacy Drive Plano, Texas 75024
Location of the place of performance of the proposed contract	312 Hurricane Lane Williston, Vermont 05495
Type of ownership (e.g., public company, partnership)	Independent, publicly held company
Subsidiaries or wholly owned business units	List of EDS subsidiaries can be found at the end of this section.
Total number of employees	130,429 employees as of December 31, 2002

RFP Requirement	Response
Number of personnel engaged in computer systems operation and development	Approximately 34,000 employees
Number of personnel currently engaged in MMIS systems development and operation	Approximately 4,250 employees
Number of personnel in state of Vermont	66

EDS Performance History and Reputation

RFP Reference: 3.2.2.5.1(i), p 3-7

Since its founding in 1962, EDS has been a global pioneer in the information technology (IT) field. Today, EDS is the leading global services company. We bring the right strategies, solutions, and services—independent of vendors—to eliminate boundaries, collaborate in new ways, and continuously improve both technology and business processes. EDS is an independent, publicly held company with approximately 130,000 employees worldwide.

Proven Value

We have been a trusted business partner for more than 40 years by delivering business results, including increased productivity, more predictable costs through leveraged systems, higher quality, increased customer satisfaction, and competitive agility.

Every day, we make the digital economy real for our clients by serving more than 35,000 business and government clients in 60 countries; supporting more than 3.3 million desktops around the world; enabling more than 13 billion business, consumer, and government transactions each day; providing hosting services for about 900 clients worldwide; and managing approximately 50,000 servers in 170 company-owned and client-owned data centers.

Our experience comes from the following achievements:

- Working with multiple health care clients for approximately 40 years
- Performing numerous large-scale implementations, including multiple client/server MMISs
- Incorporating what we have learned into our project management and system development methodologies
- Keeping current with industry demands and technology advances
- Bringing thought innovation to each client

With EDS, you gain innovative ideas for rapid service improvements as a result of our ability to deploy best-in-class Medicaid processes and technologies as well as our specific, detailed knowledge of the intricacies and complexities of the Vermont Medicaid Program. To provide Vermont Medicaid with gains in service improvement and business continuity, we offer the following benefits:

- Innovative ideas for service improvement and cost savings as a result of extensive successful Medicaid and heath care industry experience
- Ability to successfully implement program initiatives and improvements without disruption as the result of the unique understanding gained in supporting the complexities and intricacies of the Vermont Medicaid Program
- Confidence in the ongoing commitment to the success of the Vermont Medicaid Program as a result of our demonstrated corporate commitment to the Department of PATH and your clients
- Least costly transition because we designed and are running the existing VermontAIM; a new contractor would have to transition this system, requiring substantial time, effort, and cost for both the new vendor and you

We will describe our corporate background and reputation in more detail in the following subsections:

- Steadfast Commitment to Vermont
- Leveraging EDS' Comprehensive Experience
- Medicaid Thought Leadership
- Planning for the Next Generation MMIS
- Breadth and Depth of Medicaid Experience

Steadfast Commitment to Vermont

Our commitment to Vermont Medicaid is unmatched by any other vendor in the nation. We began providing Medicaid fiscal agent services to Vermont in 1981. We designed, developed, implemented, operate, and maintain a Centers for Medicare and Medicaid Services (CMS)-certified MMIS. We are the only vendor to provide a client/server (non-mainframe) platform with an MMIS server infrastructure and UNIX-based operating system.

Unsurpassed Vermont Medicaid Knowledge

Our Vermont team represents more than 410 years of Vermont-specific Medicaid knowledge and experience.

Additionally, we perform several specialty services that are not always included in a fiscal agent's scope of work. These services include drug rebate processing, ad hoc reporting, PC*Plus* managed care, State Child Health Insurance Program (SCHIP), and cost containment activities. We are also responsible for beneficiary identification card production and distribution.

Your 1992 request for proposal (RFP) was innovative and challenging. We were determined to meet your requirements and make the system you envisioned a reality. We were the only company to respond to the challenge at that time. Our goal was to rethink and reevaluate not only the technology but also the business processes to bring you the maximum benefit. We proposed to design and implement a new MMIS for Vermont that integrated technology, people, and processes.

The resulting system was the first of EDS' client/server Medicaid systems and the first of its kind in the country. As a first-of-its kind in the industry, open system, client/server solution, the Vermont MMIS created a paperless environment by providing desktop access to MMIS information. We put useful information, not data, at the user's fingertips. The Vermont MMIS offers scalability and flexibility to handle health care growth and reform. The system facilitates real-time claims processing and updating capabilities, in addition to giving users flexible reporting options.

We process claims from multiple departments and multiple funding sources—all under the same flexible system. In 1998, we implemented a new BusinessObjects ad hoc reporting function. It incorporated reporting for multiple state program claims and transactions, allowing for improved control and tracking of program expenditures. In 1999, we implemented the SCHIP, which allowed the state to take advantage of federal matching funds when processing child health-specific claims. Through tracking and reporting capabilities, Medicaid program administrators have access to the depth of information required to monitor health care patterns and trends associated with the SCHIP.

The following graphic highlights key events and accomplishments that have occurred throughout the many years of our working relationship with you.

Accomplishments for the STATE OF VERMONT

1981

Began providing fiscal agent services by implementing legacy mainframe MMIS on time and within budget

Helped providers transition to MMIS by using previous vendor's claim forms, provider numbers, and procedure codes

1984

Began claims processing for the Department of Developmental and Mental Health Services

1985

Implemented simultaneous federal program enhancements related to universal billing (UB-82) claims processing and HCFA Common Procedural Coding System (HCPCS) coding

Improved claims turnaround time by 27 percent by implementing electronic claims processing

1986

Reduced claims adjudication time by four days by developing a front-end force-or-deny capability

Implemented an online reporting system

Implemented federal 2082 reporting

Implemented Department of Transportation claims processing

1987

Reduced pharmacy expenditures by 7 percent by implementing federal maximum allowable charge pricing

1988

Saved the state more than $1.1 million in benefit expenditures by implementing detail crossover pricing

Implemented Department of Developmental and Mental Health Community-Based Waiver programs

1989

Added Uninsured Children and Pregnant Women Program benefits

1990

Implemented the Dr. Dynasaur program

Implemented federally mandated HCFA 416 reporting

1991

Implemented federally required copayment processing to have beneficiaries share in the cost of care, thus reducing program benefit expenditures

Implemented drug rebate program, resulting in more than $100 million in recoveries over the term of the contract

1992

Implemented federal Clinical Laboratory Improvement Amendments (CLIA)

1993

Developed and **implemented** the first client/server MMIS in the nation, featuring desktop access to information and real-time claims processing

Developed and implemented the first point-of-sale eligibility system and automated voice response system for Vermont providers

1994

Implemented electronic funds transfer capabilities that featured wire transfer for provider payments, significantly improving provider cash flow

1995

Fully certified VermontAIM retroactive to first day of processing

1996

Added HIV/AIDS claims processing and included the drug rebate processing, returning more than $80,000 to the Vermont Department of Health

1997

Implemented the Vermont Quality Improvement Process, which improved account productivity, client satisfaction rating, and staff cross-training

1998

Improved the Vermont Medicaid data warehouse by installing the Enhanced Vermont Ad Hoc (EVAH) system, which met the specialty reporting needs and placed the power of information at the user's fingertips

Implemented computer output to laser disk (COLD) system, providing instantaneous online access to paper reports

Implemented AIM Healthcare Auditing Service, resulting in an average annual return of $156,000 to the Medicaid program

1999

Created and implemented PCPlus, the state-run primary care case management program, in less than four months, thus preserving the state's 1115 Waiver program

Implemented the State Child Health Program (SCHIP), allowing Vermont to receive federal-matching funds for child health claims, which resulted in more than $25 million dollars in Department of Education billings in the first year

Implemented Breast and Cervical Cancer Treatment (BCCT) Program

Completed a year 2000 system assessment and passed the CMS IV and V audits with the lowest risk rating

Transitioned the MMIS to year 2000 with no issues or problems, earning a letter of commendation from the President's Council on Year 2000 Conversion Committee

2000

Performed complete system refresh, upgrading MMIS hardware and software and improving system run-time performance by more than 36 percent

Teamed with the Office of Vermont Health Access (OVHA) to present managed care training to providers using the Vermont Interactive Television technology for maximum coverage and impact

Received the Eileen Elliott Commissioner **Award** for our role in successfully implementing the PCPlus program

2001

Received the prestigious Hammer **Award**

Completed a full Health Insurance Portability and Accountability Act (HIPAA) MMIS system assessment

Completed Level I SAS 70 Independent Audit with no findings

Implemented General Assistance MMIS claims processing

2002

Completed Level II SAS 70 Independent Audit with no findings

Completed a full disaster recovery assessment that included installing the VermontAIM on off-site servers, successfully processed claims and ran daily, weekly and monthly cycles

Upgraded ad hoc reporting platform to DB2 and **added** IBM Content Manager OnDemand digital archive system

Implemented Department of Corrections claims processing

Initiated a cost-savings study that led to implementation of J-code processing, resulting in an additional $350,000 in drug rebates in the first year

Began HIPAA remediation of the system coordinated through the New England States Consortium Systems Organization (NESCSO) Tri-State project with potential to save the Department of PATH several million dollars

Implemented state Families in Recovery program

2003

Implemented Self-Directed Nursing Coordination claims processing program

Placed provider manuals on the state's Web site to facilitate easy access to Medicaid billing procedures

Presented three $1,500 EDS technology grants to local schools at a ceremony attended by Governor Jim Douglas, Commissioner Pat House, and Medicaid Director Paul Wallace-Brodeur

We have consistently responded to your desire for a dynamic MMIS with the implementation of various forward-thinking enhancements. This RFP provides additional enhancement opportunities, such as the platform conversion, modifications to the claims processing system to incorporate ClaimCheck and ClaimReview, the Internet enhancement, and the provider system changes. In each instance, we quickly determined the impact and scope of each enhancement, using our extensive system and program knowledge. Then, we quickly decided how to best design and implement each enhancement while minimizing disruption. Other vendors would have a significant learning curve to obtain our level of system and program understanding and to match our ability to seamlessly incorporate enhancements.

We also implemented a point-of-sale (POS) eligibility system for providers and an automated voice response system (AVRS) in 1993. In 2000, we teamed with the Office of Vermont Health Access (OVHA) to present focused PC*Plus* training to interested providers using the Vermont Interactive Television. We selected this technology to foster maximum coverage. We will continue to leverage this experience when implementing new initiatives and enhancements for the state.

Leveraging EDS' Comprehensive Experience

You have seen a glimpse of the depth of resources we provide as a world-class computer services and business process operations company. By selecting a global leader in the IT industry, Vermont gains assurance of our long-term viability, extensive capabilities, stability, **and most importantly, you will have a true business partner.**

In addition, our vendor-independent status allows us to select the right vendors to meet each client's specific needs. We are a skilled multivendor integrator, which means we are the client's single point-of-contact for vendor and subcontractor information and issues. We believe HMS is the best match for your specific needs if you select the third-party liability (TPL) optional enhancement.

EDS has a significant presence in the New England area. We have supported the following New England Medicaid or Medicaid-related programs for more than 10 years and some for more than 20 years:

- Vermont Medicaid (1981)
- Connecticut Medicaid (1981)
- New Hampshire Medicaid (1985)
- Rhode Island Medicaid (1992)
- Massachusetts Recipient Eligibility Verification system (1988)

These partnerships were formed over many years as we teamed with the states to meet their unique challenges. In Vermont, some of our team members have supported the Department of PATH since the contract's inception. Their knowledge as well as that of their peers ensures a depth and breadth of Vermont Medicaid-specific knowledge that no other vendor can provide.

Not only do we value our employees and their knowledge, but also you have recognized our team members for their exemplary service. On February 27, 2003, two members of our team—Reporting Specialist Louise Brooks and Systems Engineer Chrissie Racicot—were recognized for service excellence by Commissioner Patricia House of Vermont's Department of PATH. She presented these two individuals with the Commissioner's Award.

This is the second year Commissioner House has presented awards to EDS team members. In citing Chrissie's year 2000 experience as well as her understanding of Health Insurance Portability and Accountability Act (HIPAA) compliance and VHAP benefit issues, Commissioner House said, "You are the one we count on to be there, behind the scenes, applying the detail that makes a change…come to life. Your ability to work with just about anybody and the clarity of your thinking is much appreciated."

Your praise for our employees affirms your recognition of our commitment.

Praiseworthy Performance

"You have become an irreplaceable asset for the Department…your ability to live in two worlds—EDS and the Department of PATH—is remarkable… your ability to educate, to synthesize, and to move at the speed of light is appreciated by all of us…"

--Patricia House
Commissioner of Medicaid in regards to 21-year EDS employee Louise Brooks

We are constantly looking for ways to better serve our clients. For example, we partnered with four New England Medicaid clients (Vermont, New Hampshire, Rhode Island, and Connecticut) to address the implementation of HIPAA transaction and code sets rules. By leveraging our resources, we are able to provide savings to these clients.

New Hampshire, Rhode Island, and Vermont will share system programming modifications, saving millions of dollars of federal funds and saving each state hundreds of thousands of state-matching funds. Connecticut, New Hampshire, Rhode Island, and Vermont will share translator services. **By sharing with other states, each state avoids considerable IT investment and realizes additional savings in its local EDS contract by minimizing custom programming.**

In addition, we work to make the best use of subcontractors who are best able to fill our clients' specific needs. **Being vendor-independent allows us to select the best match based on a needs analysis, not a contractual commitment.** Our corporate purchasing power often allows us to negotiate contracts designed to provide quality services and products at the best price. For the Vermont optional TPL enhancement, we determined that HMS is the best choice for data matching services.

Medicaid Thought Leadership

As the Medicaid program changes and technology advances, we remain dedicated to increasing performance, efficiencies, and cost-effectiveness of our Medicaid systems. We do this through increased capability, greater flexibility, and innovative application of technology. For example, **EDS was the first, and remains the only, contractor to have developed and integrated a client/server relational database system specifically for the Medicaid environment.** Other vendors claim to have client/server MMIS technology when in fact they use a client/server component attached to a legacy mainframe system. We created, maintain, and enhance a client/server (non-mainframe) platform with a MMIS server infrastructure and UNIX-based operating system for the Department of PATH. We have done so since November 1993.

You gain innovative ideas for improving cost containment, increasing program efficiency, and meeting future technological challenges, such as HIPAA compliance, by selecting the Medicaid thought-leader, EDS. Among Medicaid contractors, we are the national leader in providing the innovative application of technology and process improvement to manage large-scale complex programs. We began working with the Medicaid program as soon as the legislation was enacted and have provided MMIS services to more states longer than any other contractor in the industry. We have continued to grow and modify our services to meet evolving client needs and changes in the health care industry.

For example in 2002, we knew Vermont, like other states, faced escalating health care expenditures and severe budget constraints. Without being asked, we canvassed other EDS Medicaid accounts for cost containment and money-saving ideas. From this initiative, we offered a list of 22 potential activities. You chose to incorporate several of these ideas such as the J-code drug rebate and the two-year recertification process for providers. The result was a significant savings for Vermont. This type of initiative is what you have come to expect from us and we consider it a part of our responsibility to you.

Forward Thinking Technology

We designed, developed, and implemented a client/server (non-mainframe) platform with an MMIS server infrastructure and UNIX-based operating system for the 1992 contract renewal.

The Self Managed Nursing program demonstrates our innovative and proactive approach to supporting you with new services. This program allows families to manage nursing services for special needs family members when there is a lack of agency services. What began in 1999 as a pilot program to address a specialized need has resulted in our taking over all payroll and billing services. We administer all duties related to this program and have streamlined its procedures. Our team handles changes to items such as rates and codes. We act as a liaison between the OVHA and the families and have hired a coordinator at your request. In addition, we distribute informational materials, timesheets, and other items needed by the family or nurses.

In fact, Vermont is working with the CMS to design the next generation MMIS. Our MMIS will feature technology designed to get critical information to stakeholders, encourage the rapid exchange of this information, and promote leveraging of information resources between appropriate users. We are already teaming with some of our Medicaid clients to provide them with components, such as Web/Internet capabilities, of this system of the future. We welcome the opportunity to continue to add enhancements to the VermontAIM that emulate CMS' evolving system.

Today, the need for real-time, current program information is not a luxury but a necessity. You recognized this fact many years ago and partnered with us to address the continuous Medicaid changes and demands specific to Vermont. Because thought leadership is the impetus for innovation, we firmly believe maintaining our excellent service to Vermont means concentrating on innovation.

Our approach to innovation will focus on the business goals and objectives of the Vermont Medicaid Program. We have a documented track record of helping our Medicaid clients provide nationally recognized service. Our clients and EDS regularly receive awards and recognition. For example, Wisconsin Medicaid and EDS were awarded *Outsourcing Journal* Editor's Choice Award 2000 for Best Government relationship for its vision and ability to make technology better serve program needs. *Financial World Magazine* cited the Wisconsin Division of Health Care's Medicaid Program as the best program in the nation.

In addition, the Indiana Family and Social Services Administration (FSSA) received national recognition from *ComputerWorld/*Smithsonian*,* and National Association of State Chief Information Officers (NASCIO) (formerly the National Association of State Information Resource Executives) for its innovative use of technology in the design and implementation of the EDS client/server relational database system.

Four EDS MMIS clients—Wisconsin, California, North Carolina, and Mississippi—were recognized by CMS at the 2001 CMS HIPAA Conference for Medicaid. They received the HIPAA Hero Award. CMS, six New England Medicaid programs, and EDS received the Hammer Award 2001 for reinventing ways that pharmacy disputes are settled and money recouped. Also, in 2002, our Medicaid data warehouses won the 2002 Business Objects Customer Excellence Award for innovation and vision in using business intelligence technology. Already in 2003, our Delaware MMIS became the first state Medicaid system to become fully HIPAA compliant. We will strive to achieve the same results for the Vermont program as we continue our partnership.

We highlight EDS' innovations and achievements in support of the Medicaid industry in the following graphic.

Evolving Solutions for Changing Medicaid Programs

Date	Achievement	Description
1967	First Medicaid System	EDS offered Texas the first Medicaid system in the nation to support Medicaid claims processing.
1976	Medicaid Administrative Services and Data Processing	EDS implemented for North Carolina both data processing and administrative services as part of North Carolina's Medicaid Prepaid Pharmaceutical Program.
1982	Electronic Processing	EDS implemented for Texas paperless processing for claims resolution and adjustments, dramatically reducing cycle time, improving accuracy, and reducing administrative cost.
1992	First Online, Real-Time Multi-Claim Type Processing	EDS implemented for Arkansas the first Medicaid system performing online, real-time processing of medical, dental, EPSDT, inpatient, outpatient, long-term care, vision, and pharmacy claims processing.
1993	First and Only MMIS with Real-Time Processing	EDS began operating the Medicaid industry's first client/server MMIS in Vermont and Rhode Island; the system remains the only transaction-based system available.
1995	Health Benefits Manager	EDS became the health benefits manager for Delaware.
1997	First Learning Technology to Identify Medicaid Fraud	EDS implemented the first neural network fraud and abuse detection system for the Texas Medicaid Program.
1997	First Medicaid Decision Support Solution (DSS) With a Star Schema Design	By implementing the first star schema database design in a Medicaid DSS, EDS gave interChange DSS users in Arkansas the ability to compare multiple claim types and access commonly used information quickly.
1998	Two States Request EDS to Takeover/Replace Troubled DSS	Mississippi and Vermont replace other vendors' attempts with a successful EDS-led DSS implementation.
2000	First Web-Based Project Workbook	EDS developed and implemented the first Web-based, relational database-driven Project Workbook to provide real-time access to all project-related documentation for the Oklahoma Medicaid implementation.
2000	First Web-Based Claims Transactions	EDS implemented the first Web-based claims submission system for the state of California to provide interactive, real-time Web-based access to eligibility, share of cost, spend down, and drug pricing information as well as the ability to submit all claim types and access remittance advices through the Web.
2000	interChange HIPAA Compliance Services Introduced	EDS implemented a suite of tools and services to manage HIPAA assessment and compliance activities. Eighteen Medicaid clients use these services.
2001	Adaptable in Program Change Requirements	EDS Completes 16 successful year 2000 conversions in the Medicaid industry.
2002	First Certified Client/Server MMIS for a Large Medicaid Program	Texas *Compass21* was the first client/server MMIS to receive CMS certification for a program that processes more than 50 million claims per year.
2002	First Certified HIPAA-Compliant MMIS	EDS implemented the first HIPAA-compliant MMIS in the country for Delaware Medicaid.

Figure 007_05_02_0203

In addition to our award-winning technology and innovation, our reputation rests upon our experience that is unmatched in the industry.

Planning for the Next Generation MMIS

The state of Vermont is taking the lead in working with CMS to design the next generation MMIS. The next generation MMIS will provide vastly improved capabilities for connecting consumers to programs, reflecting the exciting 21st century world of the digital state. The next generation of the MMIS is one of the most discussed topics in Medicaid today:

- An article in the November 2002 issue of the *MMIS Messenger* described the first MMIS summit, which was held in Vermont and led by Chairperson of the State Technology Advisory Group (STAG) and Commissioner of Medicaid Pat House. The summit was called, in part, because Ms. House and her MMIS staff want the design for the new MMIS to capitalize on Internet technology advancements.
- In that same issue of the *MMIS Messenger*, the writer of another article stated that future health care systems must include "key features that are designed to facilitate the flow and exchange of critical information throughout the Medicaid business enterprise and to promote leveraging of information resources between Medicaid and other programs that serve the same populations."
- At the Medicaid conference in Hunt Valley, Maryland, in the Fall of 2002, the MMIS Re-Design Work Group stated that CMS' Medicaid Information Technology Architecture (MITA) must bring the following functions:
  - Monitor and assess trends in Medicaid delivery of care, expenditures, and outcomes
  - Guide prevention and intervention programs
  - Inform Medicaid policymakers
  - Identify issues that need to be researched further, including additional data collection and analysis
  - Provide information for community and program planning
  - Protect confidentiality while providing information to those who need to know
  - Enhance quality of care through better feedback to providers and users
  - Provide information sharing instead of data sharing only
  - Ensure HIPAA compliance
  - Standardize data across agencies and nationally
  - Conduct real-time claims processing

EDS is working with Medicaid clients across the country to realize many of these objectives **now**. For example, a number of the objectives for enhanced use of Web/Internet capabilities are being implemented today for our Medicaid clients in Oklahoma, Kansas, California, and Indiana. For more information about our approach to the Internet optional enhancement, please refer to our response to RFP requirement 2.8.3.1 in the "Work Plan and Schedule (Enhancements/Modifications)" subsection of Section J: "Enhancements/Modifications Narrative."

With EDS continuing to support and enhance the VermontAIM, the state will not have to wait for CMS to finalize the MITA. You can realize many of these benefits with the VermontAIM in the next contract period.

Breadth and Depth of Medicaid Experience

Making Our Clients Successful

We implemented the first fully HIPAA-compliant MMIS for the state of Delaware.

Our experience in ensuring states achieve regulatory compliance in areas such as HIPAA and in incorporating new technology such as Web-enabled provider enrollment or document imaging allows us to leverage lessons learned for the benefit of all of our Medicaid clients.

In fact, we are the first to have successfully implemented and operate a fully HIPAA-compliant MMIS, in 2002 for the state of Delaware. Chief Administrator, Delaware Heath and Social Services, Division of Social Services Kay Holmes had this to say about the Delaware HIPAA achievement:

> "Thanks to EDS, the Delaware MMIS met the new HIPAA requirements a full three months ahead of the deadline. The work EDS has done in assuring Delaware is HIPAA-compliant in transaction and code set rules assures HIPAA readiness for the Delaware Medical Assistance Program and eases the transition to HIPAA for Delaware providers and managed care organizations."

We met the requirements three months before the original HIPAA deadline. The following graphic illustrates the breadth and depth of our experience.

Broad Experience in the Medicaid Industry

States	AL	AR	CA	CO	CT	DE	FL	GA	ID	IN	KS	KY	LA	MA	MI	MO	MS	NC	ND	NH	NM	NY	OK	OR	PA	RI	TN	TX	VA	VT	WA	WI	WY
Facilities Manager	●	●	●		●	●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		●	●	●	●
Medicaid Management Information System	●	●	●	●	●	●	●	●	●	●	●	●	●			●	●	●	●	●	●		●			●	●	●	●	●	●	●	●
Fiscal Agent	●	●	●		●	●	●	●	●	●	●	●	●			●	●	●		●	●		●			●	●	●		●		●	●
System Design and Development	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Large-Scale Transfer	●	●	●		●	●		●	●		●	●	●			●	●	●	●	●	●		●	●	●	●	●			●	●	●	●
Large-Scale Turnover	●		●	●			●			●	●	●	●			●	●		●		●			●			●				●	●	●
Implementation	●	●	●		●	●		●	●	●	●	●	●	●	●	●		●	●	●	●	●	●	●	●	●	●	●		●	●	●	●
Health Benefits Manager/ Enrollment Broker						●		●		●	●	●					●	●		●						●	●	●				●	
Medicaid Fraud and Abuse Detection			●								●												●		●			●					
Children's Health		●	●			●		●			●											●	●		●			●		●			
Eligibility System for all State Programs														●	●																		
Hospital Cost Settlement															●													●					

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The Department of PATH can be confident that we will mitigate program risks, meet operational capacity needs, and present new ideas based on our broad portfolio of Medicaid experience.

EDS

We have implemented 28 MMISs and currently provide Medicaid-related services for 26 state Medicaid programs across the country. We have extensive client/server experience, having implemented certified client/server MMISs in Vermont (1993), Rhode Island (1993), New Hampshire (1993), Indiana (1994), Idaho (1997), and Texas (2001).

We recently implemented certifiable client/server MMISs in Delaware and Oklahoma. In fact, our Oklahoma team just completed a successful 27-month MMIS implementation, meeting all milestones and coming in under budget. The Oklahoma MMIS is both HIPAA- and Administrative Simplification Compliance Act-compliant and will be implemented in Kansas, Pennsylvania, and Tennessee in 2003 and 2004.

Partnering for a Successful Implementation

"Our client worked side-by-side with EDS in a total partnership, making this large-scale MMIS implementation successful."

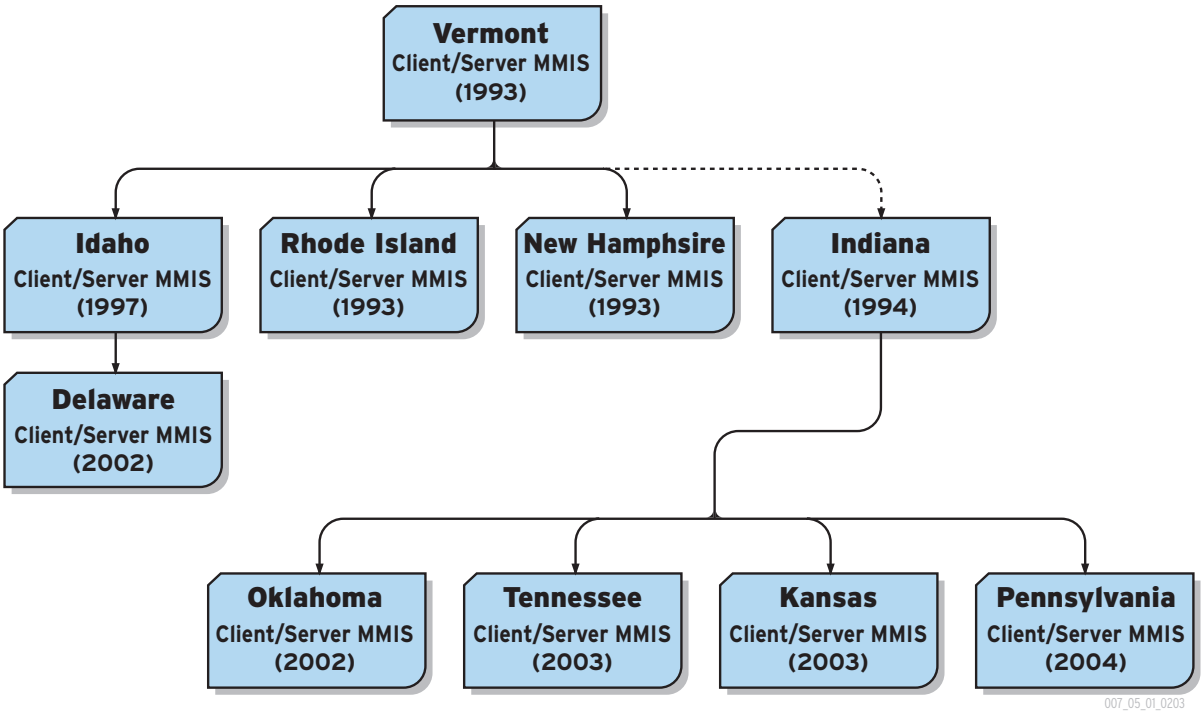
--Marc VanDenbark
Client Delivery Executive
EDS Oklahoma Medicaid

Our client/server MMIS supports both current and future needs. It is designed to provide quicker access to more information and flexibility to easily manipulate data to make it meaningful. Users are able to access data from desktops using online inquiries via user-friendly windows, perform ad hoc database searches, and create desktop reports. This capability matches your desire for an MMIS that builds upon business needs, thereby connecting beneficiaries to programs and state employees with relevant, meaningful information.

The EDS Medicaid client/server offering started with the VermontAIM replacement system that went live in 1993. From this initial client/server system, nine other client/server MMISs have evolved.

The following exhibit illustrates the generations of the client/server MMISs, all of which started with the VermontAIM. Dates reflect when each client/server system became active. To satisfy the requirements of the mandatory and optional enhancements and modifications, we are transferring several functions from later versions (the Delaware and Oklahoma systems) of the client/server MMIS that started in Vermont.

Vermont's Client/Server MMIS Heritage



Vermont led the way for implementing the client/server MMIS. For more than 10 years, EDS has designed, developed, and implemented state-of-the-art client/server Medicaid systems.

We currently perform a variety of tasks for our Medicaid-related state clients. Partnering with our clients in each of these states has permitted us to be responsive to their current and future needs. We have performed 40 system replacements and eight MMIS takeovers. We are in the process of implementing our CMS-certified interChange client/server MMIS in Kansas, Pennsylvania, and Tennessee.

We use the name "interChange" to identify all of our client/server MMISs that we have implemented since 2000. The client/server interChange MMIS integrates with other interChange Government Health Portfolio offerings such as the decision support system. It combines interactivity, flexibility, access to information, and responsiveness. It provides e-business capabilities for online eligibility, real-time claims status, and interactive submission of all claim types as well as compliance with HIPAA security requirements for electronic health care data.

Through numerous implementations, we have gained valuable experience and insight, which has been incorporated into our project management methodology and change management approach. Change can be stressful, and EDS works to minimize the negative aspects of change by assuring that key stakeholders are familiar with system changes early. Our approach to managing change, coupled with an effective communication plan, has repeatedly been successful.

Our training plans detail the support necessary so that all users can take full advantage of new tools and processes resulting in program efficiency and effectiveness. Intelligent integration of technology, design, and architecture brings a next generation MMIS that is unique in its innovation, stability, and reliability. It positions the Department of PATH to address not only today's challenges but also future needs.

Innovation and Cost Containment for Vermont

We have continuously worked with the Department of PATH over the years to identify areas of cost containment and innovation. The judicious use of every Medicaid dollar is imperative with today's reality of budgetary cuts and constraints. The implementation of the innovative VermontAIM in 1993 is a prime example of innovation. In 2002, we initiated a cost savings study to recommend savings to the Medicaid program. We consulted several other EDS Medicaid states to develop a list of potential savings for Vermont to consider. Our list represented more than $48 million in cost savings realized for Vermont and more than $55 million in potential savings ideas. Several of these recommendations have been implemented for Vermont such as the J-code processing and biannual provider recertification.

Saving Vermont Medicaid Money

The addition of J-code processing to the VermontAIM thus far has resulted in an additional $204,000 in drug rebates.

Optimizing Drug Rebate

Leveraging the experience of other EDS Medicaid teams, we determined that the OVHA might be able to save significant benefit dollars through the collection of additional drug rebates. We discussed the idea with you and then implemented the J-code processing as part of the VermontAIM. This implementation resulted in an additional $204,000 in drug rebates. We also added a pharmacist consultant, at no additional cost, who oversees our drug rebate collection activities and advises us on best practices in this area.

Vermont Medicaid Data Warehouse

Another example of our innovation is the Enhanced Vermont Ad Hoc (EVAH) system we installed in 1998. This new ad hoc system uses BusinessObjects query software to simplify the state's needs for specialty reporting. EVAH allows rapid, efficient access to the wealth of information captured from the MMIS. The system also provides a link to a geographical information system called MapInfo, which allows program managers to present their data in a map format. Mapping has proven very useful when discussing topics such as availability of care or distribution of beneficiaries in different counties or regions. This capability is one excellent example of fulfilling a business need with easy-to-use graphical information.

A Reliable Solution

When a competitor's data warehouse project came up short, Vermont turned to EDS to expand its ad hoc reporting system with data warehouse capabilities.

We were not awarded the Vermont decision support system contract. When the winning contractor experienced a number of delays, you asked us to add an enhancement to the existing ad hoc system. The resulting system, which was EVAH, was so successful that it became the OVHA's decision support tool.

In fact, EVAH's success has extended beyond the Medicaid agency, and it now serves eight other agency user groups:

- Department of Developmental and Mental Health Services
- Attorney General's Office
- Department of Dental Health
- Department of Health
- AIDS Medication and Prevention Office
- Planning and Evaluation Division
- Department of Aging and Disabilities
- Commissioner's Office

The BusinessObjects application will soon become even more valuable if the state chooses the optional enhancements included in Amendment 1. Our team is currently designing an enterprisewide recipient database. When this database is complete, it will span all state-funded recipient programs and be available for reporting using BusinessObjects.

Award-Winning Transition

At Vermont's request, we established a state-run PCCM in less than four months and enrolled providers to care for 65,000 beneficiaries. The success of the program was recognized with the Human Service Commissioners Award for service.

Vermont Medicaid Primary Care Case Management: Leveraging Experience to Promote Client Access

In June 1999, Kaiser Permanente, one of the companies providing managed care coverage to Vermont Medicaid beneficiaries, announced its plan to withdraw from the Northeast Region. Shortly thereafter, Blue Cross/Blue Shield of Vermont announced it would not be renewing its managed care contract for Medicaid beneficiaries. In light of this, Vermont Medicaid officials asked EDS to create a primary care case management program (PCCM) to help provide health services for about 65,000 Vermont Medicaid beneficiaries.

In less than four months, we were given the following challenge:

- Create and implement a process in which to pay a monthly per-member-per-month administrative capitation to each provider enrolled as a primary care provider
- Recruit and enroll primary care providers to participate in the program
- Use Vermont Interactive Television to train all participating providers
- Train and assist the member services staff to seamlessly transition all beneficiaries from the two managed care companies into the PC*Plus* program

To ensure a successful transition, our employees contacted our Idaho Medicaid team to understand how EDS' processing system was used and to adopt that account's best practices to absorb beneficiaries into the state-run system in the short time frame. Client Delivery Executive Barbara Davis said, "We wanted to make sure we had a clear insight. The Idaho Medicaid team faced some of these problems, and we wanted to make sure to leverage that experience and avoid any foreseeable issues."

The success of this program prompted our customer to nominate the PC*Plus* transition and enrollment team for the Human Service Commissioner's Award for service in 1999, which we were subsequently awarded. We will strive to continue to provide you with the same level of proactive service, innovation, and fiscal vigilance.

EDS Goals That Are Relevant, Closely Related, or Will Complement This Project

RFP Reference: 3.2.2.5.1(j), p 3-8

Our corporate goals coincide with the goals of the Department of PATH and this project. We are the leading global services company, providing strategy, implementation, and business transformation and operational solutions for clients like you who are managing the business and technology complexities of the digital economy. Your desire to have an MMIS that builds upon business needs is a clear articulation of your focus, and your vision of the digital state reflects your particular portion of the digital economy.

Our corporate vision is simple yet distinctive, and it is focused on how we deliver value to our clients:

"EDS … the recognized global leader in ensuring clients achieve superior value in the Digital Economy…

- By delivering the right strategies, solutions and services
- Through superior execution on a sustained basis."

We understand that, as a service company, EDS is defined almost entirely by what its employees do and say each day. You have witnessed this daily dedication for the past 21 years. In the following paragraphs, we have identified the EDS core beliefs that are deeply embedded in our culture and add value to Vermont and other EDS clients.

Our Service Excellence

Just as you strive for excellence in your service to your various stakeholders, we do the same. For EDS, Service Excellence embodies the never-ending pursuit of excellence in services and solutions that support our clients' success. We promote service excellence in many ways.

We see our Service Excellence as critical in making our service performance a competitive distinction for our clients and our potential clients. It is the thread that binds together our corporate culture, values, people, and other components that make up EDS. Through Service Excellence:

- Client-specific performance concerns stay highly visible to EDS executives
- Client issues are addressed quickly
- Client and EDS teams work as one

Service Excellence is about establishing and maintaining an open, active, and trusting relationship with our clients such as you. It is the visible corporate, and more importantly our Vermont team's, statement that we take pride and ownership in the solutions and services we provide to the Department of PATH and other Vermont Medicaid stakeholders.

We measure and communicate our performance through the **Service Excellence Dashboard**, an internal Web-based tool we use to provide a real-time, graphical report of our delivery performance. The Dashboard provides a consistent and highly visible means of reporting the status of client relationships globally. All EDS managers have access to the Dashboard and review its information regularly. It allows them to monitor their peers needs and to offer additional assistance, thus leveraging the skills available throughout our company. Also, our clients have access to this dashboard and frequently make use of it.

An abstract of a May 10, 2002, article by Robert Goodwin for Gartner Dataquest, summarizes the Dashboard: "EDS' Service Excellence Dashboard promptly identifies and resolves clients' problems. A focal point for improving client satisfaction, it has been well-integrated into EDS culture and operations." We know that every member of our EDS team plays a key role in representing Service Excellence to you. Thus, in addition to the Dashboard, we also promote Service Excellence through our behaviors. By settling for nothing less than Service Excellence from our employees, we set ourselves apart from our competitors.

Our Values

Our values are based on our people because they are the foundation upon which EDS is built. Our corporate product is not a commodity. Rather it is service, which is provided by our employees.

We look for people who share our values and our vision. When we take care of our people and they share common beliefs and goals, then they can focus on the business. And when they focus, we do great things that add value for our clients and shareholders. The people of EDS live by a values system that guides our behavior toward our people, our clients, and our business:

- **Our People**—We provide a challenging and rewarding place to work; value and respect the individual; promote open, honest and candid communication; actively facilitate the flow of information and learning; and we operate as a collaborative community.
- **Our Clients**—As stated before, we ensure clients achieve superior value by delivering the right strategies, solutions, and services through superior execution on a sustained basis. To accomplish this goal, we provide service excellence; deliver on our commitments and display a sense of urgency to meet client needs; maintain long-term client relationships based on trust, respect, and mutual benefits; and lead the market in applying innovative solutions that increase the value of our client's business.
- **Our Business**—We conduct our business by applying the highest standards of ethical behavior and superior business judgment. By putting this principle into practice, we contribute to the growth of our clients and EDS; we are recognized as global thought leaders; and we welcome change and the growth opportunities it provides.

We apply our value system as we partner with clients like you, the Department of PATH. We work with you to form a single team to achieve your goals so that you are successful and are able to better serve your clients, the provider and beneficiary communities of Vermont. Our success is dependent upon your success.

Our Culture

Our culture is defined by the behaviors of our people. We have a distinctive culture—one of our key strengths. If our culture could be defined by a few attributes, those attributes would be:

- We get the job done.
- We care about people.
- We stick together and support each other.
- We set and keep high standards.
- We do not sit still.

Vermont has seen these attributes in action: before and during the 1992–1993 implementation of the VermontAIM and every day since.

Ethics and Business Conduct

EDS lives by its reputation. The integrity of our people is an essential part of the service excellence we deliver to our clients. Our values are what the people of EDS live by and they guide our behavior toward our people, our clients, and our business. We work to operate as a collaborative community. We ensure clients superior value by delivering the right strategies, solutions, and services through superior execution on a sustained basis. To accomplish this, we offer the following commitments:

- Provide service delivery excellence to our clients
- Deliver on our commitments and display a sense of urgency to meet client needs
- Maintain long-term client relationships based on trust, respect, and mutual benefit
- Lead the market in applying innovative solutions that increase the value of our client's business
- Use compelling industry insight to guide our direction and serve our clients

Ethical conduct is the way we protect our credibility as a company, establish respect, and earn the trust of our employees, partners, clients, and the community. We promote ethical leadership, ownership, and accountability to better serve our client partners such as the Department of PATH.

Our Communities

Our Vermont team is made up of individuals who live and work in Vermont. Because our employees are also members of the community, they take their responsibility to give back to the community and improve it very seriously. Their actions demonstrate their commitment to Vermont and its citizens, not only at work but through their community involvement. In addition, we strive to provide economic growth for the community by using local vendors whenever possible.

Community involvement activities do more than improve the neighborhoods in which we live. As a result of this involvement, we strengthen our business by building relationships, supporting diversity and employee recruiting, improving company image, and promoting positive employee morale. As part of a corporate grant program, we award three $1,500 technology grants to Vermont schools each year. These grants assist teachers in bringing innovative information technology products into the classroom to enrich the students' learning experiences and prepare them to be productive in the digital world.

Demonstrated Vermont Commitment

"I just wanted to thank you again for everything! My students had a fantastic time today at the State House, and it was great for them to meet not only Governor Douglas but also their state representative and senator. We bought the microscope and laptop today, and many folks in the room were about to check it out first hand."

--Bob Stone,
2003 EDS technology grant recipient,
Westminster Center School

Each year, our employees make a difference in their communities through Global Volunteer Day. This day gives us the chance to perform volunteer projects and give back to our communities. In 2002, EDS employees assisted with a Haunted Forest, with proceeds benefiting the Vermont Youth Orchestra. In 2001, we spent Global Volunteer Day assisting the Vermont Respite House with multiple tasks, such as painting, making repairs, and doing yard work.

Our community efforts go far beyond Global Volunteer Day. EDS personnel in Vermont have supported such diverse organizations as the following:

Serving and Supporting Our Community

"It is always so significant when people in our community join the fight against hunger by becoming involved with the Food Bank, which is what EDS has done. It means a great deal to the Food Bank and to the community."

--Deborah Flateman
Vermont Food Bank CEO

- **Vermont Food Bank—**The EDS Vermont team made one of the largest donations received during the recent food drive for this organization. We collected and donated more than 890 pounds of food for Vermont's needy.
- **Chittenden County United Way Program—**Our team has supported the United Way program for several years, raising more than $7,200 over the past four years. As a result, we were awarded the Bronze Award for Outstanding Service.
- **AIDS Ride for the Cure—** Carrie Marchant, one of our systems engineers, completed a 490-mile bike ride from Montréal to Portland, Maine, last fall to raise money and awareness for a cure for AIDS. She joined more than 2,000 cyclists and raised more than $3,500 for AIDS research.
- **SERVE—**Barbara Davis has been the distribution coordinator for the Barre SERVE program, which is a volunteer organization that distributes food to families in need locally. The focus of the organization is on eliminating world hunger.
- **Cochran Ski Area—**Bob Randall, one of our systems engineers, heard that a Richmond, Vermont ski area was having difficulty attracting skiers. So, he volunteered to help them by designing, developing, and maintaining its local non-profit ski area Web site. It can be viewed at http://www.cochranskiarea.com.
- **Boy Scouts—**Chris Haskins, another EDS employee, organized a "Jean Day" at our facility to raise money so that a local Cub Scout pack could purchase the materials needed to build a float for the Richmond Fourth of July parade.
- **Vermont Youth Orchestra—**Seventeen members of our staff supported the Haunted Forest this past Halloween to raise funds for the Vermont Youth Orchestra. They served refreshments, conducted tours, and painted scenes for the event.
- **Christmas Sponsors for Williston Family—**Our entire team "adopted" a mother and her two young sons for a Christmas celebration. We organized the gift selections and wrapping and delivered a complete holiday dinner and a car full of gifts.
- **March of Dimes—**For the past four years, we have participated in the annual March of Dimes Walk in Burlington to raise money to help prevent birth defects. Since 1999, we raised approximately $4,800 through sponsorships, walking, and holding special raffles at the EDS facility to support this worthy cause.

This list is not complete, but it demonstrates that we believe in strengthening and giving back to the communities in which we live and work.

HMS Capabilities

We are pleased to provide the requested corporate capabilities information for HMS, the subcontractor we will use if the state selects the TPL optional enhancement. As a member of our team, HMS represents significant added value for Vermont. We include background information of the company and its size and resources (items a through h) in the following table. We then provide performance history and reputation (item i) and relevant goals that are closely related or will complement this project (item j).

Health Management Systems

RFP Requirement	Response
Date established	1974
Location of principal place of business	401 Park Avenue South New York, NY 10016
Location of the place of performance of the proposed contract	312 Hurricane Lane Williston, Vermont 05495
Type of ownership (e.g., public company, partnership)	HMS' parent company, HMS Holdings Corp., is publicly held (NASDAQ: HMSY)
Subsidiaries or wholly owned business units	HMS is a wholly owned subsidiary of HMS Holding Corp.
Total number of employees	125 employees
Number of personnel engaged in computer systems operation and development	25 employees (In addition, HMS uses the expertise of three consultants and also taps the information technology resources of HMS Holdings Corp., which has approximately 30 development and operations staff members.)
Number of personnel currently engaged in MMIS systems development and operation	N/A (Although HMS' main line of business is not the development and operation of the MMIS, its Medicaid projects require frequent interaction with MMISs.)

HMS Performance History and Reputation

RFP Reference: 3.2.2.5.1(i), p 3-7

HMS concentrates on providing revenue recovery services to a variety of health care institutions and agencies using state-of-the-art information management and processing technology. HMS is a pioneer in applying information management techniques to enhance client recoveries and reduce program and administrative costs.

Through the development and application of information, analytics, and process enhancements, HMS provides strategic advantage to its clients across the adjudication continuum. HMS offers the following core competencies to its clients:

- Capacity to aggregate, purify, and enhance massive volumes of data from varied and nonintegrated sources—Provides ever-increasing value to clients as they seek to control and gain insight from the broadest spectrum of detailed data possible
- Capacity to design and apply proprietary analytics—Permits the gaining of retrospective, prospective, and concurrent insights from client data to maximize recoveries and improve processes
- Capacity to produce mission-critical information impacting financial health and quality of operations—Facilitates the realization of strategic value from the client's own data

As a health care data integrator and information manager, HMS annually produces 15 million Medicaid reclamation claims. HMS proudly owns and operates all of its data processing equipment and systems.

Through its work on behalf of 30 state Medicaid agencies, HMS brings unique and critical experience and knowledge of TPL identification and recovery, revenue maximization, and cost savings for its clients:

- **Proven methodologies**—HMS methods combine data analytics and algorithms to effectively determine overpayments.
- **Sophisticated IT systems**—HMS information technology systems can capture and control claims data.
- **Extensive expertise**—HMS staff is skilled in reimbursement consulting and health care regulatory environments.

Demonstrated Innovation and Recovery Capability

HMS pioneered the use of the Medicare Enrollment Database and Medicare Adjudicated Claims roles to increase third-party recoveries from Medicare by more than $80 million.

HMS is a pioneer in the application of information management techniques to enhance client recoveries and reduce program and administrative costs. The following list identifies HMS' most notable achievements:

Proven Cost Avoidance Savings

HMS has generated more than $2 billion in cost avoidance savings for its Medicaid state agency clients.

- HMS has provided revenue recovery services for health and social service agencies in 30 states and the CMS.
- HMS has recovered $1.7 billion for clients using its specialized revenue recovery services. **HMS is the first vendor to reach and exceed the $1.0 billion mark for recoveries**.
- HMS has an unparalleled network of insurance carrier databases, which provides the largest source of third-party coverage identification and recovery. HMS' in-force agreements represent an average of 85 percent of the health insurance universe in client states.
- HMS is the only revenue recovery vendor to help states obtain Medicare adjudicated claims data and perform recovery projects using those data, resulting in more than $50 million in recoveries.
- HMS is the only revenue recovery vendor that has a systematic process for claims follow-up and the only vendor with dedicated staff assigned to this process.
- HMS is the only revenue recovery contractor that has a staff unit dedicated to ensuring effective provider relations, resulting in greater provider cooperation and higher recovery levels from its disallowance and specialized overpayment recovery projects.
- As the national leader in third-party coverage verification and cost avoidance, HMS has generated more than $2 billion in cost avoidance savings for its Medicaid state agency clients by identifying and verifying more than 750,000 insurance policies.
- HMS submits 80 percent of Medicaid TPL claims through various electronic platforms, including custom carrier interfaces that HMS has developed, WebMD Transaction Services, and Companion Technologies (the CHAMPUS/TRICARE claims clearinghouse).
- HMS is the first contractor to perform electronic billings to pharmaceutical benefit managers (PBMs). Approximately 80 percent of the pharmacy claims that HMS bills go to PBMs. In addition, **HMS has more than 10 years of experience billing National Council for Prescription Drug Programs (NCPDP) claims and currently bills approximately 63 percent of its pharmacy claims in this format.**
- HMS has established detailed verification processes to confirm the accuracy of the third-party coverage it reports. HMS verification protocols include obtaining data through telephone calls to carriers and performing online coverage verification through electronic linkages with 21 carriers.
- HMS performs a full array of revenue recovery activities, including on-site provider reviews, Medicare coordination of benefits, specialized overpayment recovery projects, and federal financial participation (FFP) enhancement projects.

HMS will leverage its unique knowledge of the complexities of third-party recovery (TPR) operations with EDS' expertise to continue increasing TPR cost avoidance and recoveries. Additionally, HMS will apply successful approaches used in 30 other states where it supports recovery of third-party resources. The following table shows a breakdown of TPL recoveries by state through December 2002.

HMS TPL Recoveries

State/Entity	TPL Recovered ($ million)
Arizona	$21.91
Arkansas	$9.80
California	$55.36
CMS (HCFA)	$1.30
Colorado	$34.06
Connecticut	$110.94
District of Columbia	$35.43
Florida	$137.75
Georgia	$17.35
Illinois	$25.00
Indiana	$50.24
Iowa	$83.59
Kentucky	$26.27
Louisiana	$165.26
Maine	$15.33
Maryland	$67.64
Massachusetts	$120.78
Michigan	$37.04
Missouri	$54.20
New Jersey	$371.70
New York	$49.54
Ohio	$114.16
Oklahoma	$1.20
Pennsylvania	$62.51
South Carolina	$0.73

State/Entity	TPL Recovered ($ million)
Virginia	$80.52
West Virginia	$7.16
Total	**$1,756.77**

HMS currently performs TPR projects under subcontract to EDS in Indiana, Kansas, and Delaware. HMS currently performs or has performed TPR projects under direct contract to Medicaid agencies in the following states where EDS is the Medicaid fiscal agent: Connecticut, Pennsylvania, California, Oklahoma, Georgia, and Arkansas. Hence, HMS has extensive knowledge of the various EDS MMIS data file structures and layouts needed to perform accurate and timely TPR services for Vermont.

HMS Goals That Are Relevant, Closely Related, or Will Complement This Project

RFP Reference: 3.2.2.5.1(j), p 3-8

HMS distinguishes itself from competitors through an unequaled ability to recover on the broadest range of claim types, including inpatient, outpatient, physician, long-term care, home health, pharmacy, mental health, managed care, and Medicare crossover claims. Furthermore, HMS bills Medicaid reclamation claims to a wide range of third-party resources, including all major commercial carriers, many Blue Cross/Blue Shield Plans, TRICARE/CHAMPUS, Medicare Parts A and B, HMOs, PPOs, workers' compensation carriers and plans, and various Federal Employee Plan (FEP) participating carriers.

Sensitive to the fact that many states are experiencing escalating health care expenditures, and at the same time, facing severe budget constraints, HMS is rapidly developing expertise in the field of federal revenue maximization. HMS is developing a variety of revenue maximization and cost avoidance projects to optimize retrospective and prospective federal revenues for state Medicaid agencies.

In every state where HMS has succeeded other vendors, it has flattened the learning curve commonly associated with operational start-ups. And, in states using an external TPR contractor for the first time, HMS has implemented revenue recovery projects rapidly and efficiently. HMS looks forward to applying its successful TPR practices to generate maximum coverage identification and recoveries for you in partnership with EDS.

EDS Subsidiaries

The following table lists EDS subsidiaries around the world.

Location	Subsidiary Name
Argentina	A.T. Kearney Argentina S.A. Electronic Data Systems (EDS) de Argentina S.A. Unigraphics Solutions International Inc Sucursal Argentina
Australia	A. T. Kearney-CoNext Australia Pty Ltd A.T. Kearney Australia Pty Ltd Cyberlynx Procurement Services Pty Limited EDS (Australia) Pty Limited EDS (Australia) Superannuation Fund Pty Ltd EDS (Business Process Administration) Pty Limited EDS (Operations) Pty Limited EDS (Queensland) Pty Ltd EDS (Services) Pty Ltd. SDRC Australia Pty. Ltd. The Lacek Group Pty Ltd. Unigraphics Solutions (Australia) Pty Ltd
Austria	A.T. Kearney Ges.m.b.H Electronic Data Systems (EDS Austria) GmbH Unigraphics Solutions (Austria) GmbH
Bahrain, State of	EDS Gulf States, WLL
Bangkok, Thailand	A.T. Kearney (Thailand) Limited
Barbados	Engineering Animation FSC, Inc. Systemhouse (Barbados) Inc.

Location	Subsidiary Name
Belgium	A.T. Kearney NV EDS Defense N.V. EDS-Scicon N.V. Electronic Data Systems Belgium N.V. Fin-Force N.V. Management Computer Equipment S.A. Memorex Telex Consulting S.A. SDRC Belgium SA/NV SHL Systemhouse Belgium N.V. Systematics N.V. Unigraphics Solutions N.V.
Bermuda	A.T. Kearney (Bermuda), Ltd. IGBF, Ltd. Ward FSC, Ltd
Brazil	A.T. Kearney Ltda. EDS Desenvoluimento de Productos Ltda. EDS-Electronic Data Systems do Brasil Ltda Interchange Servicos SDRC Brazil Ltda. Unigraphics Solutions do Brasil Ltda.
Canada	502300 New Brunswick Inc. A.T. Kearney Ltd. Cognicase E.D.S. Canada Leasing Ltd. EDS Canada Inc. EDS Finance Partnership (Canada) L.P. Insurance Software Solutions Corp. (dba SOLCORP) SHL Subco 1 Inc. SHL Subco 2 Inc. SHL Subco 3 Inc. SHL Subco 4 Inc. SHL Subco 5 Inc. SmartHealth Inc. Spectra Securities Software Inc. Teramira Holdings, Inc. Unigraphics Solutions Canada Ltd.

Location	Subsidiary Name
Cayman Islands	EDS Strategic Funding Ltd.
Chile, Republic of	Electronic Data Systems Chile, S.A.
China	A.T. Kearney (Shanghai) Management Consulting Co. Ltd. EDS (China) Co., Ltd. Unigraphics Solutions (China) Co., Ltd.
Colombia	Electronic Data Systems Colombia, S.A.
Costa Rica	Electronic Data Systems (EDS) de Costa Rica S.A.
Czech Republic	EDS, s.r.o. Unigraphics Solutions s.r.o.
Denmark	A.T. Kearney A/S EDS Danmark A/S Unigraphics Solutions Danmark A/S
Dominican Republic	Electronic Data Systems (EDS) Dominicana, S.A.
Ecuador	Electronic Data Systems (EDS Ecuador) CIA, LTDA
Egypt	Citymax Egypt SAE Electronic Data Systems (Egypt) SAE
England	3301942 Media Accounting Services Limited A.T. Kearney Limited Citymax Integrated Information Systems Ltd. Citymax RA Limited Clarion Training Limited COGSYS Limited Computer Marketing Ltd. Computers North East Limited DVOIT Limited E.D.S. International Limited eBreviate UK Limited EDS (Electronic Data Systems) Limited EDS 1994 Trustee Limited EDS Credit Services Limited EDS Defence Limited EDS Europe EDS Finance plc EDS Nominees Limited

Location	Subsidiary Name
	EDS Secretarial Services Limited EDS Trustee Limited EDS UK Limited Eisis Limited Electronic Data Systems Limited GeoVision Systems Limited Memorex Telex UK Limited Planning Consultancy Ltd. S. F. Services S.D. International Limited Scicon Arabia Limited Scicon Limited SD-Scicon Europe Limited SDRC UK Limited SHL Outsourcing Services (UK) Limited SHL Systemhouse Europe Limited SHL Systemhouse U.K. Limited SHL Technology Solutions Limited Spartan Funding Company Strategem Ltd. Systems Designers Aviation Limited Systems Designers Estates Limited Systems Designers Limited Systems Programming Limited Systems Programming Overseas Limited Trans-Act Limited Transaction Systems Limited Unigraphics Solutions Limited Universal Money Systems Wolsingvale Limited
Finland	A.T. Kearney Oy EDS Finland Oy Ab

Location	Subsidiary Name
France	A.T. Kearney (S.A.S.) eBreviate SARL EDS (Electronic Data Systems) France S.A.S. EDS Answare S.A. EDS EPSYDRE S.A. EDS Ingevision S.A. EDS Progical S.A. Inso France Development S.A. Kearney Interactive SAS La Francaise De Maintenance SCS (“LFM”) Memorex Telex Assistance SARL Memorex Telex France S.A. SDRC France S.A. Unigraphics Solutions France SAS
Germany	A.T. Kearney GmbH Active Logistics GmbH Andante Computer Vertriebs GmbH BEANS AG BOG Koblenz GmbH BOG Logistik GmbH Consulting Innovation & Technology AG e-Gent GmbH eBreviate Gesellschaft mit beschranker Haftung EDS Consulting GmbH EDS Customer Care Services (Deutschland) GmbH EDS Deutschland GmbH EDS Electronic Data Systems Berlin GmbH EDS Gesellschaft für Online-Dienste mbH EDS Holding GmbH EDS Schweinfurt GmbH EDS Systematics Beteiligungs GmbH EDS Vermögensverwaltungs GmbH & Co. KG EDS Verwaltungs GmbH EDS-Padcom Clinical Research Beteiligungs GmbH Eucarnet GmbH GHP GmbH

Location	Subsidiary Name
	Industrie Software-Systementwicklungs GmbH & Co. KG (ISE KG) Info Ware GmbH IQproducts GmbH Memorex Systemhaus GmbH move It solutions AG MSH International Service AG Padcom Clinical Research GmbH PlanOrg AG PlanOrg Info Beteiligungs GmbH PlanOrg Info GmbH & Co. KG PlanOrg Informatik GmbH PlanOrg IT Services Beteiligungs GmbH PlanOrg IT-Services GmbH & Co. KG PlanOrg IT-Systeme GmbH PlanOrg Medica GmbH Pyra GmbH SDRC Software & Services GmbH SDT Industrie-Leasing GmbH (SDT) Sherpa Systems GmbH & Co. KG Sherpa Systems Verwaltungs GmbH SPMV Unternehmensberatung STS Spektrum GmbH Systematics AG Systematics Communications GmbH Systematics INTEGRATONS Gesellschaft für EDV-Dienstleistungen mbH Systematics Network Services GmbH Unigraphics Solutions GmbH web@active GmbH Wnet Partner AG YIC AG
Greece	A.T. Kearney Monoprosopi Epe EDS International (Greece) SA
Guatemala	Electronic Data Systems (EDS) de Guatemala S.A.

Location	Subsidiary Name
Hong Kong	A.T. Kearney (Hong Kong) Limited EDS Electronic Data Systems (Hong Kong) Limited Systems Designers International Limited Transportation Community Network Ltd. Unigraphics Solutions (HK) Limited
Hungary	A.T. Kearney Kft. EDS Electronic Datasystems Hungary Limited
India	A.T. Kearney India Private Limited EDS-Electronic Data Systems (India) Private Limited SDRC India Pvt. Ltd.
Indonesia	P.T. Electronic Data Systems Indonesia PT A.T. Kearney PT Danamon-EDS Technology Services PT Indo-EDS Daya Selaras PT Unigraphics Solutions Indonesia
Ireland	EDS Financial Services Company (Ireland) Limited Electronic Data Systems (Ireland) Limited Memorex Telex Ireland Limited Neodata Services Limited Sarsfield Systems Limited SHL Systemhouse Ireland Limited Special Machine Services Limited
Israel	Electronic Data Systems (EDS) Israel, Ltd.

Location	Subsidiary Name
Italy	A.T. Kearney - Applications & Technology S.P.A. A.T. Kearney S.p.A. Agora s.r.l. Ar@ncia S.r.l. Basintel S.p.A. Database Tecnologie S.p.A. EAI Animation Italy S.r.L. EDS Electronic Data Systems Italia S.p.A. EDS Electronic Data Systems Italia Software S.p.A. EDS Pubblica Amministrazione S.p.A. Effe Sistemi S.p.A. ICCRA S.p.A. Istiservice S.p.A. M&DR Consultans Marketing and Data Research S.r.l. Nova Domus S.r.l. Roma Servizi Informatici S.p.A. SDRC Italia Srl Servizi ICT S.r.l. Sistemi Sanitari S.p.A. Unigraphics Solutions S.p.A.
Japan	A.T. Kearney K.K. Japan Network System Japan Systems Company Limited K.C.E. Company, Limited K.K. Nihon Game Cards Nippon EDS Company, Ltd. SDRC Japan K.K. Unigraphics Solutions Japan, Ltd.
Korea	EDS (Korea) Ltd. SDRC Korea Limited Unigraphics Solutions (Korea) Ltd.
Luxembourg	EDS Electronic Data System Luxembourg S.A.

Location	Subsidiary Name
Malaysia	EDS MSC (Malaysia) Sdn Bhd EDSCICON (Malaysia) Sdn. Bhd. Electronic Data Systems IT Services (M) Sdn. Bhd. UMW Holdings Berhad Unigraphics Solutions (Malaysia) Sdn. Bhd. UPE Systems Services Sdn. Bhd.
Mexico	A.T. Kearney, S.A. de C.V. E.D.S. de Mexico, Sociedad Anonima de Capital Variable Integradora de Servicios Central, S.A. de C.V. Integradora de Servicios S.A. de C.V. (ISSA) SDRC Mexico S. de R.L. de C.V. SHL Systemhouse De Mexico, S.A. DE C.V. Unigraphics Solutions de Mexico, S.A. de C.V.
Namibia	EDS Namibia (Proprietary) Limited
New Zealand	A.T. Kearney New Zealand Limited Databank Systems Limited EDS (New Zealand) Limited EDS (New Zealand) Pensions Limited GCS Limited
Nicaragua	Electronic Data Systems (EDS) de Nicaragua y Cia Ltda.
Norway	A.T. Kearney AS A.T. Kearney International AS EDS Norge AS Habberstad Consulting AS Unigraphics Solutions Norge AS
Panama	Electronic Data Systems (EDS) of Panama Corp. Keisai Panama, S.A.
Peru	EDS Electronic Data Systems del Peru S.A.
Philippines	EDS Electronic Data Systems (Philippines), Inc.
Poland	A.T. Kearney Sp. z.o.o. EDS Poland Sp. z.o.o. Unigraphics Solutions Sp.z.o.o.

Location	Subsidiary Name
Portugal	A.T. Kearney (Portugal) Consultadoria de Gestao Lda EDS-Electronic Data Systems Processamento de Dados Informaticos, Lda. Nova EDS-Petro, Electronic Data Systems de Portugal, Processamento de Dados Informaticos, Lda. Premida-Comércio, Gestao e Serviçios, Lda
Russia	OOO “Unigraphics Solutions”
Scotland	Systems Programming (Scotland) Limited
Singapore	A.T. Kearney Pte. Ltd. EDS International (Singapore) Pte. Limited SDRC Singapore Pte. Ltd. Unigraphics Solutions Pte. Limited
South Africa	A.T. Kearney (Proprietary) Limited ABS Application Systems (Pty) Ltd. ABS Computer Sales (Pty) Ltd. ABS Computer Services (Pty) Ltd. ABS Computers (Pty) Ltd. ABS Information Technology (Pty) Ltd. Atraxis Africa (Pty) Limited EDS Africa Limited EDS Enterprise Solutions Africa (Pty) Limited EDS South Africa (Pty) Ltd EDS Vanco (Pty) Ltd. Information Systems Solutions (Pty) Ltd. M&DY Corporation (Pty) Ltd. Oel Systems (Pty) Ltd. White House Consulting (Pty) Ltd. White House Midrange Services (Pty) Ltd. White House Technologies (Pty) Ltd. Wynberg Executive Travel (Sunninghill) (Pty) Ltd

Location	Subsidiary Name
Spain	A.T. Kearney, S.A. eBreviate S.L. Electronic Data Systems España S.A. Memorex Telex S.A. Rol. 20, S.A. SDRC España S.A. Unigraphics Solutions España, S.A.
Sweden	A.T. Kearney AB EDS Försvars Services AB EDS Sweden AB Habberstad Partners AB SDRC Svenska AB Unigraphics Solutions Sverige AB
Switzerland	A.T. Kearney (International) AG A.T. Kearney AG eBreviate GmbH EDS (Europe) S.A. EDS (Schweiz) AG EDS Information Business GmbH EDS Informatique S.A. SDRC AG (Switzerland) Systematics Soft Solution S.A. Systemhouse Internationale S.A. Unigraphics Solutions AG
Taiwan	A.T. Kearney Co., Ltd Unigraphics Solutions Asia Pacific Incorporated, Taiwan Branch
Taiwan, Republic of China	Electronic Data Systems Taiwan Corporation
Thailand	EDS Electronic Data Systems (Thailand) Co., Ltd. SV-EDS Technology Services, Ltd. Unigraphics Solutions (Thailand) Co., Ltd.

Location	Subsidiary Name
The Netherlands	A.T. Kearney B.V. eBreviate B.V. Electronic Data Systems (EDS) International B.V. Memorex Telex Nederland B.V. Memorex Telex Unirepair B.V. MIQ Consultants BV SDRC Nederland BV SHL Systemhouse Nederland B.V. Systematics N.V. (Netherlands) Unigraphics Solutions B.V.
Turkey	A.T. Kearney Yönetim Danismanlik A.S. EDS Electronic Data Sistemleri Ticaret Limited Sirketi
Uruguay	Edley S.A.
United States	A.T. Kearney International, Inc. A.T. Kearney Procurement Solutions, Inc. A.T. Kearney, Inc. E.D.S. International Corporation E.D.S. Spectrum Corporation E.D.S. World Corporation (Far East) E.D.S. World Corporation (Netherlands) EDS Asia Pacific Services Corporation EDS Digital Economy Fund LP (fka EDS/ATK Alliance Fund 2000 LP) EDS Digital Ventures, Inc. (fka EDS/A.T. Kearney Ventures, Inc.) EDS Global Services, Inc. EDS Information Services L.L.C. EDS Insurance Vermont, Inc. EDS Investment Fund, Inc. EDS Japan LLC EDS Properties Corporation EDS Resource Management Corporation EDS Technologies Corporation EDS Technologies Operations L.L.C. EDS Technologies Services L.P. EDS World Services Corporation EDS/A.T. Kearney Employee Ventures LP Legacy Receivables LLC

Location	Subsidiary Name
	National Heritage Insurance Company Trusco Services, Inc. Unigraphics Solutions Asia/Pacific Incorporated Unigraphics Solutions Inc. Unigraphics Solutions International Inc. Wendover Financial Services Corporation Wendover Funding, Inc.
Venezuela	A.T. Kearney de Venezuela, C.A. Electronic Data Systems de Venezuela “EDS” C.A. Keisai Asociados, C.A. SHL Systemhouse De Sur America, C.A.
Zimbabwe	EDS Zimbabwe (Pvt) Limited

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FINANCIAL STATEMENTS

RFP Reference: 3.2.2.5.2, p. 3-8

We are pleased to include annual reports for EDS and Health Management Systems, Inc. (HMS) for 1999, 2000, and 2001.

EDS Financial Information

The following table lists the page number of the report that contains requested information for EDS. Our 2002 annual report will be published in late April and we will provide a copy upon publication.

Cross-Reference of Requirements to EDS Annual Reports

RFP Requirement	2001 Annual Report	2000 Annual Report	1999 Annual Report
Statement of income	Page 26	Page 20	Page 20
Balance sheet	Page 27	Page 21	Page 21
Statements of changes in financial position during the last three years	Page 29	Page 23	Page 23
Statement of cash flow	Page 29	Page 23	Page 23
Auditor's reports	Page 25	Page 19	Page 19
Notes to financial statements	Page 30	Page 24	Page 24
Summary of significant accounting policies	Page 30	Page 24	Page 24

Online and downloadable versions of our annual reports are available for the years 1998, 1999, 2000, and 2001 at www.eds.com/investor_relations/ir_annuals.shtml.

Our financial statements for the past 10 years are available online at www.eds.com/investor_relations/ir_fin_overview.shtml.

Health Management Systems Financial Information

Following the EDS annual reports, we include annual reports for HMS for years 1999, 2000, and 2001. The following table lists the page number of the report that contains requested information for HMS.

Cross-Reference of Requirements to HMS Annual Reports

RFP Requirement	2001 Annual Report	2000 Annual Report	1999 Annual Report
Statement of income	Page 32	Page 32	Page 31
Balance sheet	Page 30	Page 30	Page 29
Statements of changes in financial position during the last three years	Page 32	Page 33	Page 32
Statement of cash flow	Page 33	Page 34	Page 33
Auditor's reports	Page 29	Page 29	Page 28
Notes to financial statements	Page 34	Page 35	Page 34
Summary of significant accounting policies	Page 34	Page 35	Page 34

EXPERIENCE AND REFERENCES

RFP Reference: 3.2.2.5.3, p. 3-8

Experience in Vermont for more than 21 years is one of our strongest qualifications for continued support of the Vermont Medicaid and other Department of PATH programs. **References** for our own work and the work of Health Management Systems, Inc. (HMS), our proposed subcontractor, will demonstrate the satisfaction clients have for our fiscal agent and MMIS design, development, and operation services.

We provide information about the relevancy, breadth, and depth of experience, which is followed by our response to RFP-requested references and experience information for both EDS and our subcontractor. The major subsections for this section include the following:

- Reference Information (EDS followed by HMS)
- State of Vermont Contracts
- Contract Terminations

Relevancy, Breadth, and Depth of Experience

EDS is the largest provider of information technology and process management services to the health care, insurance, and managed care markets. We are pleased to provide the following information that demonstrates the relevancy, breadth, and depth of our corporate resources and Medicaid history, as well as the detailed information you requested for each of our references.

We offer a unique combination of relevant experience that is unsurpassed in the industry.

Relevancy—Our experience and references depict expertise that is relevant to both the work we currently perform for Vermont and the work we will perform based on the mandatory and optional enhancements you have defined.

For example, you requested "Previous system takeover experience with a client/server (nonmainframe) platform with an MMIS server infrastructure and UNIX-based operating system." EDS is the only vendor who can respond to this requirement, because **we pioneered the client/server platform concept and technology when we created the first such platform for Vermont in 1993.**

Our experience goes far beyond takeover. It is embodied in the actual creation and evolution of client/server technology for 10 years. Since 1993, we have designed and implemented nine other true client/server platforms as well as continued to refresh existing client/server MMISs based on our clients' needs and new technology.

Another example of the relevancy of our references comes from our demonstrated Medicaid fiscal agent experience using a client/server (nonmainframe) platform with an MMIS server infrastructure and UNIX-based operating system. We selected the following Medicaid accounts to demonstrate this experience:

- Indiana
- Rhode Island
- Delaware
- Idaho
- New Hampshire

These five programs represent more than 50 combined years of Medicaid fiscal agent experience supporting a client/server platform.

Breadth—Our breadth of experience is evident in the broad range of Medicaid and similar state health care programs (such as our Michigan Medicaid Fiscal Review and our California Healthy Families Program) that we support for our many state customers.

The following graphic displays the extent of program services we offer to our Medicaid clients across the country. It reflects the relevant experience you expressed interest in for fiscal agent, MMIS, Medicaid, provider relations, and claims processing expertise. In addition, this graphic demonstrates our breadth of knowledge in various areas pertinent to your mandatory and optional enhancements and modifications such as third-party liability, management and administrative reporting (MAR), surveillance and utilization review (SUR), early and periodic screening, diagnosis, and treatment program (EPSDT), and Web-based technology.

EDS Medicaid Experience

	AL	AR	CA	CT	DE	ID	IN	KS[1]	NH	NC	OK[2]	PA[3]	RI	TN	TX	VT	WI
Automated Document Management System	●	●	●	●	●	●	●	FC	●	●	●	FC	●	●	●	●	●
Automated Eligibility	●	●	●	●	●	●	●	FC	●	●	●	FC	●		●	●	●
Automated Fraud and Abuse Detection	●	●	●	●		●		F	●		F	F	●	●	●	●	
Beneficiary	●	●	●	●	●	●	●	FC	●	●	●		●	●	●	●	●
Claims Processing	●	●	●	●	●	●	●	FC	●	●	●	FC	●	●	●	●	●
Cost Containment	●	●	●	●	●	●	●		●	●	●		●	●	●	●	●
Drug Rebate	●	●	●	●	●	●	●	FC	●	●	●	F	●	●		●	●
DSS (Ad Hoc Reporting)	●	●		●	●	●	●	FC	●	●	●		●	●	●	●	●
Encounter Claims	●	●	●				●	FC		●	●	F	●	●	●		●
EPSDT		●	●	●	●	●	●	FC	●	●	●	F	●	●	●	●	●
Family Planning	●	●	●	●	●		●	FC		●	●	F	●		●	●	
Financial	●	●	●	●	●	●	●	FC		●	●	F	●	●	●	●	●
Fiscal Agent	●	●	●	●	●	●	●	●	●	●	●	F	●	●	●	●	●
Fraud and Abuse Personnel Support								F			F				●		
Imaging	●	●	●		●	●	●	FC	●	●	●	FC	●	●	●	●	●
MARS	●	●	●	●	●	●	●	FC	●	●	●	F	●	●	●	●	●
Prior Authorization	●	●	●	●			●	FC	●	●	●	F	●		●	●	●
ProDUR	●	●	●	●	●	●	●	FC	●	●	●	F	●				●
Provider	●	●	●	●	●	●	●	FC	●	●	●		●	●	●	●	●
Reference	●	●	●	●	●	●	●	FC	●	●	●	F	●	●	●	●	●
RetroDUR			●	●	●		●	F	●		●		●				
Sampling	●	●		●	●		●										
SUR and Profiling	●	●	●	●	●	●	●	FC	●	●	●		●	●	●	●	●
Third-Party Liability	●	●	●		●	●	●	FC	●	●	●		●	●	●	●	●
Voice Response	●	●	●	●	●	●	●	FC	●	●	●	FC	●		●	●	●
Web-Based Technology	●	●	●			●	●	F	●		●	F	●				●

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1 Our responsibilities for the Kansas Medicaid Contract are expanding under the new fiscal agent contract.
C Current take over MMIS responsibilities **F** Future implementation under replacement MMIS contract
2 Oklahoma items indicated by **F** reflect future implementation.
3 Our responsibilities for Pennsylvania are expanding from front-end processor to fiscal agent, based on the new contract.

We have gained valuable experience by implementing solutions that resolve each state's unique needs while leveraging the lessons we learned to benefit all of our Medicaid clients. Our broad experience combined with our topic-specific expertise enhances our ability to quickly and accurately focus on your mandatory and optional enhancements and modifications.

Depth—Our depth of experience is evident in our long-term commitment to Medicaid customers and to the innovative technology that supports them. EDS designed and built all the true client/server MMISs that are operational today.

Depth of Experience

We have designed and developed Medicaid and Medicaid-related systems for 33 states.

We have served the Medicaid program since its beginning. During this time, we have:

- Provided fiscal agent services to 24 states
- Currently support 26 Medicaid programs in 20 states, covering such diverse program needs as recipient eligibility verification, fraud and abuse detection, and vaccines for children
- Served the following current Medicaid clients for 20 or more years:
  - Vermont
  - Idaho
  - Connecticut
  - Alabama
  - Wisconsin

  These relationships are based on more than our program understanding and technical capabilities. They reflect the skills and commitment of our employees and their dedication to our clients.
- Designed, developed, implemented, maintained, and enhanced seven client/server MMISs and are implementing three additional ones

No other company can provide the same depth of relevant experience. We hope to continue to bring you this critical depth and breadth of relevant knowledge in the future.

The following list identifies all current or recent Medicaid projects:

- Alabama Medicaid
- Arkansas Medicaid
- California Medicaid
- Connecticut Medicaid
- Delaware Medicaid
- Georgia Medicaid
- Idaho Medicaid
- Indiana Medicaid
- Kansas Medicaid
- Mississippi Medicaid
- New Hampshire Medicaid
- North Carolina Medicaid
- Oklahoma Medicaid
- Pennsylvania Medicaid

- Rhode Island Medicaid
- Tennessee Medicaid
- Texas Medicaid
- Vermont Medicaid
- Virginia Medicaid
- Wisconsin Medicaid

The following list identifies all Medicaid-related and other state health care projects:

- Arkansas Breast and Cervical Cancer Control
- California Healthy Families Program
- Delaware Healthy Children and Health Benefits Manager
- Massachusetts Recipient Eligibility Verification System
- Michigan Automated Client Care and Access Support System (ACCESS)
- Michigan Medicaid Fiscal Review
- New York State EPIC Prescription Protection for Seniors
- New York State Vaccines for Children Program
- Pennsylvania Fraud and Abuse Detection System
- Pennsylvania Vaccines for Children Program
- South Carolina MMIS HIPAA Remediation
- State of Texas Access Reform (STAR)
- Texas Immunization and Tracking Program (TX ImmTrac)
- Texas Medicaid Fraud and Abuse Detection System (TX MFADS)

In addition, EDS was a finalist in the following MMIS-related procurements between 2000 and 2002. The list also specifies contract awards made to EDS.

- Alaska Medicaid
- California Medicaid—Contract award
- Commonwealth of Pennsylvania Fraud and Abuse Detection System—Contract award
- Delaware Medicaid—Contract award
- Georgia Medicaid
- Kansas Medicaid—Contract award
- Mississippi Medicaid
- Nevada Medicaid
- Oklahoma Medicaid—Contract award
- Pennsylvania Medicaid—Contract award
- South Carolina MMIS HIPAA Remediation—Contract award
- Tennessee Medicaid—Contract award
- Texas Medicaid
- Texas Medicaid Fraud and Abuse Detection—Contract award
- Connecticut Decision Support System—Contract award
- Pennsylvania Fraud and Abuse Detection—Contract award

EDS Reference Information

RFP Reference: 3.2.2.5.3.1, p. 3-9

In the following pages, we will provide the five references required by the RFP. In fact, we are exceeding the minimum requirements by providing three additional references to further demonstrate the breadth and depth of our Medicaid program support. This section provides information about EDS projects conducted within the last 10 years that show at least three years of relevant prior experience for EDS. Each reference represents one or more of the types of relevant experience requested by the Department of PATH.

- Indiana Medicaid Program
- Rhode Island Medicaid Program
- Delaware Medicaid Program
- Wisconsin Medicaid Program
- California Medicaid Program (Medi-Cal)
- Idaho Medicaid Program
- Connecticut Medicaid Program
- New Hampshire Medicaid Program

For every project referenced, we provide the following information:

- Customer name
- List of relevant RFP criteria for that reference
- Most senior contact person's name with title familiar with the bidder's performance who may be contacted by the Department of PATH during the evaluation process
- Contact information (mail and e-mail addresses, telephone number)
- Description of work performed
- Contract term
- Staff-months expended
- Personnel requirements
- Claims volume involved, if appropriate
- Publicly funded contract cost

We submit information for one project only in this section, the Indiana Medicaid reference, which is an example of our takeover experience for a client/server MMIS platform. We designed and implemented the IndianaAIM client/server MMIS, and we were re-awarded the contract in 1998. At that time, EDS performed a complete top-to-bottom system refresh, replacing the servers and other equipment and creating the second generation of client/server MMIS. **Most importantly, we designed and built all of the client/server MMISs that are operational today.**

The following graphic demonstrates our experience.

Relevant EDS Experience

EDS Account Title / Specific Experience	Indiana Medicaid	Rhode Island Medicaid	Delaware Medicaid	Wisconsin Medicaid	California Medicaid	Idaho Medicaid	Connecticut Medicaid	New Hampshire Medicaid
Previous system takeover experience with a client/server (non-mainframe) platform with a MMIS server infrastructure and UNIX=based operating system	●							
Medicaid fiscal agent experience with client/server (non-mainframe) platform with an MMIS server infrastructure and UNIX-based operating system	●	●	●			●		●
MMIS relevant prior experience from within the past 10 years	●	●	●	●	●	●	●	●
Medicaid relevant prior experience from within the past 10 years	●	●	●	●	●	●	●	●
Provider relations relevant prior experience from within the past 10 years	●	●	●	●	●	●	●	●
Claims processing relevant prior experience from within the past 10 years	●	●	●	●	●	●	●	●

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Our depth and breath of experience in the areas identified by the Department of PATH are shown by each referenced organization's multiple areas of expertise.

Indiana Medicaid Program

EDS' support for the Indiana Medicaid Program satisfies the following RFP experience criteria:

- Previous system takeover experience with a client/server (nonmainframe) platform with an MMIS server infrastructure and UNIX-based operating system
- Medicaid fiscal agent experience with a client/server (nonmainframe) platform with an MMIS server infrastructure and UNIX-based operating system
- MMIS relevant prior experience from within the past 10 years

Legacy of Client/Server Expertise

Indiana implemented a client/server MMIS— operational in 1994— and totally refreshed it beginning in 1998.

- Medicaid relevant prior experience from within the past 10 years
- Provider relations relevant prior experience from within the past 10 years
- Claims processing relevant prior experience from within the past 10 years

EDS has served the Indiana Medicaid Program for more than 17 years. In 1991, we took over a mainframe MMIS to support the Indiana program. We then designed, developed, and implemented a client/server MMIS in 1993 and 1994. For this implementation, we developed a standalone client/server data center to support the Indiana program. In 1998, we launched our third consecutive services contract that allowed us to takeover our own client/server system and focus our efforts on refreshing the Indiana MMIS claims processing and fiscal agent services technology infrastructure.

The Indiana MMIS is one of the largest client/server database systems for any health care program in the world. The Indiana Family and Social Services Administration (FSSA) received national recognition from *ComputerWorld/*Smithsonian, and the National Association of State Information Resource Executives (NASIRE) for its innovative use of technology in the design and implementation of this EDS client/server relational database system.

Following are examples of benefits Indiana has received from using this system:

- Reduced average adjudication time
- Increased processing speed, improved responsiveness, and enhanced reliability of computer operations
- Implemented a new Medicaid Web site that gives providers rapid access to information, including a history of the state and Medicaid program, bulletins, comments, forms, manuals, and training schedules
- Implemented a document management system that coordinates, standardizes, and delivers all internal and external publications
- Provided Web-based, interactive claim status and eligibility status for providers

EDS is the prime contractor for two contracts in Indiana—fiscal agent services as well as third-party liability (TPL) services. Besides the client/server MMIS, EDS has introduced other innovations, such as a bulletin board system for rapid communication between the program and the managed care organizations (MCOs). This technology has eliminated paper and tape encounter claims. EDS also uses the bulletin board to post enrollment rosters.

The following list identifies the most prominent of our achievements with the Indiana Medicaid Program:

- Takeover experience involving a client/server (nonmainframe) platform with an MMIS server infrastructure and UNIX-based operating system as we took over our own EDS-developed client/server MMIS and focused on enhancing and refreshing its technology with the latest hardware and software advances
- Medicaid fiscal agent experience totaling more than 17 years. This experience includes designing, implementing, operating, and refreshing a client/server (nonmainframe) platform with an MMIS server infrastructure as well as TPL and drug rebate responsibilities.
- MMIS experience involving a large-scale, complex system development, maintenance, takeover, and enhancements to accommodate multiple programs and incorporating leading-edge technology refreshes
- Medicaid experience including system enhancements such as point-of-service (POS), online pharmacy claims adjudication; automated voice response system (AVRS); client/server platform; and plastic recipient eligibility cards
- Provider relations including an interactive Web site that allows providers to determine the status of a submitted claim within hours of submission and full-service AVRS that handles 200,000 calls and supports 450,000 transactions from Indiana providers each month
- Claims processing of multiple claims including an additional 3 million encounter/capitation claim details

The following table provides RFP-required information about our experience working with the Indiana Medicaid Program.

Indiana Medicaid Program

RFP Requirement	Response
Customer name	Office of Medicaid Policy and Planning
Contact name and title	Ms. Pat Nolting Director, Program Operations Office of Medicaid Policy and Planning
Contact information	402 West Washington Street Indianapolis, IN 46204 1 317 232 4318 e-mail address: pnolting@fssa.state.in.us

RFP Requirement	Response
Description of work performed	We designed and implemented a client/server (nonmainframe) platform with an MMIS server infrastructure and UNIX-based system that became operational in 1994. In 1998, the takeover involved our Indiana-focused client/server system, which we refreshed through a series of technology platform upgrades. Our 1998 takeover and refresh activities included: • Hardware upgrades: Sun production hardware from SPARCcenter 2000 to Ultra Enterprise 5500 and 6500 and new disk storage arrays. In addition, new tape drives and tape libraries were implemented. • Software upgrades: Solaris operating system from 2.3 to 2.6 and Oracle databases from 7.3 to 8.0 and upgraded system support software • We minimized client impact by setting up the new refresh environment on the new hardware, thereby allowing the current system to run uninterrupted. Thus, it was business as normal for the current system during the upgrade activities. • Processes were designed to extract production data from the current servers. We then copied the data to the new environment that was running the new claims process. We performed this task using an extensive data validation methodology as well as continuous system and database backups to prevent any data loss from either the old or new systems. The actual system switch occurred over a holiday weekend and at carefully selected points during production to ensure a seamless transition. The Indiana MMIS is one of the largest client/server database systems for any health care program in the United States. We also perform several specialty services for Indiana that are not always included in a fiscal agent's scope of work. These services include drug rebate processing, nursing home field audits, and operation of the retrospective and prospective drug utilization review systems. We provide desktop and telecommunications support between the client and us. We also provide audit services for nursing homes, home-based community residences, and waiver programs using a traveling staff of health care professionals.
Contract term	1981 to 1985 1991 to 2003

RFP Requirement	Response
Staff months expended	14,784 months
Personnel requirements	EDS provides approximately 325 leadership, professional, technical, and clerical staff positions in support of our Indiana client.
Claims volume involved, if appropriate	42 million claims per year
Publicly funded contract cost	$150 + million Total of current contract combined with amendments, extensions, and options
Number of enrolled providers, if applicable	17,800

Rhode Island Medicaid Program

EDS' support for the Rhode Island Medicaid Program satisfies the following RFP experience criteria:

- Medicaid fiscal agent experience with a client/server (nonmainframe) platform with an MMIS server infrastructure and UNIX-based operating system
- MMIS relevant prior experience from within the past 10 years
- Medicaid relevant prior experience from within the past 10 years
- Provider relations relevant prior experience from within the past 10 years
- Claims processing relevant prior experience from within the past 10 years

Proven Pharmacy Savings

SmartPA has already proven beneficial in reducing the state's pharmacy expenditures within the first several months since its implementation with decreased pharmaceutical spending in excess of $660,000.

We implemented a client/server MMIS for Rhode Island in 1993. The system has features that make it easy to use, such as graphical user interfaces and enhanced reporting capabilities. We have also automated claims processing tasks and consolidated functions previously handled manually. The Rhode Island MMIS includes AVR and POS technologies. The EDS team, using the relational data base client/server MMIS, delivers the following benefits for the Rhode Island Medicaid Program:

- Timeliness of claims processing through automation of tasks previously completed manually and consolidation of automated processes handled by multiple systems
- Consistency in processing, pricing, and claim control through the use of integrated systems

- Enhanced data access with online, real-time inquiry, update, and reporting capabilities to help the state monitor and control benefit dollars. BusinessObjects query tools are deployed on several client desktops.
- User friendliness and ease of maintenance to support program administration
- Proven technical capability to ensure compliance with federal and state requirements

Rhode Island recently awarded EDS a project to bring the state's MMIS into compliance with federal HIPAA guidelines. This project is part of a joint purchase relationship between EDS and regional New England states with EDS claims processing contracts (Vermont, Rhode Island, New Hampshire, and Connecticut). They formed the relationship to implement the HIPAA transaction and code sets rules. By working together, each state avoids considerable IT investment, plus it accrues savings in its local EDS contract by minimizing custom programming. This example demonstrates teamwork and partnering between our New England clients and us.

In February 2002, EDS partnered with Heritage Information Systems to provide an innovative, cost-effective tool, SmartPA, a prior authorization (PA) system. Rhode Island's Department of Human Services (DHS) became the first location, nationwide, to implement this enhanced PA system. When a POS pharmacy submits a targeted drug request, the transaction interacts with the MMIS, extracting claims history and information, which is sent to SmartPA where the request is processed through a rules engine and set of predefined criteria. The turnaround from POS request to POS response with an approval or denial message to the pharmacy POS occurs within 13 seconds. While innovative, the main implementation reason was to provide a cost savings measure for DHS. In the three months since implementation, the savings associated with SmartPA have been more than $660,000. The state will realize additional savings once we add other drug criteria in the future.

Provider relations are integral to EDS' commitment to service excellence. The provider community is supported through various outreach methods, including monthly provider update newsletters, site visits by EDS provider representatives, training classes, and small seminar groups, as well as the daily telephone support by the customer service help desk and the provider representatives. Communication and training are primary considerations for achieving a well functioning provider support and claims processing mechanism.

Two other innovations are the Rhode Island Public Transportation Authority (RIPTA) Bus Pass Program and the Direct Member Premium Reimbursement (DMPR). The RIPTA Bus Pass Program allows beneficiaries to obtain monthly bus cards at local supermarkets rather than waiting in long lines at DHS offices. The DMPR project permits EDS/DHS to make payments directly to recipients participating in the RIte Share program. RIte Share recipients have payroll deductions made for their health care coverage and are reimbursed by the state. This project focused on recipient enrollment, cost sharing, and financial controls.

This reference demonstrates our ability to provide the following:

- Medicaid fiscal agent experience of more than 10 years, including fiscal agent experience involving a client/server (nonmainframe) platform with an MMIS server infrastructure and extensive pharmacy benefit management services. Not only do we process pharmacy claims in NCPDP 5.1 HIPAA standard, we offer a robust inventory of other pharmacy services, which includes the following:
  - Edits to protect patients from therapeutic duplications
  - Edits to ensure timeliness of prescription refills with the early refill edits
  - Edits to provide for preferred dispensing of maintenance drugs
  - Edits to ensure appropriate drug dispensing with edits for drug fill quantities
  - Automated prior authorization process through SmartPA
  - Clinically managed lock-in programs
  - Intervention programs targeting clinically defined populations with mailings and information
  - Prospective and retrospective drug utilization review capabilities
  - Disease management targeting and data collection
  - Drug rebate processing, invoicing, and collection
- MMIS experience involving a large-scale, complex system development, maintenance, and enhancement to accommodate multiple programs and leading-edge technology, such as client-server, automated voice response, and POS
- Medicaid experience including support of innovative and wide-ranging managed care enhancements using both technical systems solutions and people-oriented business support functions
- Provider relations supporting the option of submitting claims electronically by tape, diskette, or modem, in addition to interactive and batch POS. EDS supplies Provider Electronic Solutions, an electronic media submissions software package, free of charge.
- Claims processing of multiple claim types through paper or electronic media/methods. In the last quarter of 2002, we processed more than 2.6 million claims including fee-for-service claims, POS claims, and encounter/ capitation transactions. In the final quarter of 2002, we processed in excess of 98 percent of all submitted claims, turning them around within 30 days.

The following table provides RFP-required information about our experience working with the Rhode Island Medicaid Program.

Rhode Island Medicaid Program

RFP Requirement	Response
Customer name	Department of Human Services
Contact name and title	Mr. Frank Spinelli, Administrator Department of Human Services
Contact information	600 New London Avenue Cranston, RI 02920 1 401 462 1869 e-mail address: fspinell@gw.dhs.state.ri.us
Description of work performed	EDS provides the following services to the Rhode Island Medicaid Program: • Claims processing • PA processing, including SmartPA • Drug rebate • Retrospective drug utilization review (retroDUR) • Provider relations • Reporting • SUR • TPL • Security • System maintenance, operations, modifications, and enhancements • Web development • Web hosting EDS implemented its client/server-based MMIS for the Department of Human Services. This system distributes more than $1 billion in Medicaid benefits each year to 176,000 beneficiaries eligible for the Rhode Island Medicaid Program. In 2002, the Rhode Island MMIS processed more than 5 million claims. In addition, EDS also trains the state's personnel to use the MMIS and supports the POS network 24 hours a day, 7 days a week.
Contract term	1992 to 2004
Staff months expended	7,476

RFP Requirement	Response
Personnel requirements	EDS provides approximately 85 leadership, professional, medical, technical, and clerical staff positions in support of our Rhode Island client.
Claims volume involved, if appropriate	5 million claims per year
Publicly funded contract cost	$ 72.1 million Total of current contract combined with amendments, extensions, and options
Number of enrolled providers, if applicable	12,063

Delaware Medicaid Program

EDS' support for the Delaware Medicaid Program satisfies the following RFP experience criteria:

- Medicaid fiscal agent experience with a client/server (nonmainframe) platform with an MMIS server infrastructure and UNIX-based operating system
- MMIS relevant prior experience from within the past 10 years
- Medicaid relevant prior experience from within the past 10 years
- Provider relations relevant prior experience from within the past 10 years
- Claims processing relevant prior experience from within the past 10 years

Exceeding Client Expectations

"Thanks to EDS, the Delaware MMIS met the new HIPAA requirements a full three months ahead of the deadline."

--Kay Holmes
Chief Administrator
Delaware Health and Social Services, Division of Social Services

For the Delaware Division of Social Services, we have served as fiscal agent for the MMIS since 1989. In addition, we also provide member enrollment, education, and outreach for the Diamond State Health Plan and the Delaware Healthy Children Program (DHCP) managed care programs. The state of Delaware selected us in a competitive procurement to implement our interChange MMIS. This client/server MMIS features a relational database design and began operating on time and within budget on June 24, 2002.

Most recently, we have successfully implemented and are operating a HIPAA transaction- and code set-compliant MMIS, enabling the Delaware MMIS to be the first state Medicaid system to become HIPAA-compliant. Employing our multifaceted E.business Exchange translator as the clearinghouse for HIPAA transaction processing, Delaware's new MMIS enhances the collection of medical assistance program data and increases user access to information on the desktop. It also enables full pharmacy benefits management for Delaware Medical Assistance and Delaware Prescription Assistance Program clients.

As Delaware's fiscal agent, we process capitation payments and capture encounter data from MCOs. As Delaware's Health Benefits Manager, we support members by providing the following services:

- Member enrollment
- Member education
- Member advocacy
- Statewide outreach
- Statewide member satisfaction surveys

We also have an active outreach program and help desk support that work together to respond to billing questions and educate providers. We also provide member services in support of the primary care case management (PCCM) program.

This reference demonstrates our ability to provide the following:

- Takeover experience involving a client/server (nonmainframe) platform with an MMIS server infrastructure and replacement system with the IdahoAIM as the base system for Delaware
- Medicaid fiscal agent experience of more than 13 years, including fiscal agent experience involving a client/server (nonmainframe) platform with an MMIS infrastructure, health benefits management, and pharmacy benefit management services
- MMIS experience involving a large-scale, complex system transfer and development, maintenance, and enhancements to accommodate multiple programs such as the Delaware Healthy Children Program, the Delaware Prescription Assistance Program (DPAP), and the Chronic Renal Disease Program (CRDP)
- Medicaid experience including system enhancements such as managed care pricing, encounter data processing and reporting, client enrollment and reporting system, and automated file transfer capability between EDS and the state's systems
- Provider relations experience including training, inquiry, and help desk support
- Claims processing of multiple claim types, including institutional, pharmacy, medical, crossover, encounter, and capitation, currently process more than 1 million encounter and capitation claims

The following table provides RFP-required information about our experience working with the Delaware Medicaid Program.

Delaware Medicaid Program

RFP Requirement	Response
Customer name	Delaware Department of Health and Social Services—Division of Social Services
Contact name and title	Phil Soule, Division of Social Services Deputy Director Delaware Department of Health and Social Services—Division of Social Services
Contact information	1901 N. DuPont Highway Lewis Building New Castle, DE 19720 1 302 255 9627 e-mail address: psoule@state.de.us
Description of work performed	EDS performs the following services for the Delaware Medicaid Program: • Claims processing and claims resolution • Drug rebate • Drug utilization • Prospective drug utilization review (proDUR) and retroDUR • Provider relations and services • Security • System maintenance, operation, modifications, and enhancements • TPL processing As the Medicaid program's health benefits manager, which is a separate contract, we support the Delaware Department of Health and Social Services managed care programs. The EDS Health Benefits Manager serves as the enrollment broker for the Diamond State Health Plan (the Medicaid managed care program) and the Delaware Healthy Children Program (Delaware's state children's health insurance program). Enhancements to the Delaware MMIS have included the following: • Table-driven handling for provider payments • Managed care pricing • Encounter data processing and reporting • Client enrollment and reporting system • Automated file transfer capability between EDS and the state's systems

RFP Requirement	Response
	We designed, developed, and implemented a transfer MMIS based on our Idaho client-server architecture. The new client-server MMIS is in the CMS certification process.
Contract term	Medicaid contract: 1989 to 2008 Health Benefits Management contract: 1995 to 2003
Staff months expended	6,216
Personnel requirements	EDS provides approximately 80 leadership, professional, medical, technical, and clerical staff positions in support of our Delaware client.
Claims volume involved, if appropriate	In excess of 6 million claims per year
Publicly funded contract cost	$73.5 million Total of current contract combined with amendments, extensions, and options
Number of enrolled providers, if applicable	7,300

Wisconsin Medicaid Program

EDS' support for the Wisconsin Medicaid Program satisfies the following RFP experience criteria:

- MMIS relevant prior experience from within the past 10 years
- Medicaid relevant prior experience from within the past 10 years
- Provider relations relevant prior experience from within the past 10 years
- Claims processing relevant prior experience from within the past 10 years

For the Wisconsin Division of Health Care Financing, EDS performs fiscal agent services to support the Medical Assistance Program, Wisconsin's Medicaid Program. EDS also supports a call center for providers and clients participating in Wisconsin's Child Health Insurance Program (CHIP), BadgerCare. The Wisconsin Medicaid project won *Outsourcing Journal's* editor's choice award for best government relationship in 2001.

Thinking Outside the Box

In the February 2001 Awards Issue of *Outsourcing Journal* magazine, Peggy Bartels, administrator of Wisconsin's Division of Health Care Financing, identified MEDS as an example of our willingness to try new approaches. She said EDS "made it into something we really hadn't envisioned."

The Wisconsin decision support system twice won a *ComputerWorld/*Smithsonian laureate award. The decision support system is used to generate 20,000 reports a month that enable the comparison of Medicaid and public health data.

Following is a list of accomplishments that EDS has achieved for Wisconsin Medicaid:

- Process 14 million claims each year
- Process more than 80 percent of claims electronically
- Process 30 percent of PA requests electronically
- Attain an average PA processing time of 3.98 days
- Process 17 million eligibility transactions annually
- Respond to more than 815,000 provider and beneficiary telephone calls annually
- Maintain a data warehouse and executive information system/decision support system (EIS/DSS) for the client that is used to produce more than 20,000 reports monthly

EDS maintains a staff of 120 programmers and analysts to continuously enhance the state's MMIS. Recent enhancements include plastic ID cards, recipient verification eligibility system, POS system for pharmacy claims, proDUR system, automated workflow system, and provider handbooks on CD-ROM. EDS has also built and currently operates a client/server Web-based immunization registry. EDS is responsible for training state staff and 40,000 providers.

When Wisconsin asked EDS to take over a failed data warehouse project, we responded by developing the Medicaid Evaluation and Decision Support (MEDS) system, one of the most powerful health care research systems available. MEDS transformed the way Wisconsin's program is administered and managed. The system accomplishes the following:

- Supports fraud and abuse detection, auditing, program integrity, decision-making, cost containment, budget management, benefit coverage and reimbursement, accountability, and managed care innovations
- Provides analytical support services
- Contains Medicaid data along with immunization records, HMO records, vital statistics, and 30 other types of information to give decision-makers a more complete view of health care

The MEDS system is now a showcase for other state agencies and twice won a *Computer World*/Smithsonian Institute Laureate award.

Our support for the Wisconsin Medicaid Program brings the following experience:

- Medicaid fiscal agent experience of more than 25 years that reflects an award-wining partnership between Wisconsin and EDS. This experience includes recipient ID card production, supporting HMO-preferred enrollment and cost containment.
- MMIS experience involving large-scale, complex system development, maintenance, and enhancements to accommodate multiple state programs
- Medicaid experience to include taking over a contract for data warehouse and decision support system development in 1996 and creating a system that updates all reference files via online screens and allows the customer to request provider and recipient history reports using online screens
- Provider relations experience focused on communications, training, education, and help desk support for pharmacy and prescribing providers
- Claims processing of multiple claims including a provider-base billing process that helped Wisconsin collect $7,989,674 in provider-based billing recoveries in 2001

The following table provides RFP-required information about our experience working with the Wisconsin Medicaid Program.

Wisconsin Medicaid Program

RFP Requirement	Response
Customer name	Wisconsin Division of Health Care Financing
Contact name and title	Peggy Bartels Handrich, Administrator Wisconsin Division of Health Care Financing
Contact information	P.O. Box 309 1 West Wilson Street Madison, WI 53701-2522 1 608 266 2522 e-mail address: bartepl@dhfs.state.wi.us

RFP Requirement	Response
Description of work performed	EDS provides the following services for the Wisconsin Medicaid Program: • Beneficiary identification cards • Claims processing • Drug rebate • POS • Prior authorization • Provider education • Provider relations • Management and ad hoc reporting • Security • System maintenance, operation, modifications, and enhancements • SUR • TPL
Contract term	1977 to 2005
Staff months expended	126,000
Personnel requirements	EDS provides more than 490 leadership, professional, medical, technical, and clerical staff positions in support of our Wisconsin client.
Claims volume involved, if appropriate	14.1 million claims per year
Publicly funded contract cost	$356.4 million Total of current contract combined with amendments, extensions, and options
Number of enrolled providers, if applicable	40,000

California Medicaid Program (Medi-Cal)

EDS' support for Medi-Cal (the California Medicaid program) satisfies the following RFP experience criteria:

- MMIS relevant prior experience from within the past 10 years
- Medicaid relevant prior experience from within the past 10 years
- Provider relations relevant prior experience from within the past 10 years
- Claims processing relevant prior experience from within the past 10 years

For the California Department of Health Services, we provide fiscal intermediary services, including systems development and maintenance, claims processing, medical and clinical consulting, field office support, and provider relations.

Our Provider Relations activity is one of the key success factors in supporting California's Medicaid Program. Our Medi-Cal Provider Relations Organization (PRO) continuously strives to improve service to California providers and beneficiaries with proactive and responsive services. Our services include call center operations, provider training and outreach, research and resolution, project management, publications, and print and media distribution.

Applying Innovation to Provider Relations

Our research analysts manned a one-on-one claims assistance booth at a Medi-Cal conference to provide personal attention to resolve provider issues, winning critical approval of the providers.

Our call center receives and responds to more than 1.1 million calls annually. Operators respond to a range of provider inquiries from complex billing questions to specific technical support for computer media claims, POS, and Internet transaction processing. We also receive and respond to beneficiary inquiries about provider billing, patient liability, and collection. We address the need to serve California's diverse population by answering these calls in English and Spanish.

Our Medi-Cal training and provider representative staff proactively delivered more than 825 classroom hours of training in 2002. We also held 390 workshops and made 4,200 on-site visits to provider offices. The team delivered a first-of-its-kind three-day comprehensive health care conference in 2000. The conference, Medi-Cal 2000, was held in San Francisco and Los Angeles. It was attended by more than 6,000 providers. The curriculum included core billing classes as well as keynote speakers and panels on critical health care initiatives such as HIPAA and an Internet lab.

During the conference, we introduced a new and innovative service offering called the Claims Assistance Room (CAR). This creative approach equips our staff with laptops and remote access to MMIS files, online provider manuals, other desktop tools, and confidential workspace to resolve provider billing issues at the conference. This new service was an overwhelming success and it has become one of our core services to providers during our training seminars.

EDS' research and resolution staff respond to more than 280,000 pieces of written correspondence annually. They conduct extensive research and communicate with providers, state personnel, legislative offices, and legal offices on Medi-Cal billing. Our experienced staff support the expert witness and legislative liaison functions that respond to subpoenas, fulfill legal document requests, and appear in court on behalf of the Department.

We understand the magnitude of the potential disruption that the HIPAA implementation will have on Medi-Cal providers. In response, we established a Project Office to effectively implement HIPAA and other high profile initiatives. Our activities have included an operations-wide assessment to analyze the impact to systems and providers, a phased implementation design that identifies timing for resources, provider outreach, focus groups, training, proactive communications, and contingency plans to minimize service disruption.

Our EDS Publications and Print Center is responsible for writing, editing, and distributing provider information through both print and Internet media channels. Our Document Control Number (DCN) Process ensures the quality and timeliness of all printed and Internet-based provider information. In 2002, we managed more than 500 DCNs that resulted in more than 170 million pages of printed material and 4.8 million pieces of mail.

In addition, the EDS team works to use technology advances and other innovative ideas to improve services. These advances and ideas include the following:

- Internet advances that include the first secure Web-based Medicaid claims submission system in the nation. The site also includes a provider relations Web page specifically devoted to providers with:
  - Check write
  - Claims status
  - Eligibility information
  - Searchable provider manuals
  - Downloadable forms
  - Training schedules
  - Frequently asked questions

  We recognize the Internet is a logical way for providers to get critical information and services when they need it.
- EDS Scenario Engine is a data-mining tool that we developed specifically for Medi-Cal that allows staff to proactively analyze provider billing trends and patterns for quicker problem resolution.
- Provider Equipment Tracking System (PETS) is an EDS-developed inventory tracking tool. We use PETS to manage the timely distribution of more than 18,000 POS devices that providers use to access critical eligibility and share-of-cost information for beneficiaries. PETS tracks inventory levels to determine just-in-time purchases of new devices to prevent equipment shortages or delays.

- EDS Medi-Cal Image Management System (IMS) provides desktop images for claims and appeals examiners. We are expanding this to a Web-based platform to make the images available to other users, including the Department.
- Medi-Cal Advanced Data Entry System (MCADES) uses sophisticated optical character recognition and business rules to quickly and accurately capture and edit data from paper claim documents.

Most recently, we were selected in a competitive procurement for a new four-year contract to continue as the fiscal agent for Medi-Cal operations. This selection is a testament to our ongoing service excellence and innovation for the client.

This reference demonstrates our ability to provide the following:

- Takeover experience of a large, complex system as well as system and program enhancements
- Medicaid fiscal intermediary experience demonstrated by more than 25 years of enhancements and improvements reflecting program changes and expansion
- MMIS experience involving a large-scale, complex system development, enhancement, and maintenance
- Medicaid experience including system enhancements such as development and distribution of provider software for claims submission; eligibility information available through provider PC interface; eligibility verification online; and pharmacy processing online
- Provider relations focused on provider satisfaction and retention by delivering responsive and proactive services
- Claims processing of multiple claim types with a volume of 201 million claims per year

The following table provides RFP-required information about our experience working with the California Medicaid Program (Medi-Cal).

California Medicaid Program (Medi-Cal)

RFP Requirement	Response
Customer name	Department of Health Services
Contact name and title	Jerry Stanger, Chief California Department of Health Services Payment Systems Division
Contact information	Headquarters Management Branch 9800 Old Winery Place Sacramento, CA 95827-1700 1 916 255 6015 e-mail address: jstanger@dhs.ca.gov
Description of work performed	EDS performs the following services for the California Medicaid Program: • System maintenance, operation, modification, and enhancement • Claims processing services • Provider relations: call center operations for providers and beneficiaries, training and outreach, research and resolution, project management, publications, and print and media distribution • Data entry services • Claim form intelligent character recognition and imaging • Mail room and internal document control services • Security • Beneficiary identification card production More than 1,100 EDS Medi-Cal employees process 201 million claims and more than 10 million encounters yearly. Eighty-two percent of the claims are submitted and paid electronically. Claim types include inpatient, outpatient, long-term care, pharmacy, medical, vision, and crossover.
Contract term	1969 to 1980 1987 to 2003 2003 to 2007
Staff months expended	Approximately 150,000 since 1987
Personnel requirements	EDS provides approximately 1,140 leadership, professional, medical, technical, and clerical staff positions in support of our California client.

RFP Requirement	Response
Claims volume involved, if appropriate	201 million claims (lines) processed in 2002
Publicly funded contract cost	$628 million Total of current contract combined with amendments, extensions, and options
Number of enrolled providers, if applicable	84,470

Idaho Medicaid Program

EDS' support for the Idaho Medicaid Program satisfies the following RFP experience criteria:

- Medicaid fiscal agent experience with a client/server (nonmainframe) platform with an MMIS server infrastructure and UNIX-based operating system
- MMIS relevant prior experience from within the past 10 years
- Medicaid relevant prior experience from within the past 10 years
- Provider relations relevant prior experience from within the past 10 years
- Claims processing relevant prior experience from within the past 10 years

Our client-server MMIS for Idaho processes nearly 6 million claims per year, including inpatient, outpatient, home health, hospice, nursing home, dental, pharmacy, medical, and crossover claims. EDS' Idaho staff performs fiscal agent services, including claims processing, generation of managed care and lock-in client case management fees, and systems maintenance and modifications.

Our MMIS enhancements in Idaho have included the following:

- Moving to a client-server platform
- Automated voice response expansion
- Automated external system interface expansions for eligibility
- Medicare crossover claim acceptance
- More fully automated and expanded prior authorization processing
- Ad hoc reporting expansion
- Electronic data interchange expansion for funds transfer, remittance advice, eligibility verification, and claims submissions
- Plastic Medicaid identification card creation and distribution

Additional responsibilities include assisting the client in defining technology advancements that will improve overall service levels. Current enhancements include intelligent character recognition (ICR), AVRS, and HIPAA assessment and remediation analysis.

The VermontAIM client/server MMIS was the base system transferred for the fourth contract signed with Idaho and became active in 1997. The Idaho system was the base system transferred to Delaware that went live in 2002.

This reference demonstrates our ability to provide the following:

- Takeover and replacement of existing contractor's system with VermontAIM (as the base system) client/server (nonmainframe) platform with an MMIS server infrastructure
- Medicaid fiscal agent experience for more than 25 years. This experience includes expertise with a client/server platform with an MMIS server infrastructure
- MMIS experience involving a large-scale, complex system transfer and development, maintenance, and enhancements
- Medicaid experience that includes fiscal agent services as well as local area network (LAN) and statewide network support and all user training on system functions. Systems enhancements include ICR, AVRS, HIPAA assessment and remediation analysis, and plastic Medicaid identification card creation and distribution
- Provider relations experience including enrollment, inquiry services, billing assistance program, training, and workshops
- Claims processing of multiple claim types including institutional, pharmacy, medical, dental, and crossover types

The following table provides RFP-required information about our experience working with the Idaho Medicaid Program.

Idaho Medicaid Program

RFP Requirement	Response
Customer name	Idaho Department of Health and Welfare
Contact name and title	Randy May Deputy Administrator
Contact information	3380 Americana Terrace, Suite 230 Boise, ID 83706 1 208 364 1815 e-mail address: MayR@idhw.state.id.us

RFP Requirement	Response
Description of work performed	EDS performs the following services for the Idaho Medicaid Program: • Ad hoc report creation • Automated eligibility verification • Claims processing and payment • Claim adjudication • Data entry • Documentation maintenance • Drug rebate invoicing and dispute resolution • Electronic data interchange (EDI) • LAN operations and support • Mail room services • Provider enrollment • Provider inquiry services • Provider relations • Provider billing assistance program • Provider training and workshops • Reference file maintenance • Reporting • Security • System maintenance, operations, modifications, and enhancements EDS performs all user training on system functions. EDS and DHW staff jointly define, develop, implement, and maintain networks and telecommunications.
Contract term	1978 to 2006
Staff months expended	4,140
Personnel requirements	EDS provides approximately 85 leadership, professional, medical, technical, and clerical staff positions in support of our Idaho client.

RFP Requirement	Response
Claims volume involved, if appropriate	6.3 million claims per year
Publicly funded contract cost	$ 47.8 million Total of current contract combined with amendments, extensions, and options
Number of enrolled providers, if applicable	16,883

Connecticut Medicaid Program

EDS' support for the Connecticut Medicaid Program satisfies the following RFP experience criteria:

- MMIS relevant prior experience from within the past 10 years
- Medicaid relevant prior experience from within the past 10 years
- Provider relations relevant prior experience from within the past 10 years
- Claims processing relevant prior experience from within the past 10 years

We provide fiscal agent services for the Connecticut Medical Assistance Program that includes Medicaid and state-funded programs such as ConnPACE, the Connecticut Pharmaceutical Assistance Contract for the Elderly and Disabled. Our support includes provider relations, ConnPACE client relations, and provider and ConnPACE client enrollment. We designed, developed, implemented, operate, and maintain a CMS-certified MMIS. Connecticut's MMIS handles the claims and financial processing needs for the state's categorically eligible Medicaid beneficiaries, as well as those eligible through the state's General Assistance Program, ConnPACE Program, and Connecticut AIDS Drug Assistance Program (CADAP). The MMIS receives claims by several methods—dial up, diskette, tape, POS, and paper—and then processes, adjudicates, and reports on them.

Growing with Connecticut's Medicaid Program

As Connecticut has added programs, our scalable, flexible MMIS has been easily modified to support them.

System enhancements have included the following:

- Automated Eligibility Verification System (including AVRS)
- Electronic claim submission software and interactive and batch eligibility verification software for personal computers
- POS drug claims adjudication and processing, including proDUR, that has been significantly enhanced over time as a result of pharmacy cost containment initiatives

- Drug rebate subsystem
- Web applications, such as the ability to locate a specific type of provider within the state and online report access
- Claims scanning (ICR/OCR process) and workstation image retrieval

Connecticut is part of a joint purchase relationship between EDS and the other three New England EDS Medicaid contracts (Rhode Island, Vermont, and New Hampshire) formed to implement the HIPAA transaction and code sets rules. Connecticut Medicaid, through its EDS contract, will purchase translator hardware, software, and telecommunication links. This example demonstrates teamwork and partnering between our New England clients and EDS.

The state of Connecticut, in keeping with its vision for the "electronic state," signed a letter of intent in March 2003 awarding EDS a contract to design and implement a decision support system (DSS) designed to serve all of Connecticut's state agencies. This data warehouse/business intelligence system will help constrain costs and improve health outcomes. It will also provide access to program data on demand and advanced analytical capabilities. It will be an effective architectural framework for an enterprisewide data warehouse.

This reference demonstrates our ability to provide the following:

- Medicaid fiscal agent experience of more than 22 years that includes fiscal agent services for both the Connecticut Medical Assistance Program and the Connecticut Pharmaceutical Assistance Contract for the Elderly and Disabled (ConnPACE)
- MMIS experience involving a large-scale, complex system that includes maintenance support and enhancements to accommodate multiple programs
- Medicaid experience including system enhancements such as Automated Eligibility Verification System, including the AVRS and Web applications
- Provider relations experience including customer service support, enrollment, training of providers on billing practices, and training of the Department of Social Services personnel on the MMIS
- Claims processing of multiple claim types including institutional, pharmacy, medical, crossover, and dental claim types

The following table provides RFP-required information about our experience working with the Connecticut Medicaid Program.

Connecticut Medicaid Program

RFP Requirement	Response
Customer name	Connecticut Department of Social Services
Contact name and title	Marcia Mains, Department of Social Services Director, Medical Care Administration Operations State of Connecticut Department of Social Services
Contact information	25 Sigourney Street Hartford, CT 06106-5033 1 860 424 5219 e-mail address: marcia.mains@po.state.ct.us
Description of work performed	EDS performs the following services for the Connecticut Medicaid Program: • Claims processing and adjudication • Claims resolution • Connecticut Pharmaceutical Assistance Contract for the Elderly and Disabled (ConnPACE) client relations • ConnPACE client enrollment • Drug rebate • Eligibility verification • Data entry • Document control • Financial • Statewide POS network • Provider relations • Reporting • Security • System maintenance, operation, modifications, and enhancements • TPL processing For Connecticut's managed care programs, we enroll network providers into MCOs. In addition to the responsibilities described above, we train the provider community on billing practices and the Department of Social Services personnel on the MMIS and other systems.
Contract term	1981 to 2003

RFP Requirement	Response
Staff months expended	10,944
Personnel requirements	EDS provides approximately 113 leadership, professional, technical, and clerical staff positions in support of our Connecticut client.
Claims volume involved, if appropriate	17 million claims per year
Publicly funded contract cost	$153.6 million Total of current contract combined with amendments, extensions, and options
Number of enrolled providers, if applicable	6,100

New Hampshire Medicaid Program

EDS' support for the New Hampshire Medicaid Program satisfies the following RFP experience criteria:

- Medicaid fiscal agent experience with a client/server (nonmainframe) platform with an MMIS server infrastructure and UNIX-based operating system
- MMIS relevant prior experience from within the past 10 years
- Medicaid relevant prior experience from within the past 10 years
- Provider relations relevant prior experience from within the past 10 years
- Claims processing relevant prior experience from within the past 10 years

We have provided fiscal agent services to New Hampshire's Department of Health and Human Services since 1985. New Hampshire's MMIS enhances the state's ability to serve the growing needs of Medicaid beneficiaries by providing a client/server solution that allows real-time access to information.

Long-Term Business Partnership

The New Hampshire/EDS working relationship began in 1985 and has continued for more than 18 years.

This reference demonstrates our ability to provide:

- Transfer of VermontAIM client/server MMIS and enhancement that became active in 1993
- Medicaid fiscal agent experience of more than 18 years
- MMIS experience involving a large-scale complex system transfer and development, maintenance, and enhancements

- Medicaid experience including system enhancements such as data entry and resolution imaging, network operation and customer access, auto case tracking system, automated cost reporting for long-term care, and plastic cards for recipients
- Provider relations experience including communications, training, and help desk support
- Claims processing of multiple claim types including institutional, pharmacy, medical, crossover, and dental claim types.

The following table provides RFP-required information about our experience working with the New Hampshire Medicaid Program.

New Hampshire Medicaid Program

RFP Requirement	Response
Customer name	Department of Health and Human Services
Contact name and title	Nita Tomaszewski MMIS Contract Officer Office of Medicaid Management Information System
Contact information	7 Eagle Square Concord, NH 03301 1 603 271 3772 e-mail address: ntomaszewski@dhhs.state.nh.us

RFP Requirement	Response
Description of work performed	EDS performs the following services for the New Hampshire Medicaid Program: • Claims processing • Provider education • Provider relations • Standard and ad hoc reporting • Security • SUR reporting • System maintenance, operations, modifications, and enhancements Through the services listed above, EDS accomplishes the following tasks: • Processes 5.7 million claims per year • Pays more than $600 million a year to the program's 13,510 enrolled providers • Responds to more than 25,000 provider inquiries per month and offers 300 provider workshops and on-site visits per year Currently, we receive 85 percent of claims electronically. We also provide a provider help desk and training. We maintain a LAN that is connected to the state's WAN.
Contract term	1985 to 1993 1993 to 2004 (current contract)
Staff months expended	More than 9,100 under current contract
Personnel requirements	EDS provides approximately 55 leadership, professional, medical, technical, and clerical staff positions in support of our New Hampshire client. (In addition, we have provided up to 50 additional team members to support Department projects, such as HIPAA.)
Claims volume involved, if appropriate	5.7 million claims per year
Publicly funded contract cost	$86 million Total of current contract combined with amendments, extensions, and options
Number of enrolled providers, if applicable	13,510

Health Management Systems Reference Information

RFP Reference: 3.2.2.5.3.1, p. 3-9

HMS has focused on providing revenue recovery services to a variety of health care institutions and agencies, using state-of-the-art information management and processing technology since 1974. HMS has:

- Provided revenue recovery services for health and social service agencies in 30 states and the federal Centers for Medicare and Medicaid Services (CMS)
- Recovered $1.7 billion for its clients using HMS' specialized revenue recovery services. **HMS is the first third-party recovery (TPR) vendor to reach and exceed the $1.0 billion mark for recoveries**.
- **Generated more than $2.0 billion in cost avoidance savings for Medicaid clients by identifying and verifying more than 750,000 insurance policies**
- Developed a nationwide network of insurance carrier databases, which provides the largest source of third-party coverage identification and recovery. **HMS' in-force agreements represent an average of 85 percent of the health insurance universe in client states.**
- Implemented various electronic platforms through which HMS submits 80 percent of its Medicaid TPR claims. These platforms include custom carrier interfaces that HMS has developed, WebMD Transaction Services, and Companion Technologies (the CHAMPUS/TRICARE claims clearinghouse).
- Developed platforms for the submission of TPR claims to pharmaceutical benefit managers (PBMs). Approximately 80 percent of the pharmacy claims that HMS bills go to PBMs. In addition**, HMS has more than 10 years of experience billing National Council for Prescription Drug Programs (NCPDP) claims and currently submits approximately 63 percent of its pharmacy claims in this format.**

Unparalleled TPR Recoveries

HMS is the first TPR services vendor to reach and exceed the $1.0 billion mark for recoveries.

High Level of Cost Avoidance Savings

HMS has generated more than $2.0 billion in cost avoidance savings by identifying and verifying more than 750,000 insurance policies.

- Established detailed verification processes to confirm the accuracy of the third-party coverage. Verification protocols include obtaining data through telephone calls to carriers and performing online coverage verification through electronic linkages with 21 carriers.
- Demonstrated the ability to perform a full array of revenue recovery activities, including on-site provider reviews, Medicare coordination of benefits, specialized overpayment recovery projects, and federal financial participation (FFP) enhancement projects.

In addition, HMS is the only TPR vendor that has:

- Established a methodology to help states obtain Medicare adjudicated claims data and perform recovery projects using those data, resulting in more than $50 million in recoveries
- Implemented a systematic process for and assigned dedicated HMS staff to performing claims follow-up
- Created a staff unit dedicated to ensuring effective provider relations, resulting in greater provider cooperation with and higher recovery levels from our disallowance and specialized overpayment recovery projects

HMS provides the following five references in support of its capabilities and expertise:

- Connecticut Medicaid Program
- Delaware Medicaid Program
- Maryland Medicaid Program
- Missouri Medicaid Program
- Virginia Medicaid Program

Connecticut Medicaid Program

The scope of HMS' revenue recovery services in Connecticut includes commercial insurance, Medicare Parts A and B, Blue Cross/Blue Shield, TRICARE/CHAMPUS, and Medicaid overpayment recovery. HMS performs data matches, identifies third-party coverage information, submits reclamation claims, and provides third-party coverage updates. Additionally, HMS performs provider (hospital and nursing home) credit balance recovery services. HMS has recovered more than $119.0 million for Connecticut through 2002.

Connecticut Is a Long-standing HMS Client

HMS has been Connecticut's Medicaid TPR contractor since 1990 and has generated more than $119 million in recoveries for this client.

In addition to the Medicaid TPR services that HMS performs in Connecticut, it also provides TPR services for the Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled (ConnPACE). ConnPACE provides prescription drug benefits to Connecticut's senior and disabled citizens.

This project demonstrates HMS':

- Ability to provide TPR services for the Department of PATH, according to RFP requirements
- MMIS experience
- Medicaid experience
- Provider relations experience

The following table provides RFP-required information about HMS' experience working with the Connecticut Medicaid Program.

Connecticut Medicaid Program

RFP Requirement	Response
Customer name	Connecticut Department of Social Services
Contact name and title	Mr. James Wietrak Director of Quality Assurance
Contact information	25 Sigourney Street Hartford, CT 06106 1 860 424 5903 e-mail address: james.wietrak@po.state.ct.us
Description of work performed	HMS has performed the following TPR services for Connecticut Medicaid: • Performs data matches to identify third-party coverage information (commercial insurance, Blue Cross/Blue Shield, Medicare A/B, TRICARE/CHAMPUS) • Issues notices to providers for recovery of Medicaid-paid claims where Medicare coverage exists • Submits reclamation claims to third-party insurers, TRICARE/CHAMPUS, and the Medicare Part B carrier • Performs third-party liability identification and recovery activities on the Medicaid managed care population (coming behind the TPL efforts of the managed care organizations) • Performs on-site hospital and nursing home audits to identify and recover excess patient pay amounts and Medicaid payments that duplicate or overlap other third-party payments • Provides medical support data match identification and verification services (pilot project) • Performs other Medicaid overpayment and federal revenue maximization projects

RFP Requirement	Response
	• Provides Medicaid paid claims file updates • Provides electronic cost avoidance updates • Prepares management reports
Contract term	1990 to present
Staff months expended	7,807
Personnel requirements	HMS provides approximately 19 leadership, professional, technical, and clerical staff positions in support of this client.
Claims volume involved, if appropriate	396,891 (2002 claims volume)
Publicly funded contract cost	$11.4 million Total of current contract combined with amendments, extensions, and options
Number of enrolled providers, if applicable	N/A

Delaware Medicaid Program

The scope of HMS' revenue recovery services in Delaware includes: commercial insurance, Medicare Parts A and B, Blue Cross/Blue Shield, TRICARE/CHAMPUS, and Medicaid overpayment recovery. As a subcontractor to EDS, HMS performs data matches, identifies third-party coverage information, submits reclamation claims, and provides third-party coverage updates. HMS was also involved in approximately one year of joint application development (JAD) and implementation activity with EDS and the Delaware Department of Health and Social Services before the contract start date to facilitate the implementation activities. Initial recoveries from this HMS project are imminent.

Commitment to Thorough and Accurate Implementation

HMS participated in approximately one year of JAD and implementation activity before the contract start date.

This project demonstrates HMS':

- Ability to provide TPR services for the Department of PATH, according to RFP requirements
- MMIS experience
- Medicaid experience
- Provider relations experience

The following table provides RFP-required information about HMS' experience working with the Delaware Medicaid Program.

Delaware Medicaid Program

RFP Requirement	Response
Customer name	Delaware Department of Health and Social Services Division of Social Services
Contact name and title	Ms. E. Beth Laucius Chief Administrator
Contact information	1901 North DuPont Highway Box 906 – Lewis Building New Castle, DE 19720 1 302 255 9525 e-mail address: blaucius@state.de.us
Description of work performed	HMS performs the following TPR services in Delaware as a subcontractor to EDS: • Performs data matches to identify third-party coverage information (commercial insurance, Blue Cross/Blue Shield, Medicare A/B, TRICARE/CHAMPUS) • Issues notices to providers for recovery of Medicaid-paid claims where Medicare coverage exists • Submits reclamation claims to third-party insurers, TRICARE/CHAMPUS, and the Medicare Part B carrier • Provides Medicaid paid claims file updates • Provides electronic cost avoidance updates • Performs other Medicaid overpayment projects, as requested • Prepares management reports
Contract term	2002 to present
Staff months expended	553
Personnel requirements	HMS provides approximately 16 leadership, professional, technical, and clerical staff positions in support of this client.
Claims volume involved, if appropriate	100,000 (2002 claims volume)
Publicly funded contract cost	$0.4 million Total of current contract
Number of enrolled providers, if applicable	N/A

Maryland Medicaid Program

The scope of HMS' revenue recovery services in Maryland includes commercial insurance, Medicare Parts A and B, Blue Cross/Blue Shield, TRICARE/CHAMPUS, and Medicare/Medicaid duplicates. HMS performs data matches, identifies third-party coverage information, submits reclamation claims, and provides third-party coverage updates. Additionally, HMS performs provider (hospital and nursing home) credit balance recovery services. HMS has recovered more than $67.6 million for Maryland through 2002.

Recently, HMS has also implemented projects to:

- Generate Child Health Insurance Program (CHIP) insurance leads
- Perform Medical Support Enforcement (MSE) services (a pilot project, implemented August 2002)

Dedication to Innovative and Responsive Service

HMS' contract in Maryland has recently expanded to include CHIP insurance lead generation and a pilot Medical Support Enforcement project—demonstrating its versatility and commitment to increasing revenues for HMS clients.

This project demonstrates HMS':

- Ability to provide TPR services for the Department of PATH, according to RFP requirements
- MMIS experience
- Medicaid experience
- Provider relations experiences

The following table provides RFP-required information about HMS' experience working with the Maryland Medicaid Program.

Maryland Medicaid Program

RFP Requirement	Response
Customer name	Maryland Department of Health and Mental Hygiene
Contact name and title	Mr. Joseph Fine Chief, Division of Medical Assistance Recoveries and Financial Services
Contact information	Medical Care Operations Administration 201 West Preston Street, Room 203 Baltimore, MD 21201 1 410 767 5369 e-mail address: jfine@dhmh.state.md.us

RFP Requirement	Response
Description of work performed	HMS has performed the following TPR services for Maryland Medicaid as the primary revenue recovery contractor: • Processes data matches to identify third-party coverage information (commercial insurance, Blue Cross/Blue Shield, Medicare A/B, TRICARE/CHAMPUS) • Submits reclamation claims to third-party insurers, TRICARE/CHAMPUS, and the Medicare Part B carrier • Provides third-party coverage updates • Provides Medicaid paid claims file updates • Performs on-site hospital and nursing home audits to identify and recover Medicaid payments that duplicate or overlap other third-party payments and excess patient pay amounts • Performs other Medicaid overpayment projects, as requested
Contract term	1988 to present
Staff months expended	11,691
Personnel requirements	HMS provides approximately 24 leadership, professional, technical, and clerical staff positions in support of this client.
Claims volume involved, if appropriate	345,111 (2002 claims volume)
Publicly funded contract cost	$8.1 million Total of current contract combined with amendments, extensions, and options
Number of enrolled providers, if applicable	N/A

Missouri Medicaid Program

The scope of HMS' revenue recovery services in Missouri includes identifying third-party coverage information, performing data matches, submitting billings based on HMS coverage identifications and information on the state's third-party resource file, tracking collections, and providing third-party coverage updates. In addition, HMS performs federal revenue maximization projects for various state agencies, upon request. **HMS has recovered more than $54.2 million for Missouri through 2002.**

This project demonstrates HMS':

- Ability to provide TPR services for the Department of PATH, according to RFP requirements
- MMIS experience
- Medicaid experience

The following table provides RFP-required information about HMS' experience working with the Missouri Medicaid Program.

Missouri Medicaid Program

RFP Requirement	Response
Customer name	Department of Social Services
Contact name and title	Mr. Mike Rehagen Assistant Deputy Director, Division of Medical Services
Contact information	615 Howerton Court P.O. Box 6500 Jefferson City, MO 65102-6500 1 573 536 4383 e-mail address: MikeRehagen@mail.medicaid.state.mo.us
Description of work performed	HMS has performed the following TPR services for Missouri Medicaid: • Performs data matches to identify third-party coverage information (commercial insurance, TRICARE/CHAMPUS) • Submits reclamation claims to third-party insurers and TRICARE/CHAMPUS • Provides Medicaid paid claims file updates • Provides electronic cost avoidance updates • Performs other Medicaid overpayment and federal revenue maximization projects, as requested • Prepares management reports

RFP Requirement	Response
Contract term	1998 to present
Staff months expended	2,757
Personnel requirements	HMS provides approximately 17 leadership, professional, technical, and clerical staff positions in support of this client.
Claims volume involved, if appropriate	1,196,535 million (2002 claims volume)
Publicly funded contract cost	$6.5 million Total of current contract combined with amendments, extensions, and options
Number of enrolled providers, if applicable	N/A

Virginia Medicaid Program

The scope of HMS' TPR services in Virginia includes commercial insurance, Medicare Parts A and B, Blue Cross/Blue Shield, TRICARE/CHAMPUS, and Medicaid overpayment recovery. HMS performs data matches, identifies third-party coverage information, submits reclamation claims, and provides third-party coverage updates. Additionally, HMS performs provider (hospital and nursing home) credit balance recovery services. HMS has recovered more than $80.5 million for Virginia through 2002.

In addition to the Medicaid TPR services that HMS performs in Virginia, HMS was recently awarded a contract to perform a broad range of revenue maximization services, including:

- Claiming for enhanced FFP for Medicaid family planning services
- Disproportionate share to hospitals (DSH)
- FFP for administrative and direct services related to school-based (special education) health care services
- FFP for administrative claims related to public health services
- FFP through statewide cost allocation plans

Long-Term Client Relationship

HMS has been Virginia's Medicaid TPR contractor since 1987. The strength of this partnership is evident in Virginia's decision to award HMS a contract for performing expanded revenue maximization services.

This project demonstrates HMS':

- Ability to provide TPR services for the Department of PATH, according to RFP requirements
- MMIS experience
- Medicaid experience
- Provider relations experience

The following table provides RFP-required information about HMS' experience working with the Virginia Medicaid Program.

Virginia Medicaid Program

RFP Requirement	Response
Customer name	Department of Medical Assistance Services
Contact name and title	Mr. Stan Fields Director
Contact information	600 East Broad Street Suite 1300 Richmond, VA 23219 1 804 786 5520 e-mail address: sfields@dmas.state.va.us
Description of work performed	HMS has performed the following TPR services for Virginia Medicaid: • Performs data matches to identify third-party coverage information (commercial insurance, Blue Cross/Blue Shield, Medicare A/B, TRICARE/CHAMPUS) • Issues notices to providers for recovery of Medicaid-paid claims where Medicare coverage exists • Submits reclamation claims to third-party insurers, TRICARE/CHAMPUS, and the Medicare Part B carrier • Provides Medicaid paid claims file updates • Provides electronic cost avoidance updates • Performs other Medicaid overpayment and federal revenue maximization projects, as requested • Performs hospital audits to identify provider credit balances and recover Medicaid payments that duplicate or overlap other third-party payments • Prepares management reports
Contract term	1987 to present

RFP Requirement	Response
Staff months expended	14,379
Personnel requirements	HMS provides approximately 27 leadership, professional, technical, and clerical staff positions in support of this client.
Claims volume involved, if appropriate	357,627 (2002 claims volume)
Publicly funded contract cost	$8.9 million Total of current contract combined with amendments, extensions, and options
Number of enrolled providers, if applicable	N/A

Established Working Relationship with EDS

HMS is the TPR subcontractor for EDS' MMIS contracts in Delaware, Indiana, and Kansas. HMS has also worked closely with us in other states (Connecticut, Pennsylvania, California, Oklahoma, Georgia, and Arkansas) where we perform or have performed TPR services as a direct contractor with the state. Hence, HMS offers unparalleled experience to the Vermont Department of PATH in performing TPR services and also experience working successfully with EDS, including the demonstrated ability to receive and process various files from EDS' AIM and interChange systems.

Client/Server Experience Is a Must-Have

The differences between the client/server AIM system and the older, mainframe legacy MMIS platforms are basic and profound. A company's mainframe system experience does not prepare it to take over and operate a client/server MMIS. Most importantly, the required skill sets needed to operate a client/server MMIS are not easy to buy or develop.

The following list highlights the most important differences between the two platforms.

- The two contrasting MMIS environments use completely different operating systems and the skill sets to develop, maintain, and support the two contrasting platforms are completely different
  - Client/server: UNIX
  - Mainframe systems: MVS

Experience Is a Must

"With a new administration, a pending reorganization of the agencies before the legislature, and the looming budget deficit, there is no time for rookies in this transition."

--Dave Nethers
Senior systems engineer and technical architect for EDS client/server systems in Indiana and Oklahoma

- The two MMIS environments use different applications:
  - Client/server: UNIX, C, PowerBuilder, Microfocus, Perl, Java, HTML
  - Mainframe: JCL, COBOL, CICS
- The two contrasting MMISs require vastly different maintenance environments:
  - Client/server: The experienced personnel needed to support the hardware and network must be local. Also, supporting capabilities such as IBM Content Manager OnDemand, networks, client system support, and LAN segments must be established and operated locally (not from a regional data center).
  - Mainframe: Mature technology, providing the technical staff with a controlled method for maintaining, compiling, testing, and executing code; usually maintained by a staff in a regional data center
- Configuration is extremely important:
  - Client/server: The UNIX primary client/server configuration requires support personnel to allocate disk space for the file system and database using UNIX and DBMS tools. This type of support requires trained systems administrators and database administrators with program-specific knowledge and skill.
  - Mainframe: Configuration issues for older legacy systems are usually handled by data center personnel with experience in this established technology.

For these reasons, the Vermont Medicaid Program is best served by EDS—the one company that brings VermontAIM experience, skills, and people.

State of Vermont Contracts

RFP Reference: 3.2.2.5.3.2, p. 3-9

We are pleased to provide the following information on our state of Vermont contracts. This contract history reflects our long partnership and EDS' commitment to Vermont.

EDS Vermont Contract Information
Initial Contract

RFP Requirement	Response
Contract name	Vermont Medicaid
Contract term	Current contract: 07/01/81 to 06/30/85 Option years: 07/01/85 to 06/30/92
Contract scope of work	EDS, as the fiscal agent, transferred, modified, implemented, operated, and maintained a mainframe CMS-certified MMIS. The services provided to the state included the following: • Mail room support • Claims entry and adjudication • Reference file updates • Financial processing • Bank reconciliation • Provider help desk • Provider enrollment, workshops, and education • Systems maintenance and modification • Early and periodic screening, diagnosis, and treatment program (EPSDT) • Management and administrative reporting (MAR) • Surveillance and utilization review (SUR)
Proposed price/actual price	Proposed price: $26,736,680 Actual price: $26,736,680
For expired contract, provide a detailed reason for termination	N/A

EDS Vermont Contract Information
Second Contract

RFP Requirement	Response
Contract name	Vermont Medicaid
Contract term	Current: 07/01/92 to 06/30/98 Option years: 07/01/98 to 12/31/03
Contract scope of work	EDS, as the fiscal agent, designed, developed, implemented, operates and maintains a CMS-certified client server MMIS. The services provided to the state include the following: • Mail room support • Claims entry and adjudication • Electronic claims submission • Drug rebate collections • Reference file updates • Financial processing • Electronic funds transfer • PC*Plus* capitated payment processing • Cash collection and processing • Bank reconciliation • Provider training, workshops, bimonthly advisories • Provider help desk • Provider enrollment • Provider call tracking • Automated eligibility voice response system (AVRS) • ID card generation • Third-party liability (TPL) support • State Children's Health Insurance Program (SCHIP) claims processing training and education • CMS waiver reporting • Systems maintenance and modification • Systems administration and LAN support • EPSDT • Ad hoc reporting • Annual SAS audit • Computer output to laser disk (COLD) reporting • MAR • SUR

RFP Requirement	Response
Proposed price/actual price	Proposed price: $76,166,103 Actual price: $76,166,103 (includes Amendments 1 through 8 to include HIPAA)
For expired contract, provide a detailed reason for termination	N/A

EDS' contract with the Department of PATH is our sole contract with the state of Vermont. However, the flexibility and scalability of the client/server MMIS has allowed this system to support the claims processing and reporting needs of additional programs as well as the Vermont Medicaid Program. Although this expanded support is covered under our contract with the Department of PATH, we believe mentioning these additional programs in our response is appropriate.

We also support the following programs:

- 19195 Home and Community-Based Waiver
- Breast and Cervical Cancer Treatment Program
- Dr. Dynasaur
- General Assistance
- Healthy Vermonters Program
- School-Based Health Services Program
- SCHIP
- Vermont Health Access Program (VHAP\PC*Plus*)
- VHAP Pharmacy—Payment Processing
- VScript—Payment Processing

Contract Terminations

RFP Reference: 3.2.2.5.3.3, p. 3-10

EDS has not had a state health care MMIS contract or other Medicaid contract terminated in the past five years.

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F. Bidder Forms

RFP Reference: 3.2.2.6, p. 3-10, Appendix H, Appendix P

In this section we include the following bidder forms.

- Affirmation of Understanding Statement AHS Rule No. 96-23
- Declaration of Narrative and Price Proposals' Effective Period
- Certification Regarding Independent Price Determination and Authorization to Sign
- Certification Regarding Warranty Against Brokers' Fees
- Certification Regarding Drug-Free Workplace Requirements
- Declaration Concerning Use of Subcontractors
- Subcontractor's Declaration
- Vermont Tax Certification

EDS is not submitting the Certification Regarding Lobbying form because we are not lobbying on the federal level for this opportunity.

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ACCESS TO INFORMATION
AGENCY OF HUMAN SERVICES RULE #96-23

Definitions

"Agency" means the Agency of Human Services or any of the offices, departments or programs that comprise the Agency.

"AHS" means the Vermont Agency of Human Services.

"Client" means an individual or family who is voluntarily served by a department, office, program, contractor or grantee of the Agency of Human Services.

"Contractor" means an individual or entity with whom the Agency or any of its departments, offices or programs has a contract to provide personal services.

"Employee" means any person who works in a full-time, part-time, temporary, or contractual position for the Agency or any of its departments, offices, or programs.

"Grantee" means an individual or entity with whom the Agency or any part thereof has a grant to provide personal services.

"Program" means a set of services, (such as determining and processing ANFC benefits, verifying and setting up delivery for WIC foods) for which the Agency bears fiscal responsibility.

"Administrative Obligations" means activities pursuant to federal or state laws or regulations (such as verification of eligibility, verification of service delivery, detection of fraud, monitoring of quality assurance, audit of expenditure reports) which provide for accountability in the use of public funds.

AHS Rule 96-23

All information specific to, and identifying of, individuals and families is presumed to be confidential and subject to these standards. Employees shall not disclose the information unless a specific exception to the presumption applies or the disclosure is authorized by the client, a court or as otherwise authorized by law or rule.

Existing Statutes

These rules are not intended to expand or diminish current provisions in law relating to disclosure of confidential information.

Information Collection

Employees shall collect and record only that information needed to fulfill the goal of serving the client and meeting administrative or legal obligations.

Informing Clients

At the initial meeting with each client, or within two weeks, employees shall review and offer to provide the rules for access to information to the client.

Permissible Disclosures

Client Consent

No information about a client shall be released without prior consent from the client, unless directly connected with the administration of a program or necessary for compliance with federal or state laws or regulations.

Sharing "Non-identifiable" Information

Information that does not identify a client may be used for statistical research, forecasting program needs, or other such purposes.

Public Information

Information defined as public by 1 VSA & 317 or other applicable statute is available to the public. The procedures in the public records statute shall be followed before public information is released.

Information Sharing for Administrative Purposes

Employees may share information which is necessary to satisfy the Agency's administrative obligations. Departments will develop written agreements limiting the kinds of information to be shared when programs are jointly administered by different Departments. No information shall be released to a person or entity that is out of state, unless directly connected with the

administration of a program or necessary for compliance with federal or state laws or regulations.

Disclosure Without Consent in Limited Circumstances

Employees must release sufficient information to comply with mandatory reporting requirements for cases involving the abuse, neglect, or exploitation of children and persons who are elderly or who have disabilities. Information may be released without consent when Vermont law creates a duty to warn identified individuals of potential harm to their person or property, in response to court orders, or to investigate or report criminal activity as required by federal or state law or regulation. Only information relevant to the situation shall be disclosed. The employee shall document the date, purpose and content of the report, the name, address and affiliation of the person to whom the information was released, and shall notify the client that the information was disclosed.

Procedures Related to Consent

Obtaining Informed Consent

Prior to releasing confidential information the Agency shall obtain the client's informed consent. This includes providing information about consent in a language and format understandable to the client. Reasonable accommodations shall be made for special needs based on the individual or family's education, culture, or disability. Employees shall inform clients that granting consent is not a pre-requisite for receiving services, and shall explain that they may apply for services separately.

Consent of Minors to Release of Information

Employees shall obtain the consent of a minor client to release information concerning treatment for which parental consent is not required.

Format for Consent to Share Information

Consent for the sharing or release of information shall ordinarily be in writing. If an emergency situation requires granting of verbal consent, written consent shall be obtained at the next office visit or within thirty days, whichever comes sooner. Required information will include:

1. Names of the people about whom information may be shared.
2. A checklist of the kinds of information to be shared.
3. A checklist of the departments within the Agency to receive the information.

4. A statement or date covering expiration of consent.
5. A statement about procedures for revoking consents.
6. Signature of individuals covered by the consent, or their parents or guardians.
7. Signature of the individual explaining the consent process with position and title.
8. A space to provide individualized instructions.

A copy of the consent form shall be provided to all signatories.

Client Access to Records

Unless prohibited by federal or state law or regulation, clients shall be permitted to view and obtain copies of their records. Each department within the Agency shall have written procedures which permit clients to verify personal information they have provided for accuracy and completeness and for placing amendments to the information in their files. Employees shall take reasonable steps to present records in a form accessible to the client, including but not limited to large type format or verbal review. A fee not to exceed the actual cost of copying may be charged for records exceeding 10 pages. This fee shall be waived if it would prohibit access.

Procedures to Protect Confidentiality

All AHS employees and all AHS volunteers and interns, shall be instructed in these rules. AHS shall train their Contractors and grantees who shall, in turn, provide the same instruction for their employees, interns, and volunteers.

An employee shall not respond to requests from outside the Agency for information about clients even to acknowledge that the person is a client, unless authorized. If a client has consented to or requests that information be released, the employee shall comply with the request.
Each agency or department shall appoint one or more trained staff members to be responsible for responding to all requests for client information when there is no written consent to release, and no statutory or administrative authority permitting release of the requested information. These individuals shall be specially trained in maintaining confidentiality. A list of the designated individuals for each department and office shall be maintained in the Attorney General's office; Human Services Division.

Employees shall sign an affirmation that they will comply with these rules. This affirmation shall be part of their personnel files. Supervisors shall review this affirmation during annual evaluations. Violation of these rules shall result in disciplinary action.

The following assurance, or one similar to it, will be included in all AHS grants/contracts signed after these rules have been approved:

[Grantee/contractor] agrees to comply with the requirements of AHS Rule No. 96-23 concerning access to information. The contractor shall require all of its employees to sign the AHS affirmation of understanding or an equivalent statement.

When referring a client to another agency for services, if the referral does not meet the criteria for permissible disclosures under Section 3.4, the initial agency shall obtain the consent of the client for the referral and alert the receiving agency that confidential client information accompanies the referral.

Requests for disclosures of client information shall be maintained in the client's file if the request does not meet the definition of a permissible disclosure under Section 3.4. Employees shall document in writing any information actually disclosed, along with the name of the person/agency to whom it was disclosed and the date of the disclosure. When permissible disclosures are made under Section 3.4, documentation may be limited to the name of the department/agency/program to whom the disclosure was made.

When developing a computerized data system, the Agency shall:

1. Develop security procedures consistent with the rule;
2. Instruct staff in the security procedures;
3. Inform clients if a computerized system is being used;
4. Establish written agreements with participating agencies outlining procedures for sharing and protecting information.
5. Develop security procedures in relation to the transmission of information.

The Agency shall develop a protocol, which is consistent with the requirements of this rule to safeguard confidential client information. Contractors and grantees shall also develop a protocol or shall adopt the protocol of the Agency. The protocol shall be designed to safeguard written information, data in computer systems, and verbal exchange of information. The protocol shall prohibit unauthorized access to records and include an appropriate disciplinary process for violations of the security rules.

Written procedures for implementing these rules shall be used as the basis for employee instruction and shall be available for review in the Agency Central Office.

Agency of Human Services
Vermont Department of Prevention, Assistance, Transition,
And Health Access
103 South Main Street
Waterbury, Vermont 05671-1201

Affirmation of Understanding Statement

As a Contractor for the State of Vermont, I affirm that I have read the Agency of Human Services (AHS) Rule No. 96-23 concerning Access to Information, and that I agree to comply with the requirements of AHS Rule No. 96-23.

I shall require all of my employees performing services under this contract to sign an affirmation of understanding statement. Employee statements need not be sent to the State, but they shall remain in Contractor's personnel records. The State can request copies of such documents if necessary.

EDS Information Services, L.L.C.
Name of Company (Print or type)

April 4, 2003
Date

Authorized Signature

Senior Vice President U.S. Government Solutions,
Sales and Marketing
Title

**DECLARATION OF TECHNICAL
AND PRICE PROPOSALS' EFFECTIVE PERIOD**

The Bidder, EDS Information Services, L.L.C.
(NAME OF BIDDER)

hereby declares that submitted proposal, including the prices shown in the Price Proposal Worksheets, will remain in effect for a period of six calendar months from the proposal due date.

(This form must be signed in ink by a corporate official authorized to legally bind the Bidder. The official's printed name, title, and the date this form was signed must be entered.)

EDS Information Services, L.L.C.
Bidder Name

Kevin J. Durkin, Senior Vice President U.S. Government Solutions, Sales and Marketing
Name and Title of Authorized Bidder Representative

Signature of Bidder Representative

April 4, 2003
Date

CERTIFICATION REGARDING INDEPENDENT PRICE DETERMINATION AND AUTHORIZATION TO SIGN

The Bidder certifies in connection with this procurement that:

(1) The prices proposed have been arrived at independently, without collusion, conflict of interest, consultation, communications, or agreement for the purpose of restricting competition, as to any matter relating to such prices with any other bidder or with any other competitor; and

(2) Unless otherwise required by law, the prices quoted have not been knowingly disclosed by the Bidder prior to the award directly or indirectly, to any other Bidder or to any competitor.

The Bidder also certifies that the person signing this proposal is the person in the Bidder's organization responsible for, or authorized to make, decisions as to the prices quoted, and that he or she has not participated, and will not participate in, any action contrary to (1) or (2) above.

EDS Information Services, L.L.C.
Bidder Name

Kevin J. Durkin, Senior Vice President U.S. Government Solutions, Sales and Marketing
Name and Title of Authorized Bidder Representative

Signature of Bidder Representative

April 4, 2003
Date

CERTIFICATION REGARDING WARRANTY AGAINST BROKERS' FEES

The Bidder certifies that it has not employed any company or person, other than a bona fide employee working solely for the Bidder or a company regularly employed as its marketing agent, to solicit or secure this contract; and that it has not paid or agreed to pay any company or person, other than a bona fide employee working solely for the Bidder or a company regularly employed as its marketing agent, any fee, commission, percentage, brokerage fee, gifts, or any other consideration contingent upon or resulting from the award of this contract.

For breach or violation of this provision, the State shall have the right to reject the proposal, annul the contract without liability, or, at its discretion, deduct from the contract price, or otherwise recover, the full amount of such fee, commission, percentage, brokerage fee, gifts, or contingencies, or to pursue any other remedies available under this contract, by law or in equity.

EDS Information Services, L.L.C.
Bidder Name

Kevin J. Durkin, Senior Vice President U.S. Government Solutions, Sales and Marketing
Name and Title of Authorized Bidder Representative

Signature of Bidder Representative

April 4, 2003
Date

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
U.S. DEPARTMENT OF EDUCATION - CONTRACTORS
U.S. DEPARTMENT OF AGRICULTURE – CONTRACTORS

This certification is required by the regulations implementing Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.). The January 31, 1989 regulations were amended and published as Part II of the May 25, 1990 Federal Register (pages 21681-21691), and require certification by grantees (and, by inference, subgrantees and subcontractors), prior to award, that they will maintain a drug-free workplace. Section 3017.630(c) of the regulation provides that a grantee (and, by inference, subgrantees and subcontractors) that is a State may elect to make one (1) certification to the Department in each Federal fiscal year in lieu of certificates for each grant during the Federal fiscal year covered by the certification. The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or governmentwide suspension or debarment.

(A) The grantee certifies that it will, or will continue to, provide a drug-free workplace by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free workplace program to inform employees about:

(1) The dangers of drug abuse in the workplace;

(2) The grantee's policy of maintaining a drug-free workplace;

(3) Any available drug counseling, rehabilitation, and employee assistance programs; and

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS (continued)

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
U.S. DEPARTMENT OF EDUCATION - CONTRACTORS
U.S. DEPARTMENT OF AGRICULTURE – CONTRACTORS

(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);

(d) Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will:

(1) Abide by the terms of the statement; and

(2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five (5) calendar days after such conviction;

(e) Notifying the agency in writing, within ten (10) calendar days after receiving notice under subparagraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within thirty (30) calendar days of receiving notice under subparagraph (d)(2), with respect to any employee who is so convicted:

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

(continued)

U.S. DEPARTMETN OF HEALTH AND HUMAN SERVICES - CONTRACTORS
U.S. DEPARTMENT OF EDUCAITON - CONTRACTORS
U.S. DEPARTMENT OF AGRICULTURE - CONTRACTORS

Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

(B) The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant.

Place of Performance (street address, city, county, state, zip code; list each location):

312 Hurricane Lane #101
Williston VT 05495

☐ Check if there are workplaces on file that are not identified here.

EDS Information Services, L.L.C.
Bidder Name

Kevin J. Durkin, Senior Vice President U.S. Government Solutions, Sales and Marketing
Name and Title of Authorized Bidder Representative

Signature of Bidder Representative

April 4, 2003
Date

DECLARATION CONCERNING USE OF SUBCONTRACTORS

The Bidder, EDS Information Services, L.L.C.
(NAME OF BIDDER)

DOES propose the use of subcontractors as part of its solution to the Vermont.

The subcontractors proposed to be used are as follows (list all subcontractors; add additional sheets if necessary):

Health Management Systems, Inc. (HMS)

If the use of subcontractors is indicated above, the Declaration entitled "Subcontractor's Declaration" on the following page must be completed and appended for **every** subcontractor proposed above.

DECLARATION CONCERNING USE OF SUBCONTRACTORS
(continued)

(This form must be signed by a corporate official authorized to legally bind the Bidder. The official's title and the date this form was signed must be entered.)

EDS Information Services, L.L.C.
Bidder Name

Kevin J. Durkin, Senior Vice President U.S. Government Solutions, Sales and Marketing
Name and Title of Authorized Bidder Representative

Signature of Bidder Representative

April 4, 2003
Date

SUBCONTRACTOR'S DECLARATION

Health Management Systems, Inc. (HMS) (hereinafter referred to as

Subcontractor), subcontractor to EDS Information Services, L.L.C.
(NAME OF BIDDER)

(hereinafter referred as the Bidder) for the Vermont MMIS project, shall perform the following functions for the Bidder, if selected (add additional sheets if necessary):

HMS will support EDS by performing various Third-Party Liability functions under the MMIS Core

Claims Processing Takeover. HMS will provide services in accordance with RFP sections

2.7.6 (Third-Party Liability Subsystem) and 2.8.3.3 (Third-Party Liability Responsibility

Reorganization and Subsystem Upgrade).

(Description of Subcontractor's Duties)

The following individual(s) shall be responsible for Subcontractor's efforts on the Vermont MMIS project (add additional sheets if necessary):

1. William C. Lucia — President
   Name — Title
2. Donna Price — Vice President of Program Management
   Name — Title
3. Keith Reinold — Senior Program Director
   Name — Title

The Subcontractor's willingness to perform the work above is indicated by the signature below.

SUBCONTRACTOR'S DECLARATION
(continued)

(SUBCONTRACTOR: This declaration must be signed by individual authorized to legally bind the subcontractor.)

Health Management Systems, Inc.
Subcontractor Name

William C. Lucia, President
Name and Title of Authorized Bidder Representative

Signature of Bidder Representative

April 4, 2003
Date

STATE OF VERMONT
DEPARTMENT OF PREVENTION, ASSISTANCE, TRANSITION,
AND HEALTH ACCESS (PATH)
103 South Main Street
Waterbury, Vermont 05671-1201

VERMONT TAX CERTIFICATION

To meet the requirements of Vermont Statute 32 V.S.A. S3113, the certification shown below must be completed, signed and returned with your bid. This certification is required by law, and without it, the Department of PATH is not able to issue your company any purchase order or contract that could result from this bid proposal.

The disclosure of your social security or federal identification number is mandatory, is solicited by the authority granted by 42 U.S.C. S405 (c) (2) (c), and will be used by the Department of Taxes in the administration of Vermont tax laws, to identify individuals affected by such laws.

By law, no agency of the State may enter into, extend or renew any contract for the provision of goods, services or real estate space with any person unless such person first certifies, under the pains and penalties of perjury, that he or she is in good standing with the Department of Taxes. A person is in good standing if no taxes are due, if the liability for any tax that may be due is on appeal, or if the person is in compliance with a payment plan approved by the Commissioner of Taxes. 32 V.S.A. S 3113.

Maximum penalty for perjury is 15 years, a $10,000 fine, or both.

I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to, or in full compliance with a plan to pay, any and all taxes due the State of Vermont as of the date this statement is made.

EDS Information Services, L.L.C.
Name of Company (Print or Type)

April 4, 2003
Date

By (Signature)

75-2714824
Federal Identification Number /Social Security Number

03-6000-264
Vermont Business ID Number

G. Overall Approach

RFP Reference: 3.2.2.7, p. 3-11

Since 1981, EDS has partnered with the Department of Prevention, Assistance, Transition, and Health Access (PATH) to provide fiscal agent services to the state of Vermont. During that time, we have been privileged to be part of the many changes in Vermont's health care landscape. Our Medicaid Management Information System (MMIS) and services have evolved in response to these changes. Vermont and EDS have invested in significant improvements since 1981, and we are committed to making future changes that will focus on your desire to have an MMIS built on business needs capable of supporting "the digital state."

During each implementation, our approach has always included the same benefits: low risk coupled with the best value for Vermont. Responsiveness to the needs of Vermont is another benefit of our approach to all phases of service to the Department of PATH. For example, when Vermont received a waiver to expand its Medicaid program to allow schools to bill for medical-related services for Medicaid-eligible students, we hired additional provider representatives to work directly with the supervisory unions to ensure correct Medicaid claim billing.

Over the past 10 years, our team has developed unique firsthand knowledge of the VermontAIM system and its intricate business processes. This, coupled with our continuing track record of successful performance, has enabled our team to develop strong, trust-based relationships with the Department of PATH staff that allow us to continue operating the system with no interruptions and no risk. The overall approaches in this section describe the close relationships, understanding of the Department of PATH's health care programs, and many other features of our service that are the result of this long-term commitment to Vermont.

We describe our approach to supporting the Department of PATH in the following sections:

(a) The Scope of Work Relationship Between Takeover, Operations, and Enhancements and Modifications

(b) Vermont's Health Access Programs, including beneficiary communication and provider relations

(c) Applicable Federal and State Requirements

(d) Contract Requirements

(e) Infrastructure Requirements

(f) Project Risks and Approach to Monitoring and Managing Such Risks

(g) Interaction With State Personnel

(h) Use of Subcontractors

(i) Assumptions and Constraints

Our response to (d) Contract Requirements includes a discussion of one of our most important contract requirements: an understanding of the 12 subsystems/functional areas that comprise the VermontAIM client/server MMIS. We discuss the essential elements of the operation and enhancements of each of these 12 areas.

(a) Scope of Work Relationship Between Takeover, Operations, and Enhancements and Modifications

RFP Reference: 3.2.2.7(a), p. 3-11

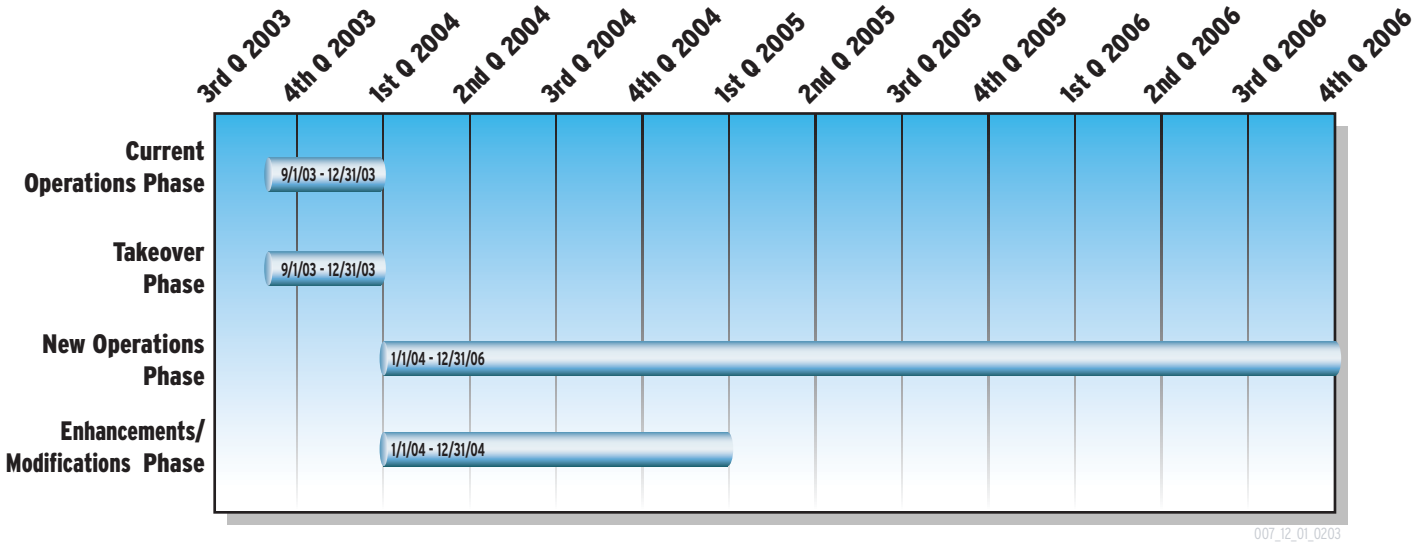
In developing our approach to meeting RFP requirements, we have carefully considered the relationships and dependencies among the three major project phases in the scope of work. **Our incumbent status gives the state the advantage of no takeover tasks or oversight, continued stability of operations, and excellent insight for effectively planning the implementation of enhancements and modifications. This advantage translates to improved service to the provider community and beneficiaries.**

Our staffing and project plans reflect our desire to fulfill the requirements of each phase with our ongoing commitment to service excellence.

Overview of Relationship Among Project Phases

In the following table, we present the time frames for each phase of the new contract as well as our responsibilities for the current contract, which overlap with the four-month Takeover Phase.

Project Time Line



This time line shows the time frame for each key project phase.

In the following sections, we discuss the relationship between each pair of consecutive phases seen in the preceding exhibit, explaining how we will oversee a smooth transition from phase to phase:

- Current Operations and Takeover Phases
- Takeover and Next Operations Phases
- Operations and Enhancements/Modifications Phases

Current Operations and Takeover Phases

As the incumbent contractor, EDS will continue to provide service excellence during the four-month period when the Operations and Takeover Phases overlap: September 1, 2003, to December 31, 2003. **Our operations functions operate smoothly today, providing a solid foundation for the takeover. The EDS team has no learning curve and will continue serving Vermont under the leadership of Client Delivery Executive Barbara Davis and her management team.**

Instead of spending energy to support a new contractor's Takeover Phase, **the Department of PATH can address budgetary concerns through the early implementation of cost-containment initiatives.**

During the Takeover Phase and at the state's request, we will begin to implement any cost-containment mechanisms the state selects from the suggested list in our "Cost Containment Mechanisms" response in the "Work Plan and Schedule (Operations)" section. In addition, we can begin implementing the mandatory and optional enhancements in September if the state agrees. Understanding the fiscal budget pressures you face, we want to get started immediately helping you to realize all potential cost savings.

In addition, we will reconvene the cost-containment review team in Williston that has made recommendations in past years for such cost-containment enhancements as ClaimCheck, biannual provider certification, and implementation of J-code processing. **We will be ready to work with the state as soon as the new contract is signed to implement cost-saving enhancements.**

Takeover and Next Operations Phases

By selecting the incumbent contractor, you eliminate disruption and risk during the transition from the Takeover Phase to the Operations Phase. Because an incumbent faces no takeover requirements, the transition will be seamless to all program stakeholders.

Additionally, you can focus on future initiatives while maintaining high service levels because it will not require additional resources to support a new contractor's time-consuming takeover projects. We will not require state resources for the takeover effort.

Providing further continuity, the management team, which includes Client Delivery Executive Barbara Davis, Program Services Manager Valerie Lewis, and Systems Manager Cherie Bergeron, will remain consistent from the Takeover to the Operations Phases.

Key activities detailed in our operations work plan are listed in the following table. Tasks we are already performing appear in a separate column from new tasks. **As the table indicates, we already perform the vast majority of takeover tasks for Vermont every day.** For us, takeover will be business as usual as we continue to process claims, perform provider services, manage finances, make changes to the VermontAIM, obtain state prior authorization, process adjustments, support certification and recertification, and continue working with state personnel under established and familiar processes. **The state can rely on us to continue operations without interruption. Furthermore, the state's effort for takeover will be minimal. With another contractor, however, takeover activities will significantly drain limited state resources and will disrupt the momentum the state has in meeting future goals.**

Operations Work Plan Tasks

Already Performing These Tasks	New Tasks
• Review/update all systems documentation • Review/update user manuals • Update operational procedures • Update the Business Continuity and Disaster Recovery Plan • Perform claims processing • Perform provider services • Perform financial management • Perform system enhancements/modifications • Obtain approval from the state prior to performing tasks with the expectation of reimbursement • Maintain regular communication with the Department of PATH and providers • Receive, process, and adjudicate valid claims and drug payment transactions • Receive, process, and adjudicate adjustment requests • Support state monitoring of our contract responsibilities • Follow state security policies • Support turnover, training state or designated staff	• Review and finalize the work plan • Acquire equipment and furniture to support enhancements • Develop the State Personnel Education Plan

Already Performing These Tasks	New Tasks
• Support certification and recertification activities • Continued compliance with Medicaid laws and regulations • Support HIPAA • Support privacy, security, and confidentiality • Adhere to SAS 70 auditing schedule and requirements • Support accounting • Retain records • Fulfill contract staff requirements • Support system reliability • Support customer service requests • Provide MMIS access • Support electronic claims submission • Perform system and acceptance tests • Meet timeliness-of-processing responsibilities • Fulfill correctness-of-payment responsibilities • Perform data entry • Perform claims resolution and suspense • Perform financial management • Perform mail room services • Provide communication tools	

Operations and Enhancements/Modifications Phases

Delivering high-quality system modifications while minimizing any disruption to ongoing operations is key to our approach to implementing system modifications during the Enhancements/Modifications Phase. This phase runs concurrently with the first year of the new Operations Phase: January 1, 2004, to December 31, 2004.

First, **we will maintain the same high level of service excellence—using established processes and experienced managers—to lead Operations Phase work**. Barbara and her managers will continue to oversee operational work.

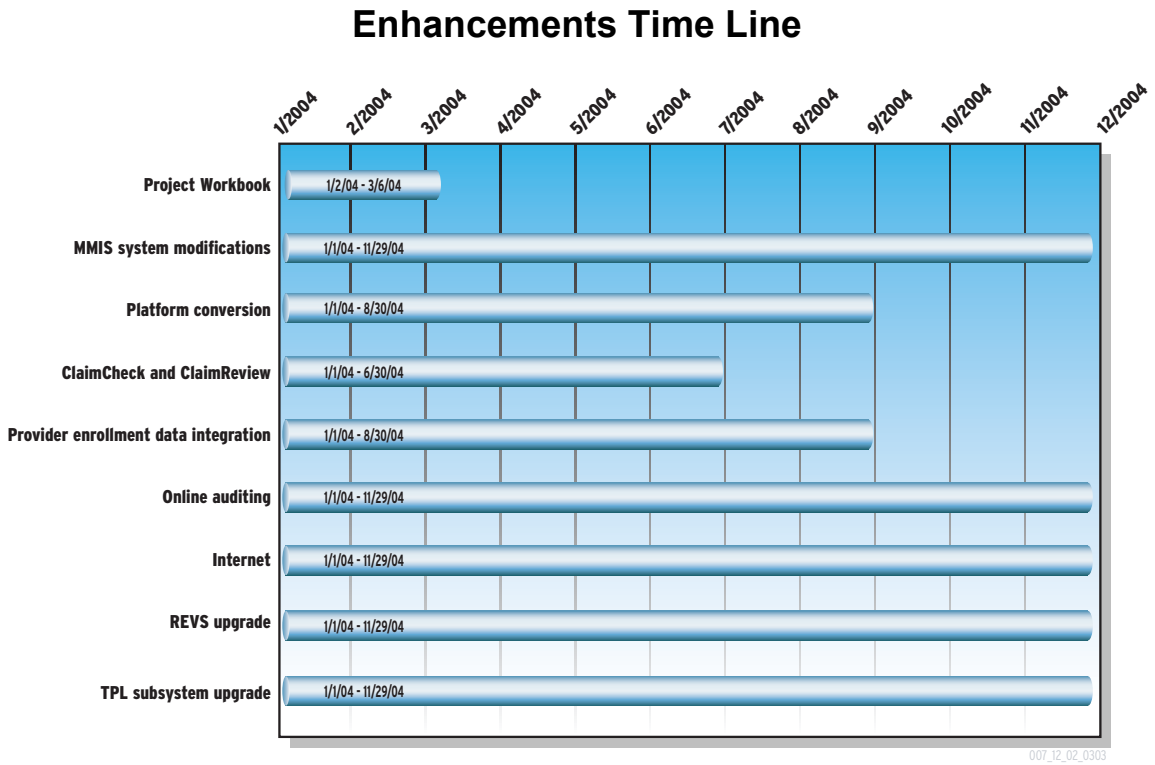
The expertise offered by this management team assures you that you can rely on us to pay providers accurately and on time so beneficiaries continue receiving services.

After we implement enhanced processes and tools, such as the Project Workbook, to support the Enhancements/Modifications Phase, we will begin leveraging these new procedures to enhance operational efforts.

Second**, Enhancements/Modifications Manager Sean Daly and his support team will lead the Enhancements/Modifications Phase effort.** We will establish a separate Enhancements/Modifications Phase team to support Sean, using experts from EDS' central support centres who have experience with similar enhancements. Sean's team will focus on the enhancements and modifications work so Barbara and her managers can remain focused on day-to-day operational responsibilities. The state will benefit because Barbara and her key operations managers will also be available to provide insight and support to Sean's team during this phase when necessary.

Third, **we will carefully protect the integrity of ongoing account operations in assigning subject-matter experts from the operational team to support enhancements and modifications**. We will backfill any operational systems engineer positions required to support the Enhancements/Modifications Phase with experienced personnel from EDS' central support centres. This approach has proven successful for Vermont in the current Health Insurance Portability and Accountability Act (HIPAA) remediation project.

The following time line identifies each enhancement project and its completion date.



The state gains early access to all enhancements by selecting EDS as its fiscal agent.

In implementing each of these enhancements, we begin by assembling our team, reviewing and finalizing the work plan with the state, and performing requirements validation for each enhancement project. Our requirements validation process involves working with the state to develop a Requirements Specification Document and to refine it into a Detailed System Design document. Both will be signed off by the state before we begin work.

To ensure the enhancement meets your expectations and begins operating on time, we will use our Global Solution Management System (GSMS) methodology practices for the implementation of all enhancements. The GSMS methodology consists of the following steps:

- Develop conversion plan
- Develop and test enhancements and modifications
- Perform system conversion
- Perform user acceptance testing and operational readiness testing
- Implement enhancements
- Update provider community
- Provide operational maintenance and technical support for enhanced MMIS

By using these sound project and systems development methodologies and our experienced people, we will implement these exciting new enhancements on time for Vermont. Furthermore, you can rest assured that, as we have done in the past, we will mold all methodologies to fit Vermont's unique project management needs.

A Well-Considered Plan

For the state, the risks associated with a project of this magnitude are significantly mitigated by our firsthand knowledge and ongoing experience with Vermont's Medicaid program and fiscal agent operations. **The Takeover Phase will feature a continued high level of service to providers and beneficiaries, experienced staff, and ongoing program momentum for the state.**

This stable foundation will serve the state well during the first year of the Operations Phase and the Enhancements/Modifications Phase. We will carefully augment our operational team of key managers and subject-matter experts with experienced systems implementation leaders and technical personnel dedicated to implementing your enhancements. You have the greatest assurance of smooth operations by selecting an experienced Vermont contractor to manage the complexities of the Medicaid program and this new contract.

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(b) VERMONT'S HEALTH ACCESS PROGRAMS

RFP Reference: 3.2.2.7(b), p. 3-11

More than 135,000 individuals, approximately 20 percent of Vermont's population, participate in one or more of Vermont's medical assistance programs. This population includes individuals deemed categorically needy and those deemed medically needy.

Federal Medicaid payments are made to Vermont through the Agency of Human Services (AHS). Operationally, the Medicaid program is delegated to the Department of Prevention, Assistance, Transition, and Health Access (PATH). Within the Department of PATH, the Office of Vermont Health Access (OVHA) manages the majority of Medicaid benefits.

In this subsection, we describe our understanding of Vermont's health access programs. Because provider relations plays an important role in the successful establishment of these programs, we also describe the activities that keep the providers satisfied participants.

Medicaid Plans

Under Title XIX of the Social Security Act, Medicaid provides medical care to aged, blind, or disabled individuals with low incomes and resources. It is jointly funded by the federal government and states, at no cost to the beneficiary.

The OVHA offers the following Medicaid plans to all eligible Vermonters. In some cases, based on eligibility, the beneficiary may be required to contribute a copayment.

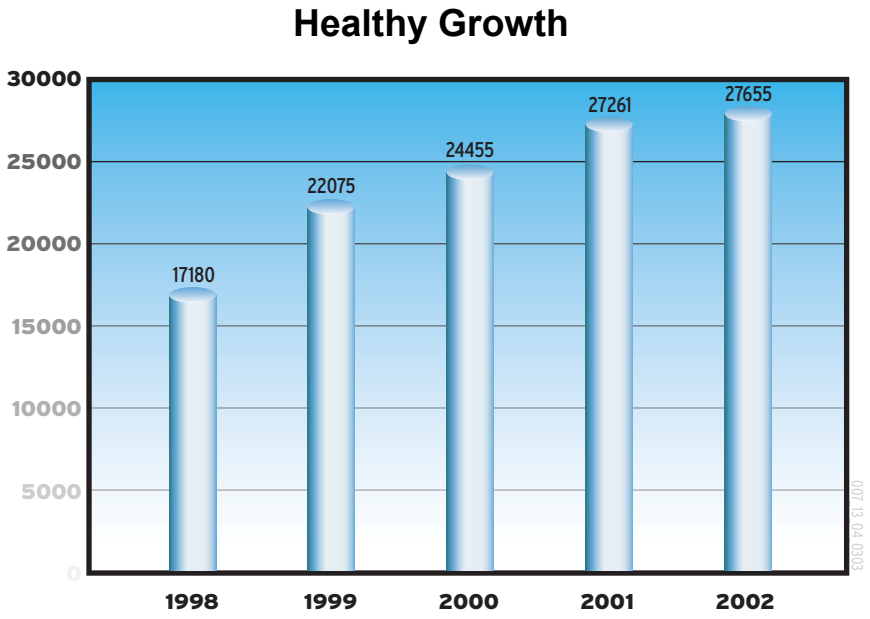
Fee-for-service—This program provides a full range of services, while affording the beneficiary the ability to seek care with any Medicaid-approved provider. Services are reimbursed to the provider at a predetermined amount. The program was initially intended as interim coverage until managed care plans were available to Vermonters. Today, the OVHA continues to provide this service to individuals from the time they are determined eligible until they are enrolled in Medicaid PC*Plus,* Vermont's primary care case management program. In addition, the OVHA enrolls the following groups into the fee-for-service plan:

- Beneficiaries possessing third-party insurance
- Beneficiaries possessing home- and community-based waivers
- Beneficiaries enrolled in the Medicaid High Tech Program
- Beneficiaries living in long-term care facilities

Managed care—The OVHA began offering Medicaid beneficiaries a managed health care option on October 1, 1996. The OVHA contracted with local health maintenance organizations (HMOs) to administer the managed care health benefits from October 1996 until May 2000. During this time, the managed care organizations (MCOs) elected to drop out of the managed care program, thus jeopardizing the state's 1115 waiver. To see what we could offer the OVHA, Barbara Davis visited the Idaho account that had just implemented a PC*Plus*-type program and brought back all the program specifications. Then the Vermont team went to work. The Systems and Program Services teams worked closely with the OVHA to design a program that would allow the state to offer "choice" to the beneficiaries, thus preserving your 1115 waiver and providing the proper oversight of beneficiary care. The OVHA, with the technical assistance of our team, developed PC*Plus* as an alternative to the commercial managed care program. Enrollment in PC*Plus* began on October 1, 1999, with all beneficiaries transitioned by May 2000.

Dr. Dynasaur—This program began in 1989 as a state-funded program for uninsured pregnant women and children under the age of seven who did not qualify for traditional Medicaid coverage. In 1992, the state integrated Dr. Dynasaur coverage into the Medicaid program under section 1902(r) (2) of the Social Security Act and expanded coverage to include children under the age of 18. This change eliminated copayments and raised the age limitation for eligibility while providing for prenatal and preventive care.

The Dr. Dynasaur program has grown considerably in the past five years as the following graphic indicates:



Since 1998, the Dr. Dynasaur program has grown by more than 10,000 beneficiaries.

Vermont Health Access Plan

In April 1995, the Vermont General Assembly signed the Vermont Health Access Plan (VHAP) into law to address medical needs not covered by Medicaid. To fund the state's share of program costs associated with the VHAP, the Legislature increased the state cigarette tax. This tax increase allowed the Legislature to approve a health care benefit package for uninsured adults and a pharmacy benefit package for lower income elderly and disabled individuals.

In July 1995, the Health Care Financing Administration (HCFA, now CMS) approved the VHAP as a Section 1115(a) research and demonstration project under the Social Security Act to assist in promoting the objectives of Title XIX.

The VHAP includes the following basic components:

- Funding for health care services for lower income Vermonters whose access to care is limited, in part, by their lack of insurance
- Prescription drug benefits for lower income elderly or disabled Vermonters
- Improved access, service coordination, and quality of care through the implementation of a managed care delivery system

Eligibility for the VHAP programs is determined by Vermont's Health Access Eligibility Unit and through applications filed with local district offices of the Department of PATH.

In addition to providing fee-for-service and managed care programs similar to those provided by Medicaid, the OVHA offers the following VHAP programs to all eligible Vermonters. Program fees are associated with these plans, based on the federal poverty level (FPL). Copayments apply for most services, and elective hospitalization is not a covered service.

- **VHAP Pharmacy**—Covers medications for short-term and long-term medical conditions for low-income elderly or disabled individuals who are Medicare-eligible or receiving social security disability benefits with an income up to 150 percent of the FPL.
- **VScript**—Provides assistance in paying for maintenance drugs only, including insulin syringes and needles, for elderly or disabled low-income Vermonters with income below 175 percent of the FPL and over the limit for VHAP Pharmacy. Vscript makes purchasing prescription drugs possible for program enrollees at Medicaid prices. Beneficiaries pay a small copayment for prescriptions with a maximum out-of-pocket cap for each calendar quarter.

- **VScript Expanded**—Provides assistance, which is normally not available to Medicaid beneficiaries, in paying for maintenance drugs only, including insulin syringes and needles, for elderly or disabled low-income Vermonters whose income falls between 175 percent and 225 percent of the FPL. Vscript makes purchasing prescription drugs possible for program enrollees at Medicaid prices. A yearly deductible and a maximum out-of-pocket cap are applicable to this plan.
- **Healthy Vermonters**—Provides discounts on prescriptions to qualified Vermonters who have insurance policies that do not provide prescription drug coverage or have a yearly limit under a commercial insurance plan. The amount of the discount varies depending on the type of drug. Discounts apply to prescriptions written for both acute and maintenance drugs. Prescription costs are based on the state's rate.

VScript and VScript Expanded beneficiaries are automatically eligible for the Healthy Vermonters program for prescriptions that the current program does not cover. VHAP Pharmacy beneficiaries are ineligible for the Healthy Vermonters program.

Beneficiary Communication

The OVHA contracts with Maximus to provide beneficiary enrollment and beneficiary support services regarding programs, eligibility, and benefits. Maximus communicates with beneficiaries about enrollment, enrollment status, and changes to benefit structure as well as reapplication for continuance of enrollment in a Medicaid program. Our team works closely with Maximus to expedite issues about claims processing and provider eligibility.

We have established a strong working relationship with Maximus during the past five years to resolve beneficiary concerns and to provide the highest level of support possible to both the beneficiary and the provider community. A provider representative is assigned as the liaison for providers and Maximus and communicates daily with Maximus to resolve any beneficiary concerns. Our provider representatives update, produce, and distribute the PC*Plus* directories to Maximus and the OVHA monthly.

Our Third-Party Liability (TPL) team works directly with beneficiaries to recoup money owed to the state for TPL and casualty claims. The TPL coordinators send the TPL questionnaire to the beneficiary requesting further information on the cause of an accident or injury. The questionnaire helps determine whether or not an insurance carrier is responsible for claim payment. The TPL clerks respond to the help desk calls regarding the letters and work with the beneficiaries to ensure they understand the purpose and process of returning the letters.

Our account team currently supports the beneficiaries in the activities we perform for you under our fiscal agent contract, and we will continue to assist you with our help desk support and beneficiary letters until these activities are phased out of the contract and turned over to the OVHA as specified in the RFP.

Provider Relations

We understand the importance of having a well-trained, highly skilled provider relations staff to serve as the point of contact for claims-related questions. Our team members address questions from a variety of individuals, including providers and state and local government agency representatives, such as district office caseworkers.

> "Keene Medical Products, Inc. has enjoyed our relationship with EDS of Vermont. Christine Haskins has been instrumental in helping us get claims processed through EDS and OVHA….I feel that EDS does go out of its way to help the provider."
>
> --Keene Medical Products

Provider representatives are ambassadors for the OVHA, conducting on-site provider visits, presenting workshops and training sessions, explaining the multiple programs and billing requirements, marketing the electronic claims submission options, and attending various provider conferences and the Vermont Health Access Advisory meetings. Provider representatives are trained to research and resolve the complicated provider inquiry issues encountered on a daily basis. We work closely with the OVHA personnel and our other operational units to bring about satisfactory resolution to provider issues.

Our approach to offering the highest level of provider support includes the following four components:

- Maintaining an automated voice response system that is available 24 hours a day, 7 days a week
- Maintaining a fully trained provider relations staff that is thoroughly versed in claim submission policies and procedures involving all of the Vermont Medicaid programs
- Equipping the provider relations staff with the necessary tools, such as laptop computers, to access claims data during on-site visits and data show projectors to show information in a more effective way during workshops
- Maintaining open lines of communication with providers by returning all calls placed to the provider relations team within 48 hours

Knowledgeable Staff

To fully comply with all OVHA policies and procedures, the providers must first understand them. Our provider representatives are dedicated to fostering this understanding. Each representative goes through an extensive training period on the claims processing system as well as the OVHA program rules, regulations, policies, and procedures. Our experienced managers, team leads, and subject matter experts (SMEs) assist in this intensive training before the representatives are awarded their own territory.

> "Thank you for your continued help while I learn this process. I appreciate you very much."
>
> --Carol Gibson Warnoch, Licensed Midwife

Because our representatives serve as the first point of contact for Medicaid and other state health care programs, they are expected to be knowledgeable resources about each aspect of beneficiary and consumer eligibility, claims adjudication activity, and program-covered services and benefit limitations. We take the training of our staff very seriously.

Our provider representatives use their laptop computers to maintain access to information on claim, policy, or system matters associated with Vermont Medicaid while working with providers at their offices. They also have access to Enhanced Vermont Ad Hoc (EVAH), which is an online reporting tool that identifies providers with high denial rates as compared to their peers in the same specialty and region. EVAH allows us to research the providers we have identified as having an abnormal number of claims denied. We can then provide the training and assistance to those providers to ensure the accuracy of claims submission.

One-on-One Visits

With the complexities of the Medicaid program and the high turnover experienced in provider billing offices, one-on-one site visits are critical to the success of the program. We conduct provider on-site visits periodically throughout the state as directed by the OVHA, when providers request a visit, and when our Provider Relations team determines a need based on review of claims processing.

While we primarily schedule a one-on-one visit to review specific claim issues, we understand that we also can use this forum as a unique training opportunity for our providers. In preparation for the one-on-one visit, we perform data queries using EVAH to determine the exact number of claims submitted by the provider, the number of paid claims, the number of denied claims, and a detailed listing of all claim errors and denial reasons. This information, combined with specific claims review, give the provider a better understanding of the full scope of the program and the complexities related to program reimbursement.

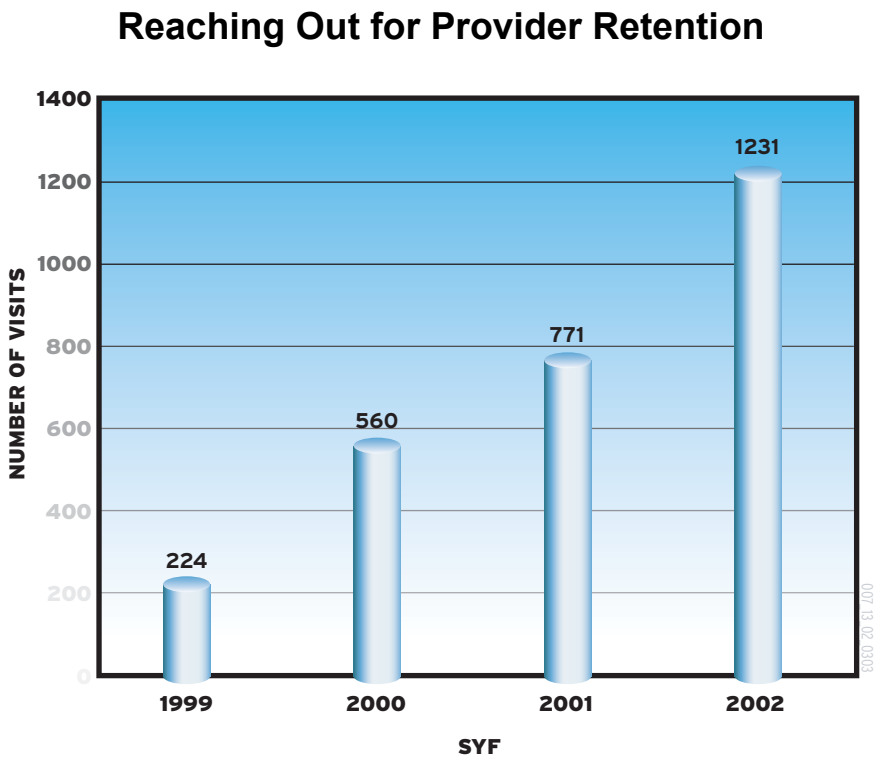
Each provider representative is responsible for supporting the providers in his or her geographic territory. Once a visit is scheduled with a provider, the representative will research provider claim and billing history in preparation for the visit, provide software and billing training, document key topics discussed, follow-up on any open issues, and monitor provider claims to ensure the resolution of issues discussed.

> "The support given by the Provider Relations Rep has been outstanding. I couldn't have resolved a major issue without her and her support."
>
> --Council on Aging South End

In 1998, we established an ongoing Quality Improvement Plan (QIP) to initiate proactive provider visits. Our goal is to identify and reach out to providers before they experience frustration with billing issues. We run ad hoc reports to identify new providers and providers who appear to have larger or more specific denial issues than others within their provider type peer group. We use proactive visits to identify common provider issues and design training plans around these issues. Training plans for claims resolution can be tailored to each provider's specific needs.

The QIP, which was co-chaired by two provider representatives, set a standard of a minimum of 25 visits each quarter per representative. We have more than doubled the current number of proactive provider visits, and we strive to increase that number even more by implementing new strategies.

The following graphic shows the annual growth of provider visits from 1999 to 2002. The personalized, timely services offered by our provider relations staff have a direct, positive impact on provider satisfaction and continued participation.

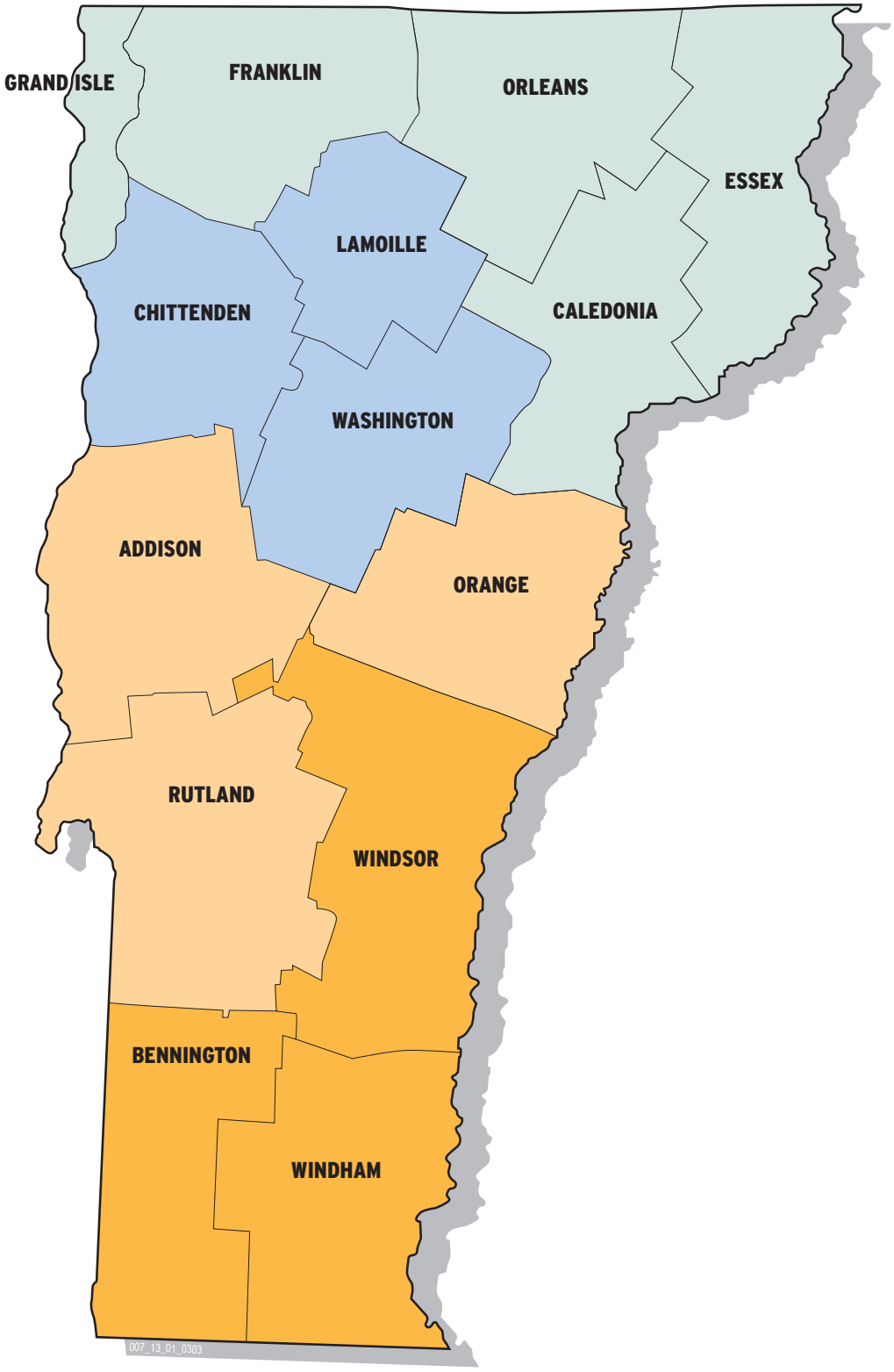


From 1999 to 2002, the number of provider outreach has grown six fold.

Our representatives work with providers in 14 counties as well as Vermont Medicaid providers in bordering states. The state is divided into four territories, and each territory is assigned to a provider representative who is responsible for servicing those providers. In addition, a fifth provider representative is assigned to work exclusively with the Community Mental Health Centers and Fletcher Allen Health Care. By using this approach, provider representative can create a strong working relationship with these "high profile" providers, which has resulted in a higher level of satisfaction.

The following graphic shows the territories supported by our provider representatives.

Regional Representatives



Our provider representatives make themselves available for on-site provider visits.

Training Opportunities

We recognize the important role of provider training, which is demonstrated by the involvement of our provider representatives in the provider community. Our provider representatives give presentations at professional association meetings, offer workshops, and provide individual training sessions, which are tailored to meet the needs of the provider and the OVHA. Each year our program services manager and the provider representatives develop a provider training plan that is presented to the OVHA. The individual and group training sessions cover the following topics:

- Provider enrollment procedures
- Billing procedures
- Coding procedures
- Responsibilities and function of the OVHA
- Early and Periodic Screening, Diagnosis, and Treatment program policies
- Claims processing functions
- Prior approval procedures
- Point-of-sale (POS) and eligibility verification systems
- Electronic claims submission guidelines
- Health Insurance Portability and Accountability Act (HIPAA)
- Claim adjustments

In addition, our provider representatives are available to develop and deliver training on other topics identified by the OVHA or providers.

Provider Associations

Provider associations are the voice of Vermont's provider community, and we actively listen to them. For the past 21 years, we have worked closely with these associations to better understand their issues and concerns and the services available in the state. Our provider representatives are actively involved with several provider associations and attend scheduled provider association meetings to assist with billing concerns or explain upcoming changes.

Our provider relations representatives attend meetings with the following associations: the New England Medical Equipment Dealers (NEMED), Vermont Patient Account Managers (VPAM), Healthcare Finance Managers Association (HFMA), Diabetic Counsel, Community Mental Health Centers (CMHCs), PC*Plus* Workgroup (including representatives from PATH, OVHA, Maximus, and EDS), Independent Mental Health Counsel, The New Hampshire and Vermont Strategic HIPAA Implementation Plan (NHVSHIP), and Bi-State Primary Care Association. We periodically present topics at association meetings that have been identified by our providers as areas of concern.

We also work with many of these provider associations during the implementation of program policy changes, supporting the unique needs of each specific provider type.

Our program services manager works closely with the heads of these associations to be sure they are comfortable with the implementation process and to identify areas of improvement. When both parties, the providers and EDS, are thoroughly knowledgeable about OVHA polices and procedures, beneficiaries will have the most appropriate access to health care without unnecessary barriers. We will continue to work with the OVHA to customize training events and outreach activities to meet the needs of the entire Vermont health care community.

Provider Publications

The Provider Relations team supports publication development and distribution with input from our key operational personnel and the OVHA liaisons. For each publication, we work with the OVHA to determine the media for the publication (Web-based, e-mail, diskette, or paper), prepare the initial copy, revise the draft, obtain approval, and distribute the final document. We work closely with the OVHA to communicate program changes. We also work with our help desk staff to address subjects of repeated inquiry or confusion.

The following list identifies the most frequent and helpful provider publications that we develop and distribute:

- **Provider manual and supplements** are used by the provider community to understand format requirements, to adjudicate claims, and to understand billing and reimbursement policies and procedures. We currently maintain the provider manual, which pertains to all enrolled providers. We also maintain the following supplements: HCFA-1500, Dental, Independent Labs, Durable Medical Equipment (DME), Prior Authorization, Rehabilitation Agencies, and Long-Term Care Facilities. Our provider representatives continue to partner with OVHA Policy Chief John Dick in revising the provider manual and all applicable supplements and will continue to modify them as specified in the RFP.

  Well-prepared and up-to-date provider manuals and supplements are a necessary prerequisite to understanding the many facets of the OVHA. We recognize that the provider manual and supplements must be accurate, complete, up-to-date, and easy to use. Clear, concise manuals enable providers to submit claims in the correct format for adjudication, avoiding unnecessary denials and rework. We provide the manuals and supplements to the OVHA in a PDF file and post them to the state's Web-site at www.dsw.state.vt.us/districts/ovha/ovha5.htm.

- **Weekly Remittance Advices** (RAs) are mailed each week to providers who have claims activity for the preceding week. The first page of the paper RA is the **Banner Page.** It contains information such as deleted and added billing codes, legislative changes, reminders, and system notifications. Also, we can target specific provider types or specialties for specialized mailings.

- ***Vermont Health Access Advisory*** is a newsletter published every other month and written in partnership with the OVHA and EDS. The *Advisory* contains important information on billing procedures, new policy directives, and changes to benefits based on legislative laws, training session notifications, and HIPAA updates.

The *Advisory* was created in an effort to provide Medicaid billers and practitioners with up-to-date information in an ever-changing environment. Billing information and policy changes are later incorporated into the manuals and the revisions are posted on the state's Web site.

- **Notices and bulletins**, in the form of letters that may or may not have attachments, are mailed to the provider community informing them of upcoming changes, clarifications, or informational topics as determined and approved by the OVHA. We also send notices and bulletins to provider associations in the state, designated state staff, area OVHA offices, and other organizations and individuals as directed by the OVHA. We use reports, provider feedback, and OVHA recommendations to determine the necessity of each proposed notice or bulletin.

Provider Relations Surveys and Other Feedback

To monitor our relations with providers, our Provider Services team sends a satisfaction survey to a random sample of 1,000 actively enrolled providers each year. Vermont providers have consistently rated EDS above average on these surveys. We ask the providers to rate our performance related to claims processing, the adjustment process, Provider Services Help Desk telephone responses, on-site visits by provider representatives, and staff professionalism.

> "It is wonderful working with OVHA and EDS, as everyone is very professional and courteous. We have a very good relationship with OVHA and EDS."
>
> --DME Provider, Yankee Medical

We sent the 2002 survey to providers on October 29, 2002. Of 1,000 surveys, 421 (42 percent) were returned to EDS by November 30, 2002. **Overall, 88 percent of providers surveyed said they were satisfied or highly satisfied with our performance, an increase of 10 percent from 2001.** Providers rated our services better in 2002 in provider services, provider relations, eligibility verification, and overall performance. This increase in provider satisfaction is a direct result of improvements we have made over the past year due to comments/suggestions made by providers in the 2001 survey. For example, last year providers voiced their concerns over long wait times, a lack of standardized training, and outdated provider manuals. We listened to this feedback and put systems and procedures in place to improve in these areas.

We installed new software to proactively monitor the telephone wait times on the Provider Services Help Desk and used additional resources on the account to offer telephone support at peak times. This has resulted in a dramatic decrease in wait times. In the past year, the help desk has consistently averaged a wait time of 50 seconds or less. We also took advantage of EDS' online education capabilities and established a standardized training program for all Provider Services staff, including implementing a series of customer service courses.

We worked in partnership with the OVHA to release updated versions of the provider manual and supplements to assist the provider community in billing Medicaid. We will continue to strive to provide excellent, professional, and timely provider service, as well as improve the timeliness of claim adjudication.

Provider Services Help Desk

When providers contact our friendly and knowledgeable Provider Services team, they know they will receive the help they need in a timely manner. Our team, under the supervision of the program services manager, includes five help desk representatives and one team lead. The help desk staff responds to provider telephone inquiries between 8 a.m. and 5 p.m., Monday through Friday.

We have effective processes in place to respond to written and verbal inquiries from the Vermont provider community. We employ a fully trained staff to respond to all types of inquiries, including the following:

- Coverage issues
- Program benefits and program limitations
- Consumer responsibility for copayment, spend down, and noncovered services
- Claims processing and payment requirements
- Consumer- or provider-initiated grievances

Our Provider Services Help Desk representatives are well versed in each aspect of providing high-quality customer service. We provide each representative with the training, tools, and processes needed to fully respond to incoming inquiries.

To ensure consistent quality, our provider services training plan includes proper telephone etiquette with follow-up reminders during weekly team meetings. For reference material after initial training, each help desk representative receives a complete manual with regularly updated policies. We use standardized procedures, available through the Vermont*AIM* online lookup function, to research and respond to provider inquiries.

To monitor quality of provider telephone service, supervisors monitor a random sample of telephone calls for accuracy and etiquette by contacting those providers for feedback on the information they received during the call and the professionalism of the person handling the call. Supervisors also contact providers who have had recent site visits for feedback and follow-up on the visit. The feedback we receive is provided to the state at the fiscal agent meeting.

"Most of my PSU experiences have been with Niki, Faith, Brian, and Cortni, and I have to tell you that they have always been friendly, patient, kind and if they don't have an answer to a question, they will go and ask someone....This means so much to a provider's office to be made to feel like it is important to EDS that we as providers have the information that we need. It is also impressive that they can maintain this pleasantness in what has to be a difficult, difficult job. I just wanted to take a moment to let you and them know how much I have appreciated their kindness and excellent service - every time. I'm really sorry that Chiropractic will no longer be a covered benefit, but it was important to me to commend them on a job well done!"

--Sean J. Heller, DC, Chiropractor

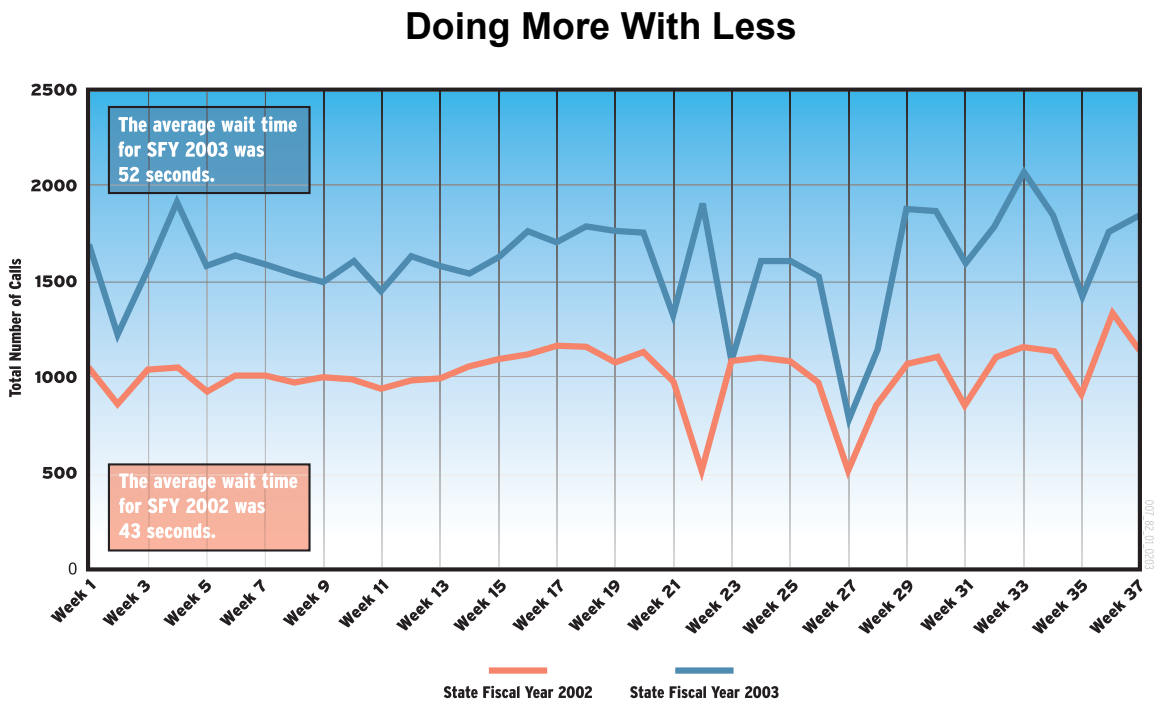
One-on-One Call Support

Using the automated call distribution (ACD) telephone monitoring and reporting software system, the Provider Services Help Desk representatives answer all incoming calls from providers and assist them with the following types of inquiries:

> "You have some great provider services staff. Niki has always been very helpful and accommodating. She is a definite asset to your staff."
> --Bettina D. Laidley, DMD

- Billing questions
- Eligibility
- Policy changes
- Limits information
- Claim status
- Requests for manuals and forms
- Prior authorization guidance
- Procedure and coverage inquiries

Team Lead Nicole Holton monitors call volumes and wait times from a desktop computer. We support unexpected surges in call volumes and seasonal peaks by relying on other team members, such as provider relations representatives, to assist with calls. We average a call wait time of less than 50 seconds, which is significantly better than the industry standard. As the following graphic demonstrates, when call volumes increased by nearly 33 percent from SFY 2002 to SFY 2003 due to the addition of new programs, legislative changes, and increased numbers of providers, wait times increased only slightly and help desk staff did not increase at all. We handled the additional volume without any increased cost to the state.



When call volumes increased by nearly 33 percent from SFY 2002 to SFY 2003(YTD), we drew upon our flexibility and innovation to handle the additional calls without increasing the help desk staff.

We document all telephone calls between our office and providers on the MMIS, allowing for reporting and information retrieval for research or legal purposes. Each call log documents the provider number, caller name, EDS representative, type of call, questions asked, and the response given. In the event that a call requires additional research and cannot be completed while the caller is on the line, the call log can be saved in an "open" status to allow for the necessary research to be completed. Once we complete the research, we call the provider and close the telephone log. We return the majority of calls within two days and return all calls within 14 days. Complex issues may not be resolved within 14 days, but our goal is to keep the provider informed each step of the way, until resolution is reached.

Written Inquiries

The Provider Services Help Desk representatives also respond to written inquiries. We request providers submit written inquiries for the following:

- Claims status
- Denial clarification
- Manuals or forms requests

The Provider Services team lead batches these inquiries daily and logs them for reporting purposes. We research all inquiries and respond to the provider within two weeks, processing and returning the majority the next day.

We respond to more than 200 written inquiries every week, while maintaining our average call wait time for answering telephone calls. We complete 100 percent of all written inquiries in less than 14 days.

Dental Fax Inquiries

Adult recipients of Vermont Medicaid are subject to a yearly benefit limit; therefore, providers are required to verify remaining benefits before providing services. To simplify this process for the providers, the Provider Services team offers a dental fax form that providers use to indicate the recipients they will treat. We return the form indicating eligibility, limits used, and other insurance information. We can give eligibility information beginning nine days prior to the service date.

Point-of-Sale Assistance

To verify eligibility prior to performing services, providers may use the recipient's identification card and a card-swipe system. Eligibility information for the recipient appears on the POS device within seconds of swiping the card. Eligibility, service limits, and other insurance information are available 24 hours a day, 7 days a week.

We have trained our Provider Services team to assist providers with questions on using and understanding their POS device. Providers routinely ask us to complete maintenance on the boxes, order new boxes, and confirm the accuracy of information given.

Voice Response System Assistance

Providers also have access to recipient information 24 hours a day, 7 days a week through the fully automated voice response system (VRS), using a touch-tone telephone. The VRS provides the following types of information:

- Beneficiary eligibility
- Remaining service limits
- Current week claims paid amount
- Third-party liability information
- Beneficiary's primary care provider

Providers who are having difficulties or need further clarification of a response given by the VRS can reach a representative by pressing "0." The provider is automatically transferred to the Provider Services Help Desk.

"If I am having trouble with the program it is always reassuring that I can call and get the help I need and get friendly service."

--Orleans/Northern Essex Family, Infant & Toddler Program

Provider Enrollment

The Vermont-based team operates and maintains the provider enrollment function that includes managing the workflow in the Provider Enrollment team. We use the many automated provider screens available with the VermontAIM MMIS to operate and maintain the provider data maintenance function. We also maintain each provider's physical paper file to store his or her license obtained from the Secretary of State's office. CMS requires each provider have an active license on file to be an active Medicaid provider. The certification or recertification form with the original signature of the provider, and as directed by the state, may also be found in the physical paper file. A checklist of required documents specific to each Vermont Medicaid provider type is included in the detailed processes and procedures that the enrollment specialists follow.

Process Improvements

We continue to streamline the enrollment process by identifying opportunities for improvement. When recent opportunities presented themselves, our Enrollment team jumped at the chance to make positive changes for new and current providers, including the following.

- Reduced re-enrollment from every year to every other year for most providers
- Created a user-friendly enrollment form
- Identified billing providers not currently enrolled
- Created a smooth process for completing file maintenance in a timely manner

Provider Certification and Recertification

We mail enrollment invitations to providers we have identified as not being certified as a Medicaid provider. Our invitation to enroll includes reimbursement rates, billing and coverage information, and a provider agreement.

When a provider returns the agreement, we review it for accuracy and appropriate licenses, enter all data elements into the MMIS, and notify the OVHA. Upon state approval, the provider is certified, and we enroll the provider into Vermont Medicaid and issue a provider number. We mail a welcome package and instructional materials to the provider.

For recertification, we print an enrollment form with the provider information currently in our system and mail it to the provider. The provider reviews the form and updates any changed information prior to returning the form to us. Upon receipt, we review and compare the information received to the information in our system to ensure accuracy.

Provider File Maintenance

The Enrollment team verifies a provider's state licensure and certification, including specialty certification. We require a copy of a provider's current state license before certifying or recertifying the provider into Vermont Medicaid. We update the system and change the expiration date, reflecting the expiration date on the license plus an additional three months.

We receive requests to update information in provider files from numerous sources, including the state, provider community, and internal sources. The information may come in electronic or paper form. We update and verify files daily. The Enrollment team assists the help desk staff by taking telephone calls when an unexpected surge in call volume occurs.

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(c) Applicable Federal and State Requirements

RFP Reference: 3.2.2.7(c), p. 3-11

The Centers for Medicare and Medicaid Services (CMS) specifies the functional capabilities for the MMIS as described in Part 11 of the State Medicaid Manual and in 42 CFR 433, Subpart C. Adherence to these specifications are mandatory to acquire federal certification and to receive the maximum allowable federal financial participation (FFP). Vermont legislative mandates expand upon the federal regulations to allow inclusion of greater populations of individuals within the OVHA's jurisdiction.

We understand your goal to receive the maximum allowable FFP while meeting the needs of Vermont's expanding medical assistance population. We will work under these federal and state contractual guidelines to ensure your needs are met as we work with you to shape the future of the Medicaid industry.

In the following subsections, we describe our understanding and approach to meeting federal and state requirements.

Federal Requirements

We consistently meet CMS' requirements for certification in all of the 15 MMIS operations that we currently manage. We currently maintain Periodic Medicaid Statistical Information System (MSIS) 2082 and CMS64 (formerly HCFA64) reporting. We also review and enhance system functions to ensure proper reporting, as when CMS published the MSIS Data Dictionary specifications for 1999.

The Health Insurance Portability and Accountability Act (HIPAA) has also expanded the federal regulation concerning the tracking and transmission of health insurance information. We have dedicated resources that fully understand the associated federal regulations and are actively working with Vermont to ensure full compliance.

For more information about our outstanding track record as an industry leader in this area, see the "Certification and Re-certification" subsection of the "Work Plan and Schedule (Operations)" section.

State Requirements

State guidelines tend to be more rigid than federal regulations. The Welfare Assistance Manual provides precise details of how the Medicaid program is to function. Review of our performance during the past 21 years demonstrates our commitment to working with Vermont to expand existing criteria within the VermontAIM to cover additional populations. For example, we incorporated the Breast and Cervical Cancer Treatment (BCCT) program into the MMIS following the waiver received from legislative mandate. We also enhanced the VermontAIM to support the entry and tracking of additional provider contact information. For example, we can track provider calls and field visits, which provide the state with documentation needed to support fraud and abuse cases.

We perform annual state audit reporting to provide detailed payment reports per provider. These reports assist the state in reviewing and analyzing payments for auditing and cost settlement purposes as well as for identifying budgetary trends.

We currently subscribe to the *Commerce Clearing House, Medicare/Medicare Rules* publication. We review each update to determine how new rules and regulations may affect the Medicaid program, and we alert the state staff at our weekly fiscal agent meetings of any potential changes.

Growing With the Medicaid Industry

The OVHA needs a partner that has the flexibility to address the changes of the Medicaid industry, including those as a result of legislative, budgetary, and client challenges. The state has seen firsthand our commitment to growing with the Vermont Medicaid Program throughout the years. We will continue to evolve with the Medicaid industry and remain a good steward of Vermont's investment in delivering Medicaid fiscal agent services.

Providing Industry Insight

With the expertise and resources of EDS' Health Care Global Industry Solutions Group, our Medicaid partners stay ahead of the game when addressing new practices, technologies, and developments in the health care industry.

We have a strong team of industry experts representing health care and government knowledge. Lynn Lyford is a member of the EDS' Government Global Affairs group that tracks key legislation comments and proposed rules and regulations, and influences significant policy that affects our customers' business.

EDS' Health Care Global Industry Solutions Group (HCGISG), led by Charles Saunders, M.D., helps our client delivery teams stay current on trends, drivers, and significant developments that affect our health care customers. The HCGISG includes individuals with extensive expertise in the health care industry. In addition, these individuals actively participate in many industry forums. The HCGISG also assists our teams in leveraging knowledge and solutions across multiple clients, such as consulting with clients on HIPAA issues. Our team relies on HCGISG's knowledge and resources to learn about significant new practices, technologies, and other developments in the health care industry.

EDS corporate leaders also participate actively in professional associations, forums, advisory groups, and task forces that examine the regulations and standards affecting Medicaid delivery. These entities include the following:

- Accredited Standards Committee X12N
- Accredited Standards Committee Health Level 7
- Association for Electronic Health Care Transactions
- CMS Private Sector-Technology Group
- National Council for Prescription Drug Programs
- Workgroup for Electronic Data Interchange
- National Uniform Code Committee
- National Uniform Billing Committee
- National Medicaid EDI HIPAA Work Group
- Center for Digital Government

Our corporate leaders serve as well-informed resources and communicate the information gathered from these forums to us on a regular basis. This involvement in industry organizations enables us to grow with the Medicaid industry as technology and health care demands change. We do not just participate on national standards boards, we are directly involved with implementing these standards. In addition, our representatives to these organizations present your issues and concerns.

In addition, EDS representatives attended several New England States Consortium Systems Organization (NESCSO) meetings during our collaboration with four states to develop a leveraged approach to HIPAA remediation for the MMISs supported in each of the states. This collaborative approach has saved each state several million dollars at a time when every state dollar is a precious resource. EDS worked with the states to develop this leveraged approach and worked closely with NESCSO to coordinate the multistate effort.

By selecting EDS, Vermont partners with a technology leader with proven operational experience in all aspects of the Medicaid program nationwide. Our experience comes from supporting Medicaid-related programs in 33 states during the past three decades, incorporating what we have learned into our methodology and processes, keeping current with industry demands and technology advances, and bringing thought innovation to each customer.

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(d) CONTRACT REQUIREMENTS

RFP Reference: 3.2.2.7(d), p. 3-11

Throughout the contract, including the Takeover Phase, EDS will meet all business requirements, be fully staffed and prepared for action, and maintain an effective relationship with the OVHA. To accomplish these goals, we will retain the skills and efforts of the talented, experienced staff already dedicated to Vermont today. EDS is committed to meeting all contract requirements as specified in the request for proposal (RFP).

With more than 30 years of Medicaid program and system operations experience, EDS has had the opportunity to develop, implement, transfer, take over, operate, and turn over hundreds of systems and operations. Our reputation and future in the health care industry rely on successful completion of all our responsibilities to each and every customer. Our approach to the contract management for Vermont includes:

- Use of EDS' performance monitoring tools and project management procedures
- Staff to participate in issue resolution process; status and planning meetings; and state and federal audits, certifications, and performance monitoring activities
- Timely access to all MMIS data, windows, reports, and technical system documentation
- Notification to the Department of PATH of any security breach attempts
- Development and testing of a Business Continuity and Disaster Recovery Plan for the MMIS

We understand that the primary performance indicator for any fiscal agent is the correct, on-time payment of all claims. One way that we achieve this goal is through our proven ability to manage projects effectively and efficiently. Contract management is an integral part of our project management methodology, PM 2. Following these procedures as part of our comprehensive approach to project management helps ensure that we continually meet or exceed the contract requirements established between the Department of PATH and EDS, regardless of the project phase in which we are working.

In preparation for our response to this RFP, we analyzed, in detail, the contractor requirements against our current operational staffing levels. Our resulting staff model represents appropriate levels to support the existing and new requirements for the VermontAIM and fully support the OVHA. Our proposed staffing levels, clear lines of authority, and proper personnel resource allocations reflect our focus on quality improvement, systems operation, and accountability to meet each of our contract responsibilities.

Additionally, because we are familiar with and successfully operate the VermontAIM system today, meeting the contract requirements does not pose the same level of challenge or risk as a transition with another contractor. Rather, we can focus our efforts on preparing for the mandatory and optional enhancements that you select to complement the existing technology.

Understanding

In this procurement, you will select the contractor most capable of meeting the current needs of Vermont Medicaid stakeholders, system users, providers, and beneficiaries while bringing the technical depth necessary for the program's future. We are uniquely qualified to fulfill this charter. Our proposal responds to your requirements, both explicit and implicit.

We recognize the absolute need for uninterrupted and timely claims payments and the need for a timely response on the help desk. We also know that the momentum of current projects must be maintained. In addition, we grasp the daily intricacies of the VermontAIM operations and know what it takes to keep things running smoothly. Just as importantly, we understand that you need actionable information and tools on program trends and costs, interfaces to core systems, and new models focused on provider and beneficiary services. Lastly, we recognize that we jointly face budgetary changes now and in the future. Our support of Vermont's Medicaid Program under the new contract consists of our continued, full dedication to anticipating and meeting your needs and ensuring that providers are quickly and appropriately reimbursed for approved services. We understand the importance of meeting all contract requirements and pledge to fulfill these responsibilities, ensuring that qualified beneficiaries will have uninterrupted access to the health care they need.

Approach

Our approach is to accommodate existing technology and services and to meet the stated requirements. As the incumbent, our approach to the contract requirements for the Takeover Phase lies in continuing to provide service excellence during this period. In addition, during this time we will not stand idle. We will begin to implement any of the cost containment mechanisms the state selects from our suggested list in our "Cost Containment Mechanisms" response in the "Work Plan and Schedule (Operations)" section. In addition, we can begin implementing the mandatory and optional enhancements in September if the state agrees. Understanding the fiscal budget pressures Vermont is facing, we want to immediately start helping you realize all potential cost savings. We will be ready to work with you as soon as the new contract is signed.

We outline our Operations approach in the "Work Plan and Schedule (Operations)" section and our Enhancements/Modifications approach in the "Work Plan and Schedule (Enhancements/Modifications)" section. The development of the work plan and schedule include the use of EDS' proprietary Web-based Project Workbook, identification and tracking and reporting procedures, and the use of change control and configuration management procedures.

The Operations Phase is schedule to begin on January 1, 2004. During this first year of operations, the state is requiring the contractor to implement the following mandatory enhancements and modifications:

- MMIS system modifications
- Platform conversion
- ClaimCheck and ClaimReview installation
- Provider enrollment data integration

At your discretion, you may also require the implementation of any or all of the following optional enhancements:

- Internet functionality
- Recipient Eligibility Verification System (REVS) upgrade
- Third-party liability (TPL) subsystem upgrade
- Fiscal and budget application

The implementation of any of these mandatory and optional enhancements or modifications will require the replacement of current technology or the addition of new technology. All of the enhancements and modifications are complex and require in-depth understanding of the Vermont MMIS' existing technology. Our experienced technical team will be responsible for implementing the enhancements, under the direction of Enhancements/Modifications Manager Sean Daly. Sean's experience with the existing system will allow him and his team to rapidly implement the modifications that will further enhance the VermontAIM.

We will meet or exceed your contract expectations and are committed to service excellence now and in the future.

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The VermontAIM Subsystems

To complete our discussion of contract requirements, we will focus on the contract's primary requirement: the VermontAIM MMIS. The RFP allows bidders a great deal of latitude in discussing the VermontAIM system and its component subsystems. In developing our approach to discussing the subsystems for this proposal, we considered the following approaches:

- Responding individually to each bullet in the "Contractor Responsibilities" sections
- Focusing on the subsystems' purpose and role within the larger context of the MMIS and highlighting recent and planned modifications that further enhance the subsystems' usefulness

In evaluating the first approach, we saw that this kind of extensive, exhaustive approach would conclusively demonstrate our understanding of the VermontAIM system. However, the page count for this type of detailed response would amount to more than 240 pages (allowing 20 pages for each of the 12 subsystems in RFP section 2.7).

We saw that the second, more compact approach would tell you the essentials of the subsystems, of their flexibility and adaptability, and in far fewer pages. For these reasons, we have adopted this approach to demonstrate our understanding of the 12 VermontAIM subsystems.

Common Technologies

Vermont has seen the value of its first-of-a-kind, client/server MMIS. The VermontAIM system's flexibility and scalability have been proven over and over again since the system's implementation 10 years ago. For this procurement, we are planning additional modifications that will further enhance the system's ability to provide nimble, flexible support for the other PATH programs that use the system. These enhancements will improve the service provided by most (and in some cases, all) of the 12 subsystems. In the following paragraphs, we describe several of these features, which you will see referenced in many of the subsystem descriptions.

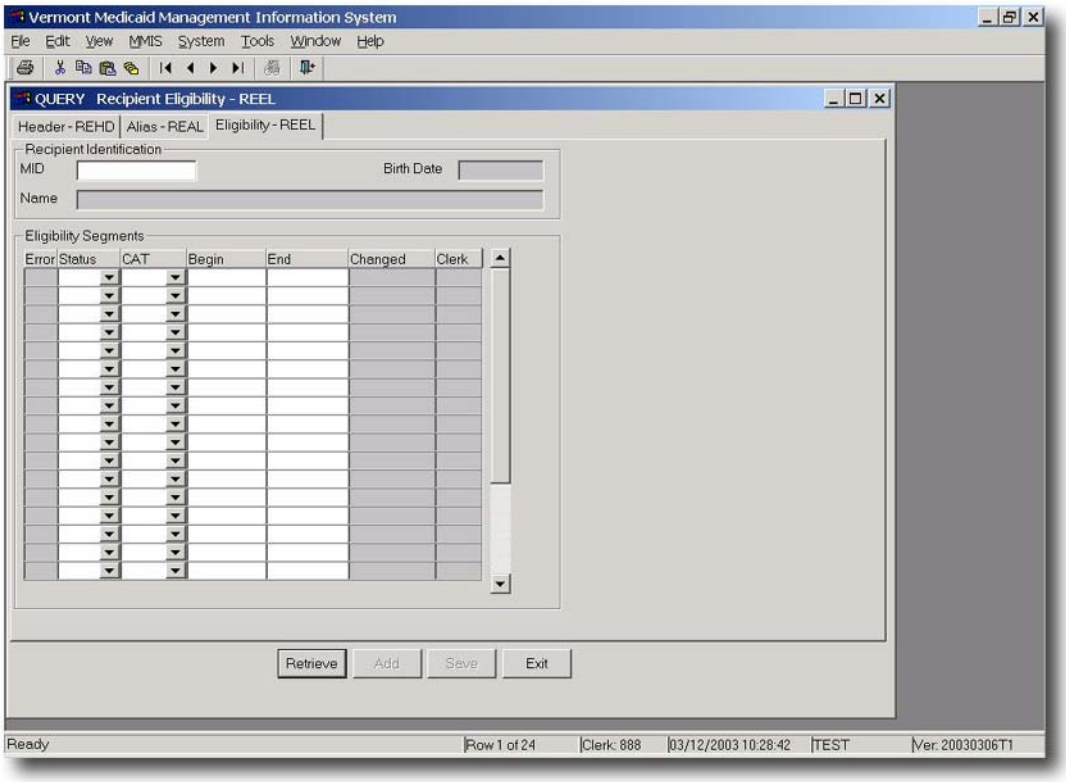
Online Audit Trails

To satisfy the platform conversion mandatory enhancement/modification, we are proposing to convert the existing Ingres database to an IBM DB2 Universal Database (DB2). One of the many benefits of this conversion is the ability to provide audit trail information for online windows with a click of the mouse. Once the DB2 conversion is complete, you will be able to see the update history for each field on any of the online windows. This history will identify the person who made the update and the date of the update. The history will also show the field's value before the update. This fast research capability replaces the current approach, where several days are required to generate the same information that will be available in seconds. Online audit trails will be available on all subsystem online windows.

PowerBuilder Windows

Barbara Davis and her Williston-based team are currently modifying the VermontAIM MMIS to comply with the regulations for HIPAA transaction and code sets. In the process of implementing HIPAA, the team is creating new online windows (known as PowerBuilder windows) that will streamline user interaction with VermontAIM. We realize that the HIPAA modifications are not a feature of the RFP; however, we refer to the new PowerBuilder windows in the Enhancements portion of many subsystem descriptions because many state users have not yet seen the new windows and may not be aware of their user-friendly features. The following screen shot provides a preview of improved features of the Recipient Eligibility – REEL window.

Recipient Eligibility – REEL Window



Color-coded window fields, multiple window capability, cut-and-paste functionality, and drop-down lists are just a few of the user-friendly features of the new PowerBuilder windows.

The new PowerBuilder windows are true Microsoft Windows screens. They are written to the full capabilities of the Windows Graphical User Interface (GUI), including color-coded fields, multiple window capability (the ability to have multiple MMIS windows open at the same time), cut-and-paste functionality, drop-down lists, and much more.

The new windows will provide the following user-friendly features:

- More descriptive field names
- Descriptive values displayed on screen (for example, it will no longer be necessary to know that FDOS means “From Date of Service”)
- Color-coded fields that allow the user to see at a glance which fields are view-only, which are mandatory, and which are optionally filled in

The new windows further demonstrate the ability of VermontAIM to evolve and keep pace with the most current advances in MMIS technology.

Scanning Solution

We will implement new technology to improve the work flows of everyone who must access copies of claims for research or other purposes. We will replace the microfilm machine we currently use to make electronic claims copies with a Kodak scanner that will create digital claims copies that can be viewed from a desktop PC.

The ability to view claims from the desktop will radically improve the work of any unit at the state or EDS that requires claims copies. Personnel will retrieve claim images from their desktop, eliminating the time required to send us a research request and the time we need to retrieve the paper or microfilm copy.

Platform for Growth Made Even Stronger

As you read through the following subsystem descriptions, please keep these leading-edge advances in mind. They will make a strong, positive impact on the VermontAIM MMIS performance and streamline the work of everyone who interacts with the system. We look forward to implementing these improvements and more during the next contract period.

Recipient Subsystem (Beneficiary Information)

RFP Reference: 2.7, p. 2-61
2.7.1, p. 2-62

The Vermont-based team has worked with Vermont Medicaid recipient data for more than 21 years, continually remaining aware of the confidentiality and sensitive nature of the information.

Recipient data access is essential to benefits delivery to Vermont's eligible beneficiaries. This function accepts and maintains accurate, current, and historical data. Maintaining accurate recipient data supports benefit delivery through claims processing, access to other insurance information, and reporting. As policies change, the recipient data access component must be flexible in supporting the evolving health care environment.

Growing With Vermont

Since 1981, our eligibility files have grown from supporting 37,000 beneficiaries to supporting more than 135,000. We keep a full history of beneficiary eligibility and TPL data and still have plenty of room to expand.

To demonstrate our understanding of the recipient subsystem and our ability to work with its data, we have organized our response in the following subsections:

- **Subsystem Objectives**—By responding to RFP objectives, we show our understanding of the role this subsystem plays in MMIS processing.
- **Proven Success**—We demonstrate our ability to work with the subsystem while keeping pace with program growth.
- **Enhancements**—We identify recent and planned enhancements that have notably enhanced the subsystem's functionality and user-friendly capabilities.

Subsystem Objectives

a. Maintain:

- **The database of:**
  - **Persons eligible for medical benefits under Medicaid and other Vermont medical assistance programs (e.g., Dr. Dynasaur and VHAP).**

The Vermont-based team understands the challenges facing the state in dealing with the rapid changes in health care and the increased need to coordinate the efforts of a variety of programs. We also recognize the logistical constraints in effectively managing the systems that support these programs. After all, we have more than 10 years of experience maintaining and enhancing the VermontAIM MMIS.

We support a wide variety of medical assistance programs, most recently including General Assistance (GA), which provides emergency services for non-Medicaid beneficiaries. We track all vouchers processed as part of our GA support.

All persons eligible for medical benefits are maintained on the recipient database. Updates to existing recipient information can be performed either online or through ACCESS update transactions. New beneficiaries may be added only through ACCESS due to the process of assigning unique ID numbers.

ACCESS sends an eligibility file, and we update the recipient master file in the order we receive the updates. All updates with discrepancies are rejected. At the end of each month, ACCESS and the MMIS perform a reconciliation to verify correct updates to recipient data.

- **Beneficiary eligibility to support provider inquiry and billing (e.g., voice response or dial-up EVS, smart cards).**

We provide information for use with voice response (Malcolm) and POS swipe cards. Eligibility information can be updated online, ensuring that these services have the latest information available. We process daily updates to beneficiary eligibility, supporting your day-specific eligibility requirements.

The recipient subsystem supports the EVS, which allows providers to verify recipient eligibility data via a voice response system (VRS) using the telephone lines or a point of sale (POS) device.

Providers who inquire via telephone interact directly with the VRS, which accesses the recipient master files on the host. The beneficiary eligibility information requested from the VRS is relayed to the provider by a recorded human voice.

- **Assigned Primary Care Provider (PCP).**

Our recipient subsystem supports the Primary Care Case Management model. We record the beneficiary's primary care physician information provided by ACCESS and create capitation payments for all beneficiaries eligible for managed care coverage. The financial subsystem generates the capitation payments to providers based on the number of beneficiaries enrolled and their payment level. This information comes from ACCESS.

- **And ensure positive control over the beneficiary eligibility data required to process claims and meet State and Federal reporting requirements.**

We ensure positive control of eligibility data by maintaining backup files and by retaining data files sent by the state for required periods of time. As a security measure, only people with proper authorization can update eligibility information.

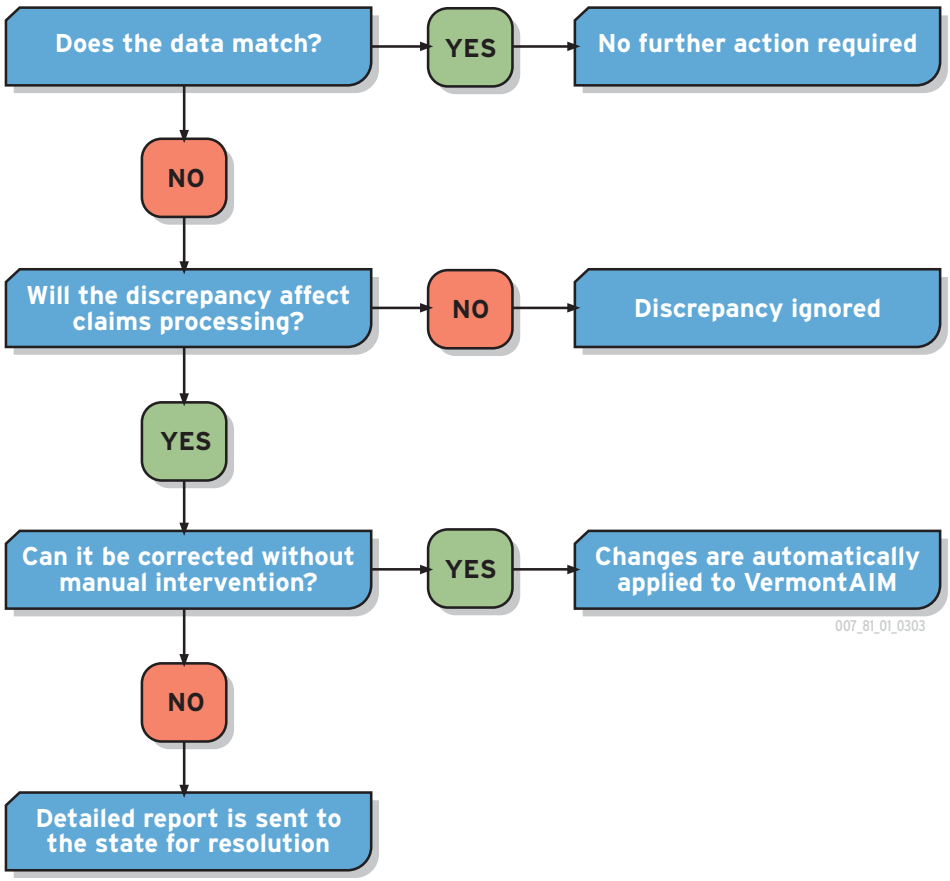
A monthly reconciliation process ensures that the VermontAIM MMIS files are in sync with the ACCESS records. The reconciliation process, performed at the end of the month, brings ACCESS and our recipient files into agreement. ACCESS creates a file that includes all persons who have been eligible at any time within two years of the creation of the file. The file is sent to us, and we run the tape against our files.

After the two files are compared, one of the following actions occurs:

- If information on both files matches, no further action is necessary.
- If there is a discrepancy between the files that does not affect claims processing, the discrepancy is ignored.
- If there is a discrepancy between the files that can be corrected without manual intervention, the changes are automatically applied.
- If there is a discrepancy between the files that requires manual intervention to correct, a hard-copy worksheet is created comparing the conflicting data.

The following flowchart shows the reconciliation process:

Monthly Reconciliation Process



Our proven reconciliation process ensures positive control over beneficiary eligibility data.

b. Manage the process by which beneficiary information is transferred to:

- **The Department of PATH's ACCESS system**

We transfer beneficiary data to the Department of PATH's ACCESS system by file transfer protocol (FTP). We FTP the files to the state's specified directory and, in some cases, send an automated e-mail message to notify personnel that we have transferred the file.

- **Standard reports and the ad-hoc query application ("EVAH")**

We provide standard reports meeting all federal and state reporting requirements, including monthly reconciliation reports showing differences between your beneficiary data and ours. Our EVAH database contains not only beneficiary eligibility history but all recipient-specific information, including demographics, lockin, and third-party information. This information is currently available through reports and online.

- **And/or received from, Pharmacy Benefits Manager (First Health), the Coverage and Services Management, and the Global Clinical Record Applications**

We have a proven record of reliability in supplying other vendors and offices with eligibility information. We provide data extracts that support the needs of other programs, often overnight. The time needed to deliver extracts depends on the size of the extract and the availability of an existing template that we use to generate the extract. One way we have been able to speed up the process is by maintaining queries for this purpose. We are currently working on creating a standardized procedure for data exchange with the Global Clinical Record application.

Proven Success

Our ability to maintain and enhance the recipient subsystem has been proven with the following program evolution:

- Beneficiary population has expanded from 37,000 to more than 135,000 in the past 21 years.
- Use of the VermontAIM has extended from Medicaid to nearly a dozen other state programs with additions to the beneficiary base.

The functionality of the recipient subsystem has expanded to keep pace with this program evolution.

- In March of 2001, we implemented virtual real-time processing for GA vouchers, which also allowed updates to beneficiary eligibility data. This meant that beneficiaries in dire need did not have to wait to have prescriptions filled or for other much-needed services. This functionality was removed when First Health took over PBM, but it could easily be put back into place if necessary.
- We also have successfully expanded aid categories to support new programs, meeting established time frames for implementation. The most recent example of this was the addition of the managed care spend-down aid categories P3 through P8. The addition of these codes automated a manual work-around process that the OVHA staff has been using for quite some time to resolve spend-down issues. Prior to adding these new categories, the only spend-down options were all fee-for-service.

Enhancements

Online Audit Trails

In response to the state's request for a platform conversion (RFP 2.8.2.2), we have chosen to convert the existing Ingres database to the leading-edge IBM DB2 Universal Database (DB2). Our DB2 database solution allows us to offer you the option of online audit trails rather than the existing Ingres table/report structures for audit trails. This online audit trail functionality will replace the cumbersome and time-consuming paper audit reports for a substantial increase in productivity.

Rather than ordering an audit report, which can take several days to generate, to view the history of an online change to a recipient window, a user will be able to view in real-time all online updates. For example, on the REBA window, if a change was made to the HOH SSN field, a user could quickly determine when that field was last changed and what the old value was. When a user clicks the History button on a recipient window, the GNAT (General Audit Trail) window appears displaying all changes made to that record, including the fields changed, what the fields used to be, the change date and time, and the users who made the changes.

Health Insurance Portability and Accountability Act

The VermontAIM MMIS is currently being enhanced to comply with the mandates set forth by CMS. In December, the recipient subsystem will begin accepting the new 270/271 electronic transactions for eligibility verification. This modification, as well as converting all CA Vision windows to PowerBuilder, will make the recipient subsystem fully HIPAA compliant. In addition, converting the windows from Vision to PowerBuilder will provide a more user friendly, Windows-based environment.

Global Clinical Record Interface

We are currently enhancing the VermontAIM MMIS to provide an interface to the Global Clinical Record (GCR) system. This interface to National Systems & Research Company will include core recipient system prior authorization (PA), reference, provider, and claims processing information. The current planned implementation date of this interface is August 2003.

We will provide the GCR with beneficiary eligibility and TPL information to be used by providers for PA and the clinical staff at the OVHA. The TPL information will be evaluated during the decision-making process for issuing a PA, ensuring that all other resources are exhausted before Medicaid makes a payment.

Because we are currently implementing the GCR, we have the depth of insight into the GCR interface that will prove critical for future enhancements and changes.

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Provider Subsystem

RFP Reference: 2.7.2, p. 2-71

The Vermont provider community is the front line for health care delivery to the Vermont Medicaid beneficiary population. The Medicaid program relies upon the quality, commitment, understanding, and participation of providers to accomplish its mission to improve the quality of life for Vermont's citizens. We understand the critical role that accurate, up-to-date provider information plays in the claims processing function.

Effective Provider Recruitment

The Vermont-based team is committed to recruiting new providers for the Vermont Medicaid Program and making the enrollment process as efficient and easy as possible. In SFY 2002, we enrolled 1,160 new providers, with an additional 1,260 estimated for SFY 2003.

Working with the state, we developed the VermontAIM MMIS and processes that:

- Support fast, easy, and accurate updates to provider information and track changes
- Encourage the participation of qualified providers in the Vermont medical assistance programs with an efficient and accurate enrollment and re-enrollment process enhanced by the use of one enrollment/recertification form
- Ensure providers are qualified to render specific services under the Vermont medical assistance programs by screening applicants for state licensure and certification and for specialty and subspecialty certification
- Process provider applications, contracts, and changes in a timely and accurate manner, using both system and manual verification
- Control provider data
- Maintain demographic and rate information to support claim record processing and reporting functions

To demonstrate our understanding of the provider subsystem and our ability to work with its data, we have organized our response in the following subsections:

- **Subsystem Objectives**—By responding to RFP objectives, we show our understanding of the role this subsystem plays in MMIS processing.
- **Proven Success**—We demonstrate our ability to work with the subsystem while keeping pace with program growth.
- **Enhancements—**We identify recent and planned enhancements that have notably enhanced the subsystem's functionality and user-friendly capabilities.

Subsystem Objectives

a. Encourage qualified providers to participate in the Vermont Medicaid program by ensuring that enrollment and re-enrollment is an efficient process.

The Enrollment team encourages providers to participate in the Vermont Medicaid Program as well as all other Health Access Programs by providing a streamlined process for the initial enrollment and for re-enrollment. When we receive requests to validate coverage from providers who are not enrolled, we validate the coverage and then contact the providers by telephone, e-mail, or letter to inform them that they must enroll. We mail the providers an invitation to enroll with information about our reimbursement rates, covered services, and a provider agreement. When a provider returns the agreement, we review it for accuracy and appropriate licenses. A number is issued and a welcome package is sent with instructional materials.

One way we encourage new providers to participate in the Vermont Medicaid Program is by making our provider services representatives available to answer questions and facilitate the process. For example, when Cathedral Square was beginning the enrollment process, Provider Services Representative Christine Haskins visited their office to educate them and answer questions regarding the enrollment process, the billing process, eligibility verification, timely filing, and the UB92 claim form.

For re-enrollment, we print an enrollment form with the information currently in our system and mail it to the provider. The provider updates any incorrect information and returns the form to us with current licensure. We then review the information for accuracy and current licenses. Once the form is complete, we update our system through the end of the provider's licensure expiration date plus three months.

b. Ensure that providers are qualified to render specific services under the Medicaid program by verifying applicants for State licensure and certification, specialty certification as applicable, and by visit to the provider by a review team, if necessary.

The Enrollment team uses the provider agreement to verify an applicant's state licensure and certification, including specialty certification. This ensures the providers are qualified to render specific services under the Medicaid program. We require a copy of a provider's current state license before enrolling the provider into Vermont Medicaid. In the event a review of the provider is necessary, a member of the Enrollment or Provider Services team will make an on-site visit.

c. Process provider applications and/or changes.

Updates to the provider master file come from a variety of sources, such as the state, provider community, and internal sources. Paper documents associated with the maintenance request, such as provider correspondence, professional license, and certification documents, drive requests from providers.

Once we enter provider applications into the provider subsystem, we review the information to ensure all data has been entered correctly. As specified by the OVHA, we will update the provider file daily to ensure updates are handled quickly.

d. Maintain:

- **Comprehensive current and historical data on providers qualified to participate in the Vermont Medicaid program**

We maintain paper agreements and all enrollment documentation in each provider file and all historical data in the provider subsystem. We purge and microfilm the paper agreements for all providers closed for more than four years. Whenever a provider number is closed, we pull the file folder from the active file and place it in the closed files storage area near document control. The files are kept in numeric order, and the document control area must microfilm all information before the paper files can be destroyed.

In addition, if the state chooses to continue in our current partnership, we will begin electronically scanning and filing documents to reduce the paper trail and its related storage. The offered scanning capabilities will make access to the information easier and quicker.

- **A single provider master file with provider data (e.g., demographic, certification, rate, and summary financial information to support accurate and timely claims processing, enhanced management reporting, and utilization review reporting and activities).**

We maintain a single provider master file with provider data, such as demographic, certification rate, and summary financial information, to support accurate and timely claims processing, enhanced management reporting, and utilization review reporting and activities. This information is accessible from the provider and financial windows of the system with a provider number or name. Also, EVAH is available to provide this information and allows the user to create his or her own reports.

- **Control over the provider data set to ensure confidentiality, security, and accessibility to only authorized users.**

We maintain control over the provider data set to ensure confidentiality, security, and accessibility to only authorized users. Only EDS personnel with an electronic badge have access to the paper provider files located in filing cabinets in the building. Only personnel with authorized IDs and passwords have access to the electronic provider information in the system. We determine whether users should have view or update access at the screen level based on the security profile established by the state.

Proven Success

In the past, providers were often unclear about their certification end date. To help providers track when they need to begin the recertification process, the Enrollment team worked with Pat House to redesign the enrollment form. Instead of the enrollment date being driven by the date the provider first enrolled in the program, the subsystem now tracks the re-enrollment status by the license expiration date. The enrollment specialist enters a date three months past the provider's license expiration date. As such, once providers reach their license expiration date, they know their re-enrollment with Vermont Medicaid is quickly approaching.

In a continual effort to minimize the obstacles to the quick and efficient processing of provider enrollment forms, the Enrollment team began using the Internet in April 2002 to access license information from the Department of Health. This access allows team members to verify a provider's license information when the provider has forgotten to include it on the form. As a result, it is no longer necessary to return the form to the provider and wait for a response. This allows the team to process applications in a much more timely fashion.

Provider Services Help Desk

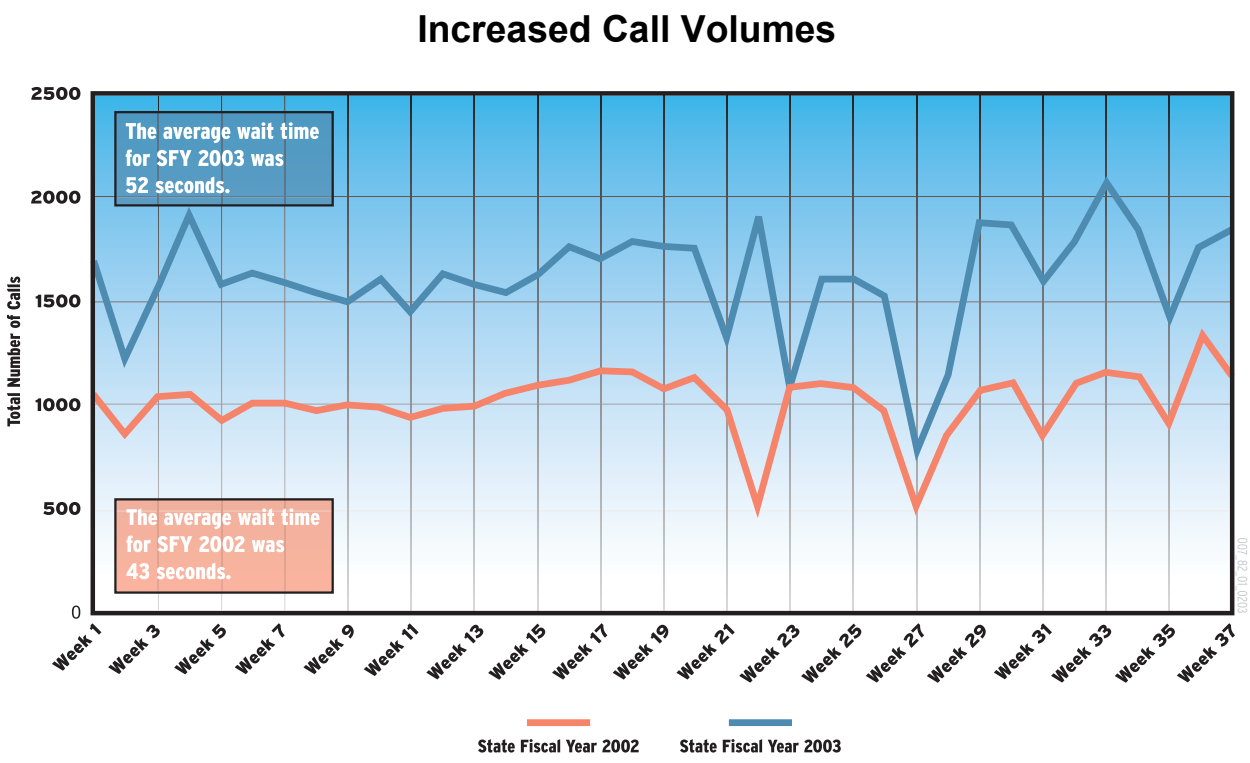
The Provider Services Help Desk responds to provider telephone inquiries between 8 a.m. and 5 p.m., Monday through Friday. Using the ACD telephone monitoring and reporting software system, the help desk answers all incoming calls from providers and assists them with the following types of inquiries:

- Billing questions
- Eligibility
- Policy changes
- Limits information
- Claims status
- Requests for manuals and forms
- Prior authorization guidance
- Procedure coverage inquiries

"It's a pleasure working with EDS. Responsive and accurate information received in a timely way. Worlds apart from many other insurance companies! Keep up the great work!"

--Kathryn C.S. Osborne, Mental Health

All telephone calls between the Vermont-based team and providers are documented on the MMIS, allowing for reporting and information retrieval. Each call log documents the provider telephone number, caller name, EDS representative, type of call, questions asked, and the response given. The help desk team responds to more than 200 written inquiries each week while also responding to telephone calls. The value in our training, experience, and fast response to questions is illustrated in the following graphic. Even with the addition of new programs, legislative changes, and increased numbers of providers, all of which led to call volumes increasing by nearly 33 percent from state fiscal year (SFY) 2002 to SFY 2003, help desk staff did not increase and wait times remained below 60 seconds.



Call volumes rose incrementally due to program changes, legislative changes, and increased provider participation without increased staffing or lengthy wait times.

Enhancements

Health Insurance Portability and Accountability Act

The VermontAIM MMIS is currently being enhanced to comply with the mandates set forth by CMS and HIPAA. Beginning in July, well in advance of the October deadline, we will implement the HIPAA translator and convert all CA Vision windows to PowerBuilder. Converting the windows from CA Vision to PowerBuilder will provide a more user-friendly, Windows-based environment. In December, we will upgrade the Provider Electronic Solutions software to include claims inquiry functionality for providers. The Provider Electronic Solutions software upgrade will allow providers to quickly and efficiently check the status of a claim online.

Online Audit Trails

In addition to the mandatory and selected optional enhancements, we are going to implement a new approach to audit trails—online audit trails. Gone are the days of requesting and then waiting several days for an audit report to see what change was made, when the change was made, and who made the change.

Our DB2 database solution allows us to offer the state real-time audit trails of online changes at the click of a button. Rather than ordering an audit report to view the history of an online change to a provider window, a user will be able to view in real-time all online updates. For example, on the Provider Program Status window, if a change was made to a provider's effective end date, any user can click the History button on that window to access the GNAT (General Audit Trail) window displaying all changes made to that record.

Scanning Solution

We are excited by the opportunity to replace the inefficient microfilm process with a state-of-the-art Kodak scanner, which we will support on the local area network (LAN). In the enhanced VermontAIM MMIS environment, input documents, such as provider enrollment recertification documentation, will be scanned and assigned a document number. Once scanned, the electronic image of the document will be stored and accessible electronically through a Web browser just like OnDemand data. We will use the images for three main functions: data entry, resolution processing, and claims research. This technology will eliminate the time-intensive chore of tracking down film rolls, will allow more than one person to view scanned images at a time, and may reduce the need for retaining hard copies.

Reference Subsystem

RFP Reference: 2.7.3, p. 2-81

The reference subsystem is at the heart of the Vermont MMIS infrastructure as it defines the parameters and supplemental policy information to adjudicate claims in accordance with the state's policies. This nucleus of critical program information ensures that all program parameters meet state and federal requirements and payment is issued only when the services provided fall within the defined coverage parameters. As such, the reference subsystem has a direct impact on the disbursement of program dollars.

Rapid Results

You can count on us to respond quickly and efficiently to requested updates to the VermontAIM MMIS. In 2001, we completed updates to **3,380 procedure codes in one day** in response to a legislative mandate.

The reference subsystem provides data to the following MMIS functional areas:

- **Claims**—Uses pricing and restriction information from level 1, level 2, level 3, and National Drug Code (NDC) files, diagnosis file limitation information, procedure code and modifier pricing information, edit disposition criteria, and explanations of benefits
- **Enhanced Vermont Ad Hoc (EVAH)**—Accesses reference subsystem data elements and makes them available for ad hoc reporting
- **Management and administrative reporting (MAR)**—Uses reference subsystem data elements to satisfy federal reporting needs

Authorized users have easy access to the reference subsystem. The flexibility of VermontAIM also allows authorized users to update reference file information, including program parameters, through the online windows. This flexibility allows program administrators to update program parameters without intervention from the technical staff. The capabilities of VermontAIM also allow batch updates, as well as mass updates, to the reference files.

To demonstrate our understanding of the reference subsystem and our ability to work with its data, we have organized our response in the following subsections:

- **Subsystem Objectives**—By responding to RFP objectives, we show our understanding of the role this subsystem plays in MMIS processing.
- **Proven Success**—We demonstrate our ability to work with the subsystem while keeping pace with program growth.
- **Enhancements**—We identify recent and planned enhancements that have notably enhanced the subsystem's functionality and user-friendly capabilities.

Subsystem Objectives

a. Provide:

- **A consolidated source of reference information to be accessed during claims processing by other MMIS subsystems (e.g., MARS, EVAH).**

The primary objective of the reference functional area is to monitor, maintain, and update Vermont's processing parameters, including the edit/audit criteria, pricing information, and service limitations. The MMIS also maintains a complete audit trail and reporting mechanism to verify the history of reference file updates. Our operational procedures promote timely and accurate updates to the reference data files. Our approach to managing the reference data maintenance involves processes that enable the state to manage changes to an increasingly complex range of health care programs.

Maintain Reference Files

Reference files are key to all aspects of claims processing and payment. Essential to the successful oversight of the reference file is the accuracy and timeliness of the updates. We understand the criticality associated with these updates and will continue to adhere to the processes that have proven successful. A representative list of files stored on the VermontAIM database includes:

- Procedure code
- Diagnosis code
- Drug code
- Revenue code
- Edit disposition and sequence
- Limitation and relationship audit
- Level 1, level 2, and level 3 pricing
- Procedure modifiers

The system allows for an unlimited number of historical segments and uses effective and end dates to monitor the information in these files. The system compares the effective dates to the dates of service submitted on the claim and adjudicates the claim in accordance with the policies in place at that time.

Perform Updates

Using the updating capabilities within the MMIS system, we are able to perform online and mass updates to reference files as specified by the state. We currently process these updates and are familiar with the process and understand its importance. We will continue to provide quality and timely service to these requests.

Batch processing differs from online updating, in which the system processes each individual transaction after the user enters the transaction. The system applies the update

directly to the online file that contains the record. When an online update is complete, the user can see the results immediately.

Batch updates have proven advantageous when numerous updates are involved. For example, we will generate mass updates to reflect rate increases made each year. At that time, the state will specify the procedure codes, effective date, and amounts or percentages to be updated. The system will search the reference files for procedure codes that meet the requirements and generate an update to add rates with the new effective date and amount. We schedule batch update processes during off hours to avoid disruption to the users.

Provide Reports

Each aspect of the MMIS' reference data maintenance function produces reports for verification or status review. Some of the reports include, but are not limited to:

- Revenue Code Maintenance
- Procedure Code Maintenance
- Diagnosis Code Maintenance
- Usual and Customary Charges
- EOB Message Text Report
- Edit Disposition Table Report
- Drug Master File
- DESI Indicator Updates

In addition to the system-generated reports, the reference data is available in the EVAH system to create "on-request" reports that reflect historical audit trail and master listing data. The EVAH system is updated weekly and extracts the updated data with exact copies of the reference file tables from the MMIS database. EVAH gives each user the flexibility to specify the selection and sort criteria using the following reference production files:

- Procedure code
- Diagnosis code
- Drug code
- Revenue code

We will use the OnDemand automated archival and retrieval system to make reports available to the state through a Web browser. Users can view reports in a user-friendly environment, printing only those pages needed.

- **Coding and pricing verification during claims processing for approved claim types and reimbursement methodologies.**

Data integrity is of utmost importance to us. The maintenance of the edit and audit data is integral to correct claims processing. This audit reporting allows for the verification of updates to the reference subsystem, maintaining data integrity and accuracy. We understand that edits and audits allow the state to suspend or deny claims that meet defined criteria in order to affect claims processing outcomes. They also allow for the maintenance of data needed to price claims, enabling the state to reimburse providers for rendered services and manage expenditures. The MMIS system is a table-based system supporting flexible maintenance of edits and audits.

The VermontAIM system allows authorized state users to perform online inquiry and updates to the reference files. We maintain the security profiles necessary to authorize the appropriate access. The online reference windows provide quick and easy access to information that is vital to successfully managing the state-funded health care programs. Important file changes can be made to immediately affect program policy and payment parameters. Thus, the state can easily adopt the growing number of legislative changes to the programs. Online update capabilities enable the following types of program updates:

- Change an edit or audit so large groups of claims pay, suspend, or deny during the next pay cycle
- Add a procedure for coverage
- Change the per diem rates that a provider may receive
- Provide remittance advice message text in the form of banner pages
- Provide explanation of benefits (EOB) codes and message text

The Vermont-based team uses specific security measures to limit update access to only those users with specific security. We will provide online audit trails that list every change made to the online windows, the user ID of the person who made the change, and the date the user made the change.

b. Maintain flexibility in reference parameters and file capacity for the MMIS to accommodate Medicaid program and data element (e.g., institutional revenue codes increased from three to four digits) changes.

The health care industry has evolved into a complex environment, and the level of complexity is increasing. The VermontAIM provides the flexibility to update the program's parameters including specific data elements to accommodate program changes.

Authorized users can perform the following functions online:

- Include or exclude procedure codes, NDC, or diagnosis codes from edits
- Update disposition maintenance
- EOB message text
- ASC-level maintenance
- Procedure audits maintenance
- Diagnosis list maintenance
- Edit/audit code maintenance
- Edit/audit dependency maintenance
- Edit sequence maintenance
- Limitation audit update
- Relationship audit update

The VermontAIM system immediately applies these online updates to claims in process.

Proven Success

In 2000, we collaborated with the state to develop and implement a new reimbursement methodology. Legislative mandates required a rate increase for specific provider types, specialties, and services. The flexibility offered by the VermontAIM allowed the integration of our newly defined policy through the addition of level 2 reimbursement. This new flexibility allows an entirely new level of reimbursement parameters into the program without technical intervention or disruption to the provider community.

Through the Quality Improvement Process (QIP), we have improved our operation of reference files by recommending ways to streamline edits and audits. A committee composed of state and EDS staff assembled to review all existing and proposed edits and audits for appropriateness and clarity. This process ensured that the edits and audits improved the process of adjudicating suspended claims. Through this joint effort, all documentation concerning resolution review was updated and converted from the manual paper process to an online resolutions edit and audit library.

Enhancements

Claim Region Codes

Recently, we implemented a new claim region code for paper claims that distinguishes paper claims with attachments from those billed without attachments. During the process of releasing a claim into the MMIS, this new region code allows us to suspend claims requiring an attachment that have the attachment and automatically deny claims without an attachment. The ability to automatically deny a claim at the time of release has reduced the review and processing time for claims missing required documentation.

Health Insurance Portability and Accountability Act

The VermontAIM MMIS is currently being enhanced to comply with the transaction and code set mandates set forth by CMS to be implemented by October 16, 2003. HIPAA changes to the reference subsystem include the addition of a fourth procedure code modifier, expanding the place of service code limitations to four codes, the HIPAA translator, and the conversion of all CA Vision windows to PowerBuilder.

Online Audit Trails

Our database solution allows us to offer the state the functionality for online audit trails instead of the cumbersome and time-consuming paper audit reports provided with the existing Ingres table/report structures.

Currently, when a user wants to know the history of an online rate change to the reference window RFPR, he or she has to order an audit report that requires several days to generate. With online audit trails, VermontAIM users will have a real-time view of all online changes made to reference information at the click of a button. When a user clicks the History button, the GNAT (General Audit Trail) window appears displaying all changes made to that record.

Diagnosis and Revenue Codes

The current HIPAA remediation process will not include the expansion of the diagnosis code to the ICD-10 or the expansion of the revenue code to four digits as indicated in your response to Bidders' Question 5. At your direction, we will begin designing these changes through the use of CSR hours and the modification process currently in place.

Claims Subsystem

RFP Reference: 2.7.4, p. 2-87

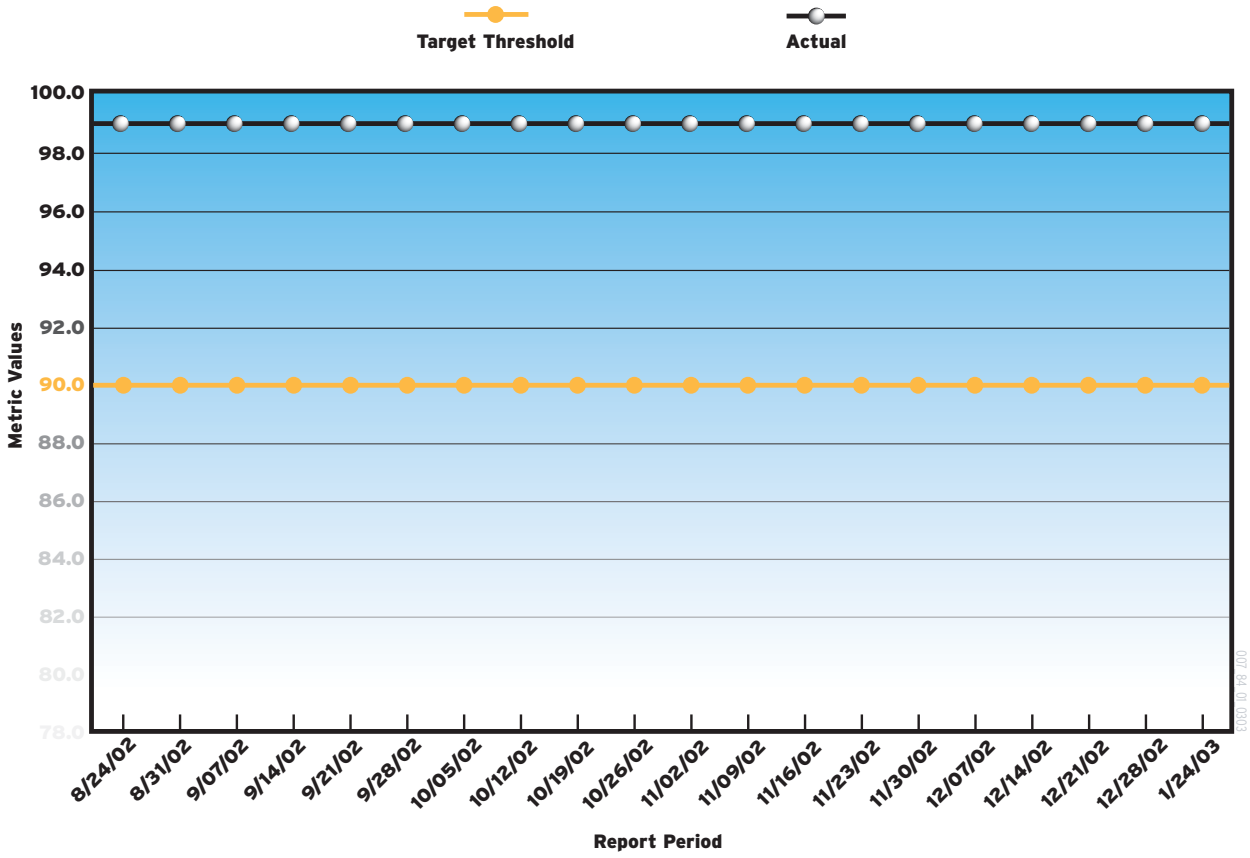
The state has seen continual improvement in the claims processing system for the past 21 years. Effective management and support of the claims processing system protects Medicaid finances, supports Vermont Medicaid Program administration, maximizes federal funding, and establishes good relationships with the providers who are essential to the success of the Vermont Medicaid Program.

Our administration of the claims processing subsystem merges a series of manual functions with the VermontAIM's automated claims processing features for results that consistently exceed minimum standards. The following chart shows that actual statistics exceed target metrics by 10 percent.

Proven Claims Processing Record

VermontAIM adjudicates 99 percent of all claims in fewer than 30 days—a rate that exceeds target standards by 10 percent.

EDS Dashboard: Exceeding Standards for Timely Adjudication



The combination of manual functions and the automated processing features of the VermontAIM claims subsystem leads to superior adjudication rates.

Please note that this response to RFP section 2.7.4, Claims Processing Subsystem, focuses on the VermontAIM's automated features. For more information about the manual functions that support claims processing, please see our "Data Entry," "Resolutions and Suspense," and "Mailroom Support" responses in the "Work Plan and Schedule (Operations)" section.

To demonstrate this understanding of the claims subsystem and our ability to work with its data, we have organized our response in the following subsections:

- **Subsystem Objectives**—By responding to RFP objectives, we show our understanding of the role this subsystem plays in MMIS processing.
- **Proven Success**—We demonstrate our ability to work with the subsystem while keeping pace with program growth.
- **Enhancements—**We identify recent and planned enhancements that have notably enhanced the subsystem's functionality and user-friendly capabilities.

Subsystem Objectives

The VermontAIM claims processing subsystem comprises the following major functions:

Claims Control

RFP Reference: 2.7.4.A, p. 2-87

a. Maintain control over all transactions during their entire processing cycle.

The VermontAIM MMIS begins the control process by assigning unique internal control numbers (ICNs) and batches to claims. The ICN serves as the permanent tracking number for all claims and remains constant from receipt through adjudication of the claim. The ICN contains the region identifying the input media, the year, the Julian date, the assigned batch number, which identifies the type of claim, and the sequence number identifying the claim numbers within each batch.

b. Provide accurate and complete registers and audit trails of processing.

During the processing lifecycle of a claim, the subsystem establishes an audit trail showing where the claim has been, what error codes were failed and corrected, who made the corrections, and the dates the corrections were made. If data was changed, the audit trail also shows the data that was originally entered and the corrected data. From the time a claim is entered into the claims processing system, it can be tracked as it moves from one location to another until it is finally adjudicated for payment or denial.

c. Monitor the location of all claims at all times.

The VermontAIM produces inventory management analysis reports and daily input control listings to monitor and track all claims from receipt to final disposition.

d. Ensure that all claims and related input are captured at the earliest possible time in an accurate manner.

The claims subsystem assigns a unique ID to claims within 24 hours of receipt. The ID indicates the date of receipt.

e. Support both manual and automated processes.

The VermontAIM MMIS has both manual and automated reconciliation procedures used to monitor and control claims, adjustments, and other transactions. These procedures start at the beginning of the processing cycle where incoming and outgoing volumes are reconciled and balanced. The procedures ensure that we account for every claim, adjustment, and any other transaction.

Claims Entry

RFP Reference: 2.7.4.B, p. 2-90

The VermontAIM claims entry process allows the entry of electronic media claims (EMC), hard-copy (paper) claims, and claim activation records. We receive claims from providers, billing services, and Medicare carriers and intermediaries via hard copy or electronic media.

We batch by claim type, microfilm, and assign a unique internal control number (ICN) to paper claims. Activation records are keyed for each batch of paper claims. A batch must have an activation record before it can enter the edit/pricing/audit process. As we key hard-copy claims into the system through Viking terminals, the accuracy, reasonableness, and integrity of claim data is ensured through the use of stub-file verification and data-entry window edits. The system prompts the data-entry operator to verify the entry of any keyed element that is in error. The operator has the ability to either rekey the field or set a screen edit.

Stub files are used to edit critical fields against reference, provider, and recipient file data. The stub files contain information extracted from the provider file, recipient file, and reference files (including procedure, revenue, and diagnosis codes). We update stub files on a daily basis to ensure the most current versions of the files are used to edit keyed fields.

We maintain procedures to ensure the integrity of electronic claims. As each tape, cartridge, or diskette arrives in the operations area, the Vermont-based team logs the date of receipt, number of records, and submitter ID on the electronic media log. These logs are useful tools in researching provider inquiries about receipt of electronic claims and provide additional assistance for providers who have submitted duplicate diskettes. Providers may also elect to submit electronic claim files through the bulletin board system. A log of all files received via the bulletin board system is also maintained to provide an audit trail of all files submitted. Electronic claims receive a system-assigned ICN and enter the system without any manual data entry.

Edit/Audit

RFP Reference: 2.7.4.C, p. 2-93

Once we accept a claim for processing, we convert the claim's input data to a common processing format. We then perform edits that test the basic integrity of the claim data by editing data fields. Field edits make checks such as alphanumeric verification, presence of required fields, high-low range, and allowable field values.

Claim auditing is the process of comparing certain fields from claims that are currently in process to other claims that are also in process and to claims history. The following are three examples of how audits work:

- Duplicate audits detect both exact duplicates and nearly duplicate billings on claim-specific adjustments that are in process by comparing these claims and adjustments against other claims in process and paid claims on the claims database.
- Relationship audits restrict services that are defined as "similar in purpose" by Medicaid policy.
- Limitation audits identify and restrict services that, based on previous services, exceed established policy limits.

All new claims are edited and audited during each claim processing cycle. Previously suspended claims are re-edited and re-audited during the edit/audit cycle. Claims are edited to the greatest degree possible; as many as 10 error code occurrences are allowed for the claim header, and up to 10 error code occurrences are allowed for the claim detail. There are instances in which certain edits are not performed due to the nature of previously failed edits. For example, if the recipient number is not found on the eligibility data store, there is no means to check for recipient limitation edits.

Claims that fail edits or audits suspend or deny based on state-defined criteria. These criteria are maintained through the use of the Edit Disposition table maintained in the reference subsystem.

The state defines all edits and audits according to current policy. When there is a policy change or a change in processing requirements, we update the edits and/or audits. At the state's request, we perform edit and audit updates through online edit sequence, edit dependency, and disposition tables, which are maintained in the reference subsystem.

Claims Pricing

RFP Reference: 2.7.4.D, p. 2-100

The claims pricing function determines the pricing methodology applied to each service, based on the claim type and provider-pricing indicator. Using the provider-pricing indicator, the rate or price is determined by using the provider ID, provider type, revenue or procedure codes, modifiers, or a combination of the above.

The following illustrate the various reference, provider, and recipient pricing tables accessed in claims pricing to obtain the appropriate price:

- Provider-specific fees for revenue or procedure codes from the level 1 pricing tables
- Provider type and/or provider specialty fees for procedure codes from the level 2 pricing tables
- Prices for fee-for-service revenue or procedure codes from the level 3 pricing tables
- Global modifier pricing rates or percentages from the Procedure Modifier table
- Per diem rates from the Provider Accommodation Data table

Once the claim has been priced, it may be cut back due to dollar, unit, or occurrence limits based on prior authorizations (PAs) or limitation audits. In addition, Medicare payments, co-payments, patient liability amounts, coinsurance, and third-party liability amounts are deducted when appropriate.

Claims Correction

RFP Reference: 2.7.4.E, p. 2-104

The online claim correction windows provide access to suspended claims of all claim types. There is a Claim Correction Selection window used by data corrections to select suspended claims for correction. The Claim Correction Header window displays all header information and as many as 10 header error codes. There is a Claim Correction Detail window for each detail, which displays all detail information and as many as 10 detail error codes. The Claim Correction Header and Detail windows allow for corrections by over-typing any field in error. Upon completion, the claim is completely reprocessed with the corrected values.

The resolutions clerks have access to online windows, displaying provider, beneficiary, and/or reference data during the correction process. These windows provide the additional information needed to resolve the edit/audit failure. If the suspended claim has failed an audit as a result of related history, the Claim Correction window indicates that related history is available. To resolve the audit, the clerk is able to access the related history ICNs from the same window.

A claims resolutions clerk corrects the fields in error and releases the claim to the edit cycle for reprocessing. If our Resolutions unit cannot fully resolve a claim, we may transfer it to another location (e.g. Medical Policy unit) for further resolution or recycling.

A claims resolution clerk also has the ability to force a claim through an edit or audit if there is supporting state policy documented in the resolution policy manual.

Claims Operations Management

RFP Reference: 2.7.4.F, p. 2-106

Our ability to work closely with the state and provider community for the past 21 years has allowed us to work in unison to provide excellent results in claims operations management. We have often worked with the state and providers to solve processing issues before they became major problems.

In the fall of 2001, we worked with Bob Butts, contract monitor for the OVHA, to eliminate the need for the 220MP Spenddown Notice of Decision for transportation providers. Trips were being denied occasionally when a beneficiary was coming off a spend down. The process that was in place required the transportation broker to contact the local Department of PATH office for a 220MP form indicating that the beneficiary owed nothing on that particular date of service. This form would then need to be attached to the claim form, requiring the broker to complete a HCFA-1500 form. This was a very frustrating process for the broker.

The Vermont-based team, with OVHA approval, quickly responded to incorporate exception logic to edit logic to bypass the requirement for transportation providers. Bob Butts was very pleased with the result, "Cherie, you are the best of the best. Thank you very much for resolving this long-standing 'thorn-in-the-flesh'!"

Claims operations management is an essential part of the Medicaid program, and we are confident that we will continue to bring value to the clients, providers, and the state.

Following are key features of the claims operations management function:

- Maintains three years of online claims history
- Maintains any claim designated as required for processing for longer than three years
- Monitors the claims inventory and location for cycle balancing and reporting
- Maintains archived claims data for claims more than three years old
- Maintains reporting capabilities and produces reports
- Maintains online claims summary windows
- Exceeds requirements to perform at least two pricing cycles weekly by performing daily pricing cycles
- Performs one weekly payment cycle
- Produces client EOMBs including summary reports
- Includes pharmacy claims from First Health as input to the claims subsystem

Prior Authorization

RFP Reference: 2.7.4.G, p. 2-111

a. Allow payment for only those treatments and/or services that are medically necessary, appropriate, or cost-effective.

The VermontAIM MMIS edits all claims for PA requirements, such as presence and validity of an active PA number, provider, diagnosis, procedure, length of stay, number of units authorized and used, and whether the service and service dates are consistent with authorization. If the procedure code billed requires a PA, the system will automatically check for a PA on file. If there is no PA on file, the claim will either suspend for review or deny based on state policy.

b. Provide support for case-management in special clinical programs (e.g., high-tech).

The VermontAIM MMIS provides the prior authorization capability for case-management for the Vermont Medicaid Program.

c. Serve as a cost-containment and utilization review measure.

Cost containment and utilization review measures are crucial to the fiscal management of the Medicaid program. By approving only medically necessary, appropriate, and cost-effective treatments, the VermontAIM MMIS prior authorization function reduces over-utilization and abuse. These functions are critical to spending Medicaid dollars appropriately when treating Vermont beneficiaries.

For more information about our claims processing support, please refer to our responses to Timeliness of Processing (2.6.20), Correctness of Payments (2.6.21), Data Entry (2.6.22), Resolutions and Suspense (2.6.23), and Mailroom Support (2.6.25) in the Work Plan and Schedule (Operations) section.

Proven Success

Our Vermont-based team will continue to work with you to ensure that Medicaid claims processing exceeds health insurance claims processing standards. We have made significant progress in streamlining claims processing.

The following are a few of our significant accomplishments:

- The VermontAIM MMIS adjudicates 99 percent of all claims in less than 30 days.
- The VermontAIM MMIS pays, denies, or suspends all claims within each nightly processing cycle.
- The average number of days from receipt to adjudication for all claim types is two.

- Eighty to 85 percent of all claims are submitted electronically.
- Resolutions are done through online corrections in a paperless resolution environment.
- We have improved edit and audit processing. The VermontAIM MMIS processes up to 10 edits/audits in both the header and detail of the claim.

Enhancements

Health Insurance Portability and Accountability Act

We are currently enhancing the VermontAIM to comply with the transaction and code set mandates set forth by CMS to be implemented by October 16, 2003. HIIPAA enhancements to the claims subsystem include the HIPAA 837 standards, the HIPAA translator, and the conversion of all CA Vision windows to PowerBuilder. The PowerBuilder windows offer a more user-friendly, Windows-based environment.

Global Clinical Record Interface

We will enhance the VermontAIM to provide an interface to the Global Clinical Record (GCR) system. This interface to National Systems & Research Company will include core system prior authorization, reference, provider, and claims processing information. The current planned implementation date of this interface is August 2003.

McKesson's HBOC ClaimCheck and ClaimReview

The mandatory enhancement to implement a fully automated pre- and post-payment auditing system using McKesson's ClaimCheck and ClaimReview (RFP section 2.8.2.3) will enhance VermontAIM's edit and audit functionality. In 2002, the Vermont-based team ran a year's worth of claims data through the ClaimCheck software. The results indicated that Vermont would have saved $3.2 million if ClaimCheck had been installed on the MMIS.

These audits provide for and process claims against the McKesson HBOC ClaimCheck and ClaimReview audits, including the capability to modify audits according to state standards and customize audits as defined by the state. Examples of the types of editing that can be included are:

- New visit frequency
- Incidental procedures for surgical procedures
- Pricing of multiple surgeries and multiple modifiers
- Add-on codes from multiple surgery editing
- Mutually exclusive procedures

- Diagnosis-to-procedure editing
- Cross-provider editing for surgeons and assistant surgeons
- Rebundling of procedures where procedure codes have been billed separately
- Pre-operative and post-operative services that should be included in the global surgery procedure
- Application of American Medical Association guidelines as defined in the CPT for asterisked (*) procedures

Scanning Solution

We recommend implementing scanning technology to replace the microfilm process. With scanning technology, input documents, such as claims and provider communications, will be scanned and assigned a document number. Once scanned, the electronic image of the document will be stored and will be accessible electronically through a Web browser just like OnDemand data. We will use the images for three main functions: data entry, resolution processing, and claims research. This technology will eliminate the time-intensive chore of tracking down film rolls, will allow more than one person to view scanned images at a time, and may reduce the need for retaining hard copies.

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Financial Subsystem

RFP Reference: 2.7.5, p. 2-113

The VermontAIM includes dynamic and proven financial management and accounting processes. The system's financial processing functions encompass claims payment processing, accounts receivable processing, accounts payable processing, and other miscellaneous financial transaction processing. It accounts for and reports all benefit dollars paid and recovered in accordance with RFP requirements. Additionally, it adheres to government-approved accounting procedures (GAAP). The current financial subsystem provides Vermont with the following benefits:

Service You Can Count On

In 21 years, the Vermont-based team has never missed a financial cycle. With EDS, this is the level of service the state of Vermont has come to expect and can depend upon in the future.

- Accurate expenditure budgeting
- Balance mechanisms to enhance fiscal control
- Opportunity for maximum federal funding
- Timely, comprehensive, and meaningful management reporting

A federally certified component of the VermontAIM, the financial subsystem satisfies all state requirements and supports multiple funding sources. Established user security and internal balancing controls prevent fraud or misappropriation of funds and maintain audit trails.

Moreover, the OnDemand reporting solution allows users to view financial reports at their desktop. Users can also download these reports to their PCs and use the financial data in other PC-based applications for specialized and ad hoc reports. EVAH is a flexible tool available for trend analysis, research, and report generation.

We share Vermont's commitment to maintain accurate funds accounting and ensure timely payments to providers. Strict internal accounting controls, system audit trails, automated cycle balancing, precise accounting, and reporting functions for claims and financial transactions provide the data necessary to effectively manage program resources. The inclusion of current Vermont business rules, funding, and payment procedures ensures continued processing without interruption or delay. Additionally, the financial functionality processes electronic remittance advice (RA) and electronic funds transfers (EFTs) that meet or exceed Vermont requirements.

To demonstrate our understanding of the financial subsystem and our ability to work with its data, we have organized our response in the following subsections:

- **Subsystem Objectives—**By responding to RFP objectives, we show our understanding of the role this subsystem plays in MMIS processing.

- **Proven Success—**We demonstrate our ability to work with the subsystem while keeping pace with program growth.
- **Enhancements—**We identify recent and planned enhancements that have notably enhanced the subsystem's functionality and user-friendly capabilities.

Subsystem Objectives

Although the RFP does not specify subsystem objectives in RFP section 2.7.5, the following list represents the objectives that the state and EDS have jointly defined during the past 10 years for this subsystem:

- **Provide accurate accounting of all MMIS payments by individual funding source**

  The draw report lists all activity within a funding source. We distribute this report to each department responsible for the funding source so the department can monitor funds. We balance all claim processing information each financial cycle against the financial information to ensure accurate payment processing. Additionally, we balance this information each month to the management administrative reporting (MAR) subsystem.

- **Complete annual SAS 70 audit to be performed by an outside independent auditing firm**

  EDS has successfully completed annual SAS 70 audits and will be completing the next audit in June 2003. The 2003 audit will encompass business continuity planning, telecommunications security, personnel, and contingency planning.

- **Complete bank reconciliation in a timely manner with detailed accounting of any discrepancies or imbalances**

  We begin the reconciliation process once the monthly account reconciliation package (ARP) process is complete and after we receive the bank statement. We complete the disbursement account and book balance worksheet and individual reconciliations to verify any outstanding balances.

Proven Success

Our history of working with the state of Vermont in managing VermontAIM provides a solid foundation of experience that prevents service disruption. For example, running the weekly financial cycle is central to maintaining budgetary integrity. **In the past 21 years, we have never missed a weekly financial cycle.** This is the level of service Vermont can count on to deliver day in and day out.

When the state needed greater budgetary flexibility, we implemented an enhanced fiscal pend process. This process allows you to "hold" claims at the end of a fiscal year due to budgetary constraints. This process allows each department (funding source) to independently pend claims as necessary.

Enhancements

Cash Control Project

In 2001, we implemented the Cash Control project to increase controls over incoming checks from the time of receipt to final disposition. The goal was to provide more comprehensive and systematic balancing and reporting. In addition, a recent modification to the financial subsystem automated cash control procedures. This enhancement led to a 10 percent increase in productivity for OVHA employee Deb Stemple, who now saves an average of four hours a week, or 208 hours per year.

Health Insurance Portability and Accountability Act

The VermontAIM MMIS is currently being enhanced to comply with the transaction and code set mandates set forth by CMS to be implemented by October 16, 2003. HIPAA enhancements include the HIPAA translator, the 835 Remittance Advice (RA), and the conversion of all CA Vision windows to PowerBuilder. The PowerBuilder windows offer a more user-friendly, Windows-based environment. In addition, we will implement the electronic RA in the Provider Solutions Software in December 2003.

Scanning Solution

We look forward to the opportunity to implement scanning technology to replace the outdated microfilm process. We will support a state-of-the-art Kodak scanner on the local area network (LAN) and use images for three main functions: data entry, resolution processing, and claims research. We will scan and assign a document number to input documents, such as refund checks, drug rebate checks, and TPL checks. Once scanned, the electronic image of the document will be stored and accessible electronically through a Web browser just like OnDemand data. This will allow the OVHA financial coordinator to view all checks received, should she need additional information about the check. This technology will eliminate the time-intensive chore of tracking down film rolls, will allow more than one person to view scanned images at the same time, and may reduce the need for retaining hard copies.

Online Audit Trails

Our DB2 database solution allows us to offer online audit trails rather than the existing Ingres table/report structures for audit trails. This online audit-trail functionality will replace the cumbersome and time-consuming paper audit reports for a substantial increase in productivity.

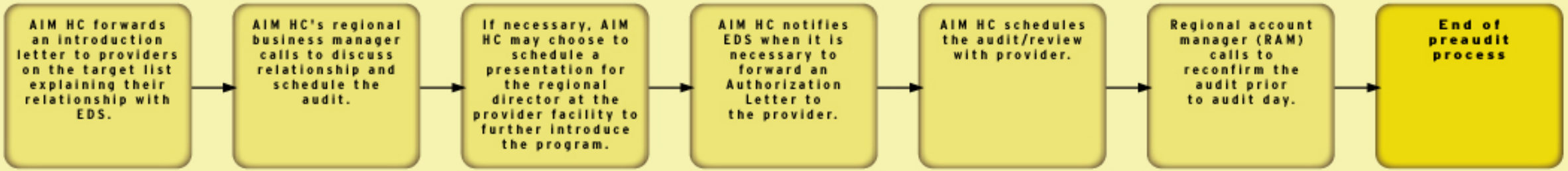
Rather than ordering an audit report, which can take several days to generate, to view the history of an online change to a financial window, a user will be able to view in real-time all online updates made to the Fiscal Pend window. When a user clicks the History button on a financial window, the GNAT (General Audit Trail) window appears displaying all changes made to that record, including the fields changed, what the fields used to be, the change date and time, and the users who made the changes.

AIM HealthCare Services Audit

In 2000, we hired AIM HealthCare Services on a contingency basis to conduct postpayment audits at hospitals. Given the nature of the recoveries, this type of audit was not something we could do on-site using the VermontAIM MMIS. When AIM HealthCare identifies and notifies us of suspected overpayment, we validate the overpayment. AIM then notifies the provider, and we reduce subsequent provider reimbursement by the overpayment amount and deny subsequent claims until overpayment is satisfied. The audit process has proved beneficial for the state. In both 2001 and 2002, the state received $156,000 in overpayment reimbursement. The following graphic depicts the complete audit process.

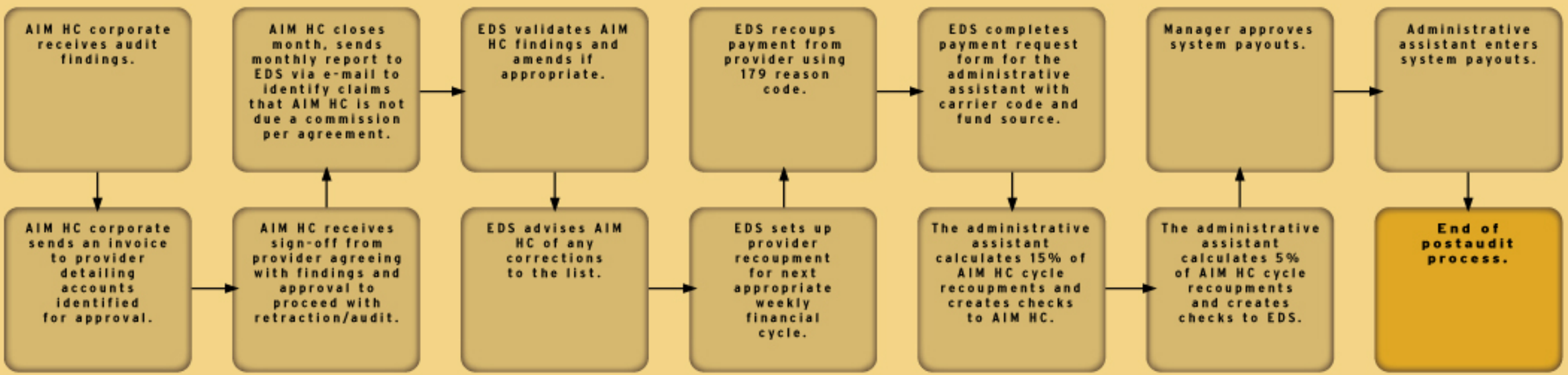
AUDIT REVIEW PROCESS

PREAUDIT PROCESS



AUDIT PROCESS

POSTAUDIT PROCESS



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Third-Party Liability Subsystem

RFP Reference: 2.7.6, p. 2-126

Pursuit of third-party liability (TPL) is critical for controlling Medicaid program costs and maintaining compliance with state and federal regulations. EDS has successfully supported TPL claims processing in Vermont for the past 10 years. A key aspect of our success in increasing TPL recoveries has been our commitment to maintaining the most accurate and up-to-date information regarding other possible payment resources for all eligible clients. Accurate resource information is essential to correctly billing third-party resources.

Increased TPL Recoveries

From 1999 to 2002, total TPL recoveries for the state of Vermont have increased more than 17 percent—from $3.5 million to $4.1 million.

In the state's current economic environment, all programs—including Medicaid—are expected to show cost reductions or savings. As a result, TPL processing will take on heightened importance and visibility. The state and the Vermont-based team have an established record that will serve as a foundation for increased TPL recoveries in the next contract period. **Total TPL recoveries increased more than 17 percent between fiscal year 1999 and 2000—from $3.5 million to $4.1 million.**

To demonstrate our understanding of the TPL subsystem and our ability to work with its data, we have organized our response in the following subsections:

- **Subsystem Objectives—**By responding to RFP objectives, we show our understanding of the role this subsystem plays in MMIS processing.
- **Proven Success—**We demonstrate our ability to work with the subsystem while keeping pace with program growth.
- **Enhancements—**We identify recent and planned enhancements that have notably enhanced the subsystem's functionality and user-friendly capabilities.

Subsystem Objectives

a. Identify and manage the private health, Medicare, and other third-party resources of Vermont's medical assistance recipients.

Our system currently performs the functions to identify and manage the private health, Medicare, and other third-party resources of Vermont's medical assistance beneficiaries. To help identify private health insurance, we produce a monthly TPL Suspect Report, which lists claims processed that had a payment amount in the Other Insurance Payment field when the beneficiary has no other insurance on file. This report is sent to the state so other possible insurance can be verified.

b. Ensure that Medicaid is the payer of last resort.

We currently support Vermont's aggressive efforts to identify all liable third parties and obtain reimbursement to continually reinforce the Vermont Medicaid Program as the payor of last resort. Fletcher Allen Health Care, a prominent health care provider in the state, recently notified us that they often identify beneficiaries with other insurance that we may not be aware of. We instituted a process by which Fletcher Allen sends a Microsoft Excel worksheet with the additional insurance information to our TPL unit. We use this information to validate the other insurance information and add this information to the system.

c. Avoid paying for claims with potential third-party coverage.

Currently, the VermontAIM system applies cost-avoidance criteria through a series of prepayment edits run against a claim for which the beneficiary is identified as having other insurance. The current system stores the beneficiary's TPL data. This TPL data is accessed during claims processing to determine the type of coverage provided by the third party.

d. Recover funds from third parties when resources are identified after claims have been paid.

Our current system has a benefit recovery process in place that is initiated when TPL information is discovered or changed retroactively. When we find a claim was paid with Medicaid funds when it should have been paid by a third-party resource, we send the third-party carrier a facsimile claim and establish an account receivable for the carrier.

In response to RFP requirement 2.8.3.3 Third-Party Liability Responsibility Reorganization and Subsystem Upgrade, we propose teaming with Health Management Systems (HMS), the leader in TPL recoveries, to ensure Vermont is provided with the optimal solution in TPL recoveries.

HMS has the resources necessary to explore and pursue all TPL recovery options. HMS currently has cross-matching agreements with more than 85 percent of the private carriers in most areas of the United States. HMS already has data sharing agreements in place with 17 of the top 25 health care insurers in Vermont (based on Year 2000 premiums paid as reported to the Vermont Department of Insurance).

e. Pay the premiums for private health insurance for recipients (including Medicare Buy-In) when it is deemed cost-effective to do so.

The current TPL subsystem contains a cost-effectiveness window that allows the user to enter health insurance premium amounts, policy holder social security number, coinsurance, deductible amounts, and covered family members. The beneficiary-specific demographic information, such as age, sex, and aid category, are automatically entered by the system.

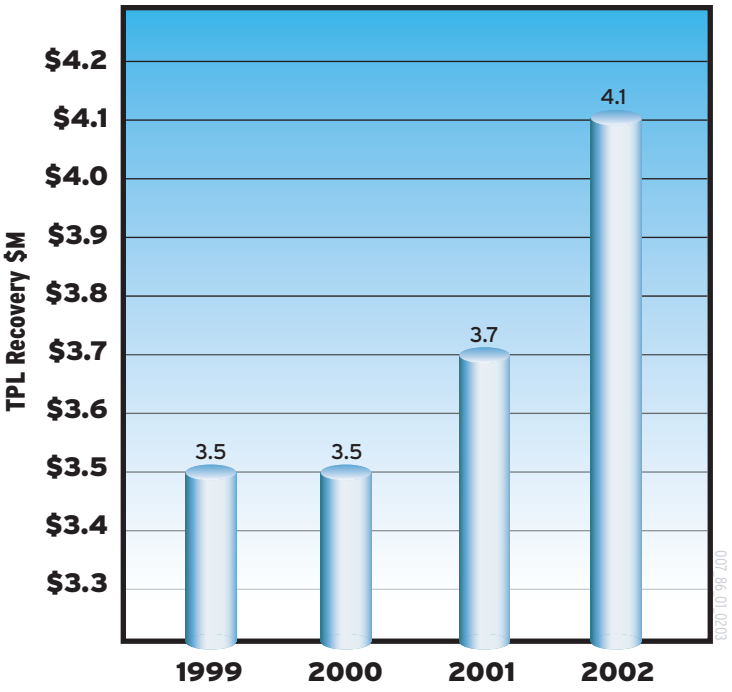
The window is a worksheet that calculates the estimated annual Medicaid payment amount for the beneficiary and compares it to the annual premium amount. The state's TPL unit can use it as a tool in the decision-making process when estimating the cost-effectiveness of paying premiums.

Once cost-effectiveness has been established, the system is capable of generating payments for a predetermined period of time, or we can process manual checks because of an approaching payment deadline.

Proven Success

The Vermont-based team works closely with the TPL staff at the OVHA and communicates with them on a daily basis. With this level of cooperation, TPL recoveries have continued to show a steady upward trend as shown in the following chart.

Total TPL Recoveries by State Fiscal Year



Since state fiscal year 2000, yearly TPL recoveries have increased by $600,000.

For the past several years, a rebill process has been in place to enable the TPL unit to follow up more efficiently on open account receivables. We run a program each month to identify accounts without activity for 90 days. A claim facsimile is automatically produced along with a letter to the insurance company informing them we are expecting payment from them.

After 120 days, if we still have not received payment, we send another letter with a statement of outstanding claims. If after 180 days, we have not recovered from the carrier, we print the account receivable information on a report for the state TPL unit to follow up with the carrier. This rebill process helps the state TPL workers track outstanding accounts, relying on the system to do follow up, freeing them to open new cases.

Enhancements

Claim Facsimile Reproduction

When the need arose for the state's TPL team to create a claim facsimile for a different carrier than was originally billed, we modified the TPL subsystem to allow users to generate a facsimile for a new carrier without having to open a new account. For example, Blue Cross/Blue Shield of Vermont frequently denies claims with an explanation "Please re-submit to drug rider." The user can now use the same account receivable and "regenerate" the claim facsimile to a new carrier. This process saves the state time and makes it much easier to recover funds that were previously written off.

Global Clinical Record Interface

We will enhance the VermontAIM MMIS to provide an interface to the Global Clinical Record (GCR) system. This interface will include core system prior authorization, reference, provider, and claims processing information. The current planned implementation date of this interface is August 2003.

We will provide the GCR with recipient and recipient TPL information. We will evaluate the TPL information during the decision-making process for issuing a prior authorization, again, insuring that all other resources are exhausted before Medicaid makes a payment.

Online Audit Trails

Our DB2 database solution allows us to offer you the option for online audit trails instead of the existing Ingres table/report structures. This online audit-trail functionality will replace the cumbersome and time-consuming paper audit reports for a substantial increase in productivity.

Rather than ordering an audit report to view the history of an online change to a TPL window, such as the TPIC-TPL Resource File window, a user will be able to view in real-time all online updates to a carrier's address, contact person name or telephone number, and so forth. When a user clicks the History button, the GNAT (General Audit Trail) window appears displaying all changes made to that record, including the fields changed, what the fields used to be, the change date and time, and the users who made the changes.

Long-Term Care Subsystem

RFP Reference: 2.7.7, p. 2-132

With an ever-growing population of elderly citizens needing long-term care (LTC) in Vermont, it is vital that the state partners with a fiscal agent who has a history of working hard to build a good rapport with Vermont's nursing home community. Building just such a rapport is what the Vermont-based team has done for more than 21 years. We understand how important it is that LTC facilities receive accurate payment in a timely fashion. With our experience, our relationships, and the leading-edge technology of VermontAIM's LTC subsystem, we are positioned like no other to keep this tradition alive.

Using Technology to Meet LTC Provider Needs

Approximately 98 percent of the LTC claims are submitted electronically with an average payment time of less than 10 days, helping LTC providers better manage cash flow.

To demonstrate our understanding of the LTC subsystem and our ability to work with its data, we have organized our response in the following subsections:

- **Subsystem Objectives—**By responding to RFP objectives, we show our understanding of the role this subsystem plays in MMIS processing.
- **Proven Success—**We demonstrate our ability to work with the subsystem while keeping pace with program growth.
- **Enhancements—**We identify recent and planned enhancements that have notably enhanced the subsystem's functionality and user-friendly capabilities.

Subsystem Objectives

a. Develop, maintain and review (as needed) payment methodologies for LTC services.

Today, we support both online submission and paper submission of LTC claims. A premium process we have delivered to the LTC providers is the Provider Electronics Solution software currently available under the existing contract. This software allows providers to easily generate their own monthly turnaround documents (TADS) and submit them via a modem or diskette. Providers can also copy the current month billings and modify them for the next month rather than re-entering the information each month.

The transformation to the Health Insurance Portability and Accountability Act requires nursing homes to use the new standard institutional claim (X12N 837) format to submit their services. The providers will continue to be able to submit claims either as paper submissions or electronically. Although there will be significant changes in the billing instructions, they will be using a standardized billing form that they use now to bill skilled nursing services to other entities.

Our provider representative staff will conduct workshops to assist providers with mapping the new revenue codes, which will replace the recipient placement levels they are used to, and to teach them how to complete the required fields on the claim form.

Approximately 98 percent of the LTC claims are submitted electronically with an average payment time of less than 10 days. Even though we have only 73 LTC providers representing 2.3 percent of the total provider community, they depend upon the Medicaid payments to keep afloat. We have been able to provide a fast turnaround of their claims making it easier for them to exist and provide care for our elderly without experiencing cash flow issues. We look forward to continuing this service in the future.

We have a dedicated clerk, Eileen Mulloy, who enters paper claims and reviews all suspensions of this specialty claim when received from the provider. To enhance our relationship with the LTC provider community, Eileen works closely with our Provider Services team to contact the facilities and resolve issues to avoid repeated denials and resubmissions.

Several other team members are trained to ensure the timely processing of LTC claims. This is an important feature as untimely processing disrupts the provider's cash flow and directly affects the business for the LTC facilities they serve.

Reporting

The current LTC system produces several reports for us and the OVHA to use in reviewing and analyzing program activity on an ongoing basis.

Input reports

Reports	Purpose
CLAR062V	Provides a trail for paper submissions. This report will be available post HIPAA but will contain modified data.
CLAR100V	Provides a trail for electronic claims received. This report will be available post HIPAA but will be modified for data content.

Editing

We have established editing for services covered and reimbursed by other entities, such as Medicare and third-party liability, to guarantee that Medicaid is the payor of last resort.

In 2002, we paid 30,239 LTC claims. The total paid amount was $83,948,068.97. Other insurance reported was $214,002.97. This total payment amount represents 12.7 percent of total Medicaid expenditures for a year.

Recipient Date-Specific LTC Data

We are able to maintain all of the following recipient date-specific LTC data:

- Admission and discharge dates
- Home leave of absence and hospital hold bed days
- Patient financial liability information
- Recipient placement level
- Date of death
- Other data elements as required by the state

To support the processing functions of beneficiary date-specific LTC data, we have the following edits:

- ESC 440—Not authorized for this beneficiary placement level. This edit was designed to compare what the provider is billing against what the customer has authorized for level of care, facility, and date specific.
- ESC 441—No applied income on file. This edit was designed to compare the patient financial liability on file to what the provider is billing. Any discrepancies are reported as requested and discussed in the output reporting section.

We currently provide, and will continue to provide, the time-delineated LTC provider and facility rates based on beneficiary level-of-care and bed classification. The provider rate accommodation files are cross-referenced to the beneficiary's level of care to ensure accurate payment for services authorized and are easily modified as updates are received from the rate-setting office at the customer site. The audit trail for these updates is the PRVR700V – Provider File Maintenance report. This provider rate file allows date-specific payments based on bed classifications such as nursing home, swing beds, rehabilitation, or nursing home hold.

In July 2003, when we implement the HIPAA modifications to the MMIS, we will provide the same level of payment methodology as we do today by cross-walking the revenue codes assigned to replace the beneficiary placement levels to the facility rates. Our audit trail tracking enhancements for online updates will be available here as well.

b. Maintain accurate beneficiary level of care information to assure appropriate payment.

We have a proven track record of maintaining accurate beneficiary level-of-care information to ensure appropriate payments. The following beneficiary windows provide the Vermont-based team with the information required to support the state's objectives:

Recipient Windows

Window	Purpose
LTEI – Nursing Home Eligibility	Verifies the level of care, facility, specific to date of service. The tracking for these updates is recorded on the REKR856V – Recipient Update Report: Long Term Care.
LTEL – Nursing Home Liability	Identifies the amount of patient liability/applied income that needs to be deducted before a payment is made. The tracking for these updates is applied to the REKR850V – Recipient Update Report: Patient Liability.
LTNH – Long Term Care History	Used for inquiry only of the recipient's hold-bed and leave-days information for the state fiscal year to date.

The updates for these windows are made through online ACCESS transactions received daily.

We also provide the following output reports:

- LTDR101V – Nursing Home Patient Liability Discrepancy Report—This report includes provider, beneficiary name, Medicaid number, from date of service, to date of service, liability on file, and liability on claim.
- LTAR101V – LTC Credit Balance Report—This report lets the LTC analyst know the amount on the beneficiary liability file, what the provider submitted as patient liability on the claim, the total billed amount, and the credit balance.
- LTRR600V – Hospital/Hold Bed Comparison Report—This report shows hold bed days billed by facility, beneficiary, and date of service.
- REKR240V – Recipient Access Update Transactions—This report shows the date of death when sent as a transaction via ACCESS. Recipient Base window (REBA) contains a field to report the death date. The LTC claim submitted by the provider identifies death by status codes 20, 21-29, and 40-42.

Proven Success

Working with the state to successfully address LTC issues is a responsibility the Vermont-based team has always been prepared and eager to do, as the following examples illustrate:

- Because retroactive rate adjustments often affect a year or more worth of claims, adjusting each claim separately was a time-consuming and inefficient process. To address this issue, the Vermont-based team designed the mass adjustment process to improve the procedures for adjusting LTC claims. The new mass-adjustment process requires minimal manual intervention and makes it much easier and more efficient for the providers to reconcile their accounts because the transactions are completed in one financial cycle.
- When the hospital provider files needed to be updated, our Provider Enrollment unit worked with the LTC personnel at the OVHA to update the files to ensure accurate reimbursement to only those facilities certified for swing bed classification.
- When it became necessary to reimburse facilities for rehabilitative services for LTC clients at a different rate, we modified the PRRM – Provider Rate Accommodations window to reflect a new reimbursement code.
- To assist providers who submit their claims electronically, we set up a process to track the Occupancy Certification form, which is required when hold-bed days are billed. The Occupancy Certification form cannot be submitted electronically. Rather than deny an electronic claim submitted without the form, the LTC team began tracking each claim and matching it to the Occupancy Certification form when it arrived in the mail. Providers are given two weeks to send in the form before the claim is denied.

Enhancements

Health Insurance Portability and Accountability Act

HIPAA requires nursing home claims be processed in the new standard institutional claim (X12N 837) format. We are enhancing the LTC subsystem to allow LTC providers to begin using the UB92 billing form in July 2003, well in advance of the October deadline. We will provide both paper and electronic media for this purpose. This will standardize billing procedures for the providers as they now bill skilled nursing services to other entities using this claim form.

In addition, the MMIS is currently being enhanced to include the HIPAA translator and the conversion of all CA Vision windows to PowerBuilder. The PowerBuilder windows offer a more user-friendly, Windows-based environment.

Online Audit Trails

Our DB2 database solution allows us to offer Vermont the option of online audit trails rather than the existing Ingres table/report structures for audit trails. This online audit-trail functionality

will replace the cumbersome and time-consuming paper audit reports for a substantial increase in productivity.

Rather than ordering an audit report, which can take several days to generate, to view the history of an online change to a LTC window, a user will be able to view in real-time all online updates. When a user clicks the History button, the GNAT (General Audit Trail) window appears displaying all changes made to that record, including the fields changed, what the fields used to be, the change date and time, and the users who made the changes. For example, on the LTEL – Nursing Home Liability window, a user would be able to view all online changes to liability (applied income) segments for a beneficiary in most recent date order.

Scanning Solution

We are excited that we can offer Vermont a state-of-the-art Kodak scanner to replace the inefficient microfilm process. In the enhanced VermontAIM MMIS environment, input documents, such as claims and provider communication, will be scanned and assigned a document number. Once scanned, the electronic image of the document will be stored and accessible electronically through a Web browser just like OnDemand data. We will use the images for three main functions: data entry, resolution processing, and claims research. This technology will eliminate the time-intensive chore of tracking down film rolls, will allow more than one person to view scanned images at a time, and may reduce the need for retaining hard copies.

Early and Periodic Screening, Diagnosis, and Treatment Subsystem

RFP Reference: 2.7.8, p. 2-135

The early and periodic screening, diagnosis, and treatment (EPSDT) subsystem is responsible for notifying all Medicaid beneficiaries under age 21 of the availability of EPSDT services and for tracking and reporting EPSDT service utilization. The primary goal of the program is to prevent illness, complications, and the need for long-term treatment by screening and detecting health problems in the early stages. These measures improve quality of life for beneficiaries and reduce the occurrence of costly diseases that can result in long inpatient hospital stays.

Meeting the Health Needs of Vermont's Youngest Citizens

In the past four years, the percentage of screenings for Vermont's EPSDT population has steadily increased from 41 percent in 1999 to 67 percent in 2002.

The EPSDT subsystem performs the following high-level functions:

- Update and maintain the EPSDT data store
- Update, maintain, and generate EPSDT notification letters
- Allow online access to EPSDT data
- Track EPSDT activity
- Produce EPSDT reports
- Interface with other MMIS subsystems to receive or provide needed data

The Vermont Department of Health (DOH) assists in EPSDT outreach and education through its Partners in Health Program. Under an agreement to implement EPSDT services, the DOH makes available to all providers established protocols and standards for screening services to ensure that beneficiaries are encouraged to take advantage of EPSDT services. The screenings with follow-up treatments, if needed, are used to gauge the effectiveness of the EPSDT program.

The Vermont-based team works with Vermont Medicaid providers to support preventive health care programs for children and young adults. We interact closely with the Medicaid provider community to enhance awareness of the benefits the EPSDT system provides. We maintain a tracking system, in which beneficiaries and services are recorded. We understand the importance of this program and are prepared to provide the processing functions to meet or exceed the state's expectations.

To demonstrate our understanding of the EPSDT subsystem and our ability to work with its data, we have organized our response in the following subsections:

- **Subsystem Objectives**—By responding to RFP objectives, we show our understanding of the role this subsystem plays in MMIS processing.

- **Proven Success**—We demonstrate our ability to work with the subsystem while keeping pace with program growth.
- **Enhancements**—We identify recent and planned enhancements that have notably enhanced the subsystem's functionality and user-friendly capabilities.

Subsystem Objectives

a. Maintain and update a procedure code-based payment logic for providers of EPSDT services, as required by the State.

We maintain and update a procedure code-based payment logic, as required by the state, for providers of EPSDT services. EPSDT services, for example office visits for children, are currently paid at an enhanced rate of 20 percent more than the rate on file.

When we receive new or updated EPSDT processing procedures and procedure codes from CMS, the American Medical Association, or the state, we immediately document them and update claims processing. This ensures the accuracy of the procedure code-based payment logic our system uses to process provider claims for EPSDT.

We immediately communicate changes to the provider community. The *Remittance Advice Report,* mailed each week to Medicaid providers after a scheduled weekly cycle, provides information on the banner page about correcting incorrectly submitted claims. We also report EPSDT code changes in the *Vermont Health Access Advisory.* These efforts are designed in coordination with the state to ensure that the most accurate and up-to-date information and policy changes are available to the provider community.

b. Maximize FFP for the provision of health care to beneficiaries.

The VermontAIM system has procedures in place to ensure that EPSDT-related services are categorized correctly so the state can determine the Medicaid costs of these services to maximize the federal financial participation (FFP) for the provision of health care to beneficiaries. EPSDT services are tracked for appropriate follow-up and reported to CMS by collection of data from the HCFA-1500 Medicaid claim form field 24H (EPSDT Family Plan). If field 24H is populated, then under section 1903(a)(5) of title XIX of the Act, the federal matching rate under Title XIX for family planning services expenditures is at 90 percent, not the regular Medicaid FMAP rate, and not the Title XXI enhanced FMAP rate. Therefore, federal-matching payments for the state's Medicaid expenditures under Title XIX for family planning would be federally matched at the 90 percent rate, and such expenditures would <u>not</u> be charged against the state's title XXI allotment.

Proven Success

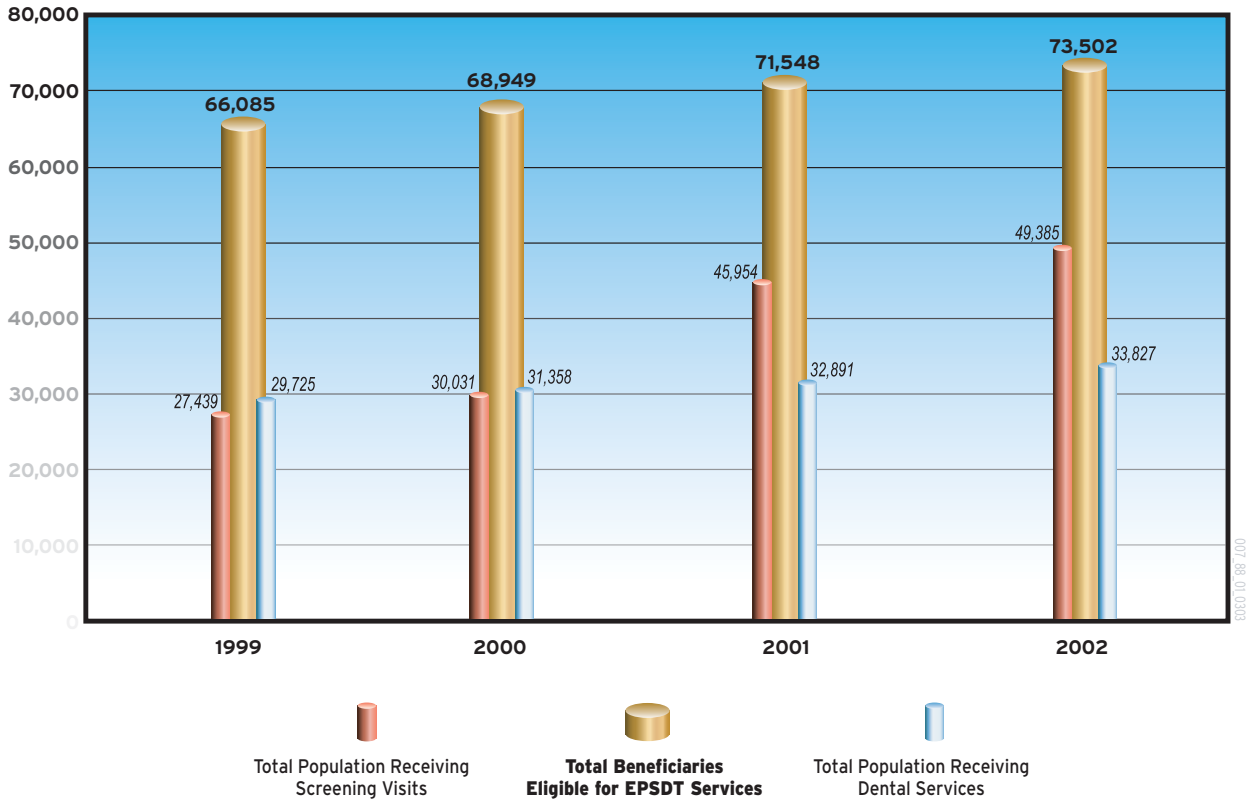
The Vermont-based team has been a committed partner helping the state of Vermont meet its EPSDT goals. The following are key deliverables related to the EPSDT subsystem:

- Delivery of EPSDT weekly initial notices
- Distribution of EPSDT periodic notices in accordance with state periodicity schedule
- Delivery of the annual CMS-416 report to CMS by April 1

We fully understand the criticality of accurate, timely delivery of the EPSDT notices and reports. The Vermont team has a proven record of never missing an EPSDT delivery deadline.

In addition, we recognize the best way to improve the quality of life for beneficiaries and reduce the incidence of costly diseases is to have a successful outreach program. As the following graphic illustrates, the number of individuals eligible for EPSDT services who received screening visits has steadily increased since 1999, and the trend for dental services received has kept pace with the growth of the EPSDT-eligible population.

Reaching the EPSDT Population



The percentage of eligible beneficiaries taking advantage of EPSDT services has grown from 41 percent in 1999 to 67 percent in 2002.

Enhancements

Global Clinical Record

We will enhance the VermontAIM MMIS to provide an interface to the Global Clinical Record (GCR) system. This interface will include claims processing information, recipient, reference, and provider base data. The implementation of the GCR will also eliminate some of the current responsibilities under the EPSDT subsystem, such as distribution of beneficiary notices and all EPSDT-specific reporting, including the CMS-416.

Management and Administrative Reporting Subsystem

RFP Reference: 2.7.9, p. 2-137

The management and administrative reporting (MAR) subsystem provides in-depth insight into elements in the VermontAIM MMIS for all PATH departments. The information the MAR subsystem provides aids in efforts to effectively plan, manage, and control all aspects of Vermont medical assistance programs and CMS reporting requirements. The reporting mechanisms within the MAR subsystem allow users to view a series of system-generated standard reports and user-enhanced ad hoc reports.

Fast, Flexible Access to MARS Data

The MAR subsystem offers fast, direct access to payment data. MAR data also feeds EVAH, which gives users the flexibility to create their own reports.

The MAR subsystem performs the following high-level functions:

- Generates MAR standard reports stored on IBM Content Manager OnDemand
- Provides flexible reporting using the Enhanced Vermont Ad Hoc (EVAH) application
- Provides for data analysis using EVAH and OnDemand
- Interfaces with other VermontAIM subsystems to provide required program-related data

The difference between planning, directing, and controlling and merely reacting to situations is information. The objective of the MAR subsystem is to provide this difference by presenting concise, meaningful, and accurate information that measures the pulse of program activity.

In acknowledgement of Bidders' Question 13 about the meaning of "partially disable" the MAR subsystem, we understand that the state's approach to generating MAR reports is going through a great deal of change and will undergo even more change in the next contract period. The following responses to the subsystem objectives are a descriptive summary of the current MAR subsystem functionality and how it serves the Department of PATH needs. As in the past, we are ready to work with the state on any changes necessary for the successful operation of the Vermont MMIS system.

To demonstrate this understanding of the MAR subsystem and our ability to work with its data, we have organized our response in the following subsections:

- **Subsystem Objectives**—By responding to RFP objectives, we show our understanding of the role this subsystem plays in MMIS processing.
- **Proven Success**—We demonstrate our ability to work with the subsystem while keeping pace with program growth.
- **Enhancements**—We identify recent and planned enhancements that have notably enhanced the subsystem's functionality and user-friendly capabilities.

Subsystem Objectives

The MARS objective is to generate:

a. Comprehensive information reported by program and authorizing department.

The base selection criteria for predefined MAR reports focus on program and authorizing departments identified by funding source codes. Currently, all predefined claim and financial reports available in EVAH have built-in prompts for funding source and reporting period. Each report provides the flexibility to select individual or multiple funding source codes for either a single report period or multiple report periods to compare a reporting period to that same period in previous years. An example of an EVAH report that meets these criteria is the Claims Payment Statistics by Provider Type report. This report shows claims paid and denied counts, units of service, and expenditures by funding source and provider type for MAR report periods. Subtotals for each funding source, as well as a total for all funding sources, are provided for each measure reported.

b. Comparisons of current program activity with activity in prior periods.

Our recent conversion from 4GL to BusinessObjects allowed for greater flexibility to compare program activity across multiple report periods. The predefined Operational Performance Dollars EVAH report is an example of one of the many reports that now provides greater flexibility to compare multiple period activity performance. The report is created with prompts in which the user can enter single or multiple report periods. Each time a report is run, the user specifies the reporting period(s), funding source(s), and categories of service he or she would like to query. This report lists funding source dollars by category of service detailing the total paid amount, denied billed amount, and claim-specific financial amounts, and a net calculated amount. In addition, the report has three tabs (Dollars, Percentages, and Counts) in one base report that provides multiple views of the data.

c. Reports depicting:

- **Program trends**

  Multiple state departments use the EVAH application to analyze program trends. The flexibility of ad hoc reporting in conjunction with predefined reports provides authorized users with information based on funding source, aid category codes, category of service, provider and recipient demographics—all key elements in the analysis of program trends. EVAH can be used to summarize past historical trends to support future program growth and funding requests.

  The capabilities EVAH has offered during the years and will continue to offer in the future provide key information during the legislative sessions. This tool assists all program stakeholders in assessing the impact of new policies or reimbursement levels and creates the necessary baseline of historical information to determine trend or potential impact (both programmatic and financial) of proposed legislation.

- **Payments by category of service**

  Reporting based on category of service can be completed either by using a predefined EVAH report, such as the Claim Payment Statistics by Category of Service, which provides funding source code summary information by category of service, or through the creation of an ad hoc query in the EVAH_MAR universe.

- **All types of claim adjustments and non-claim-specific financial transactions**

  MAR reporting incorporates all claim adjustments as well as all nonclaim-specific financial transactions. The EVAH MAR universe provides access to various claim and nonclaim-specific transactions based on provider-specific information, such as provider type and specialty, funding source, and category of service. Users can create queries to meet their specific needs, or predefined reports are available with claim and nonclaim-specific information included.

  The Claims Payment Statistics by Category of Service report includes claim and nonclaim-specific dollars within one report. This reports claims paid and denied counts, units of service, and claim and nonclaim-specific expenditures by funding source, category of service code, and provider type for MAR report periods. Subtotals for each funding source, as well as a total for all funding sources, are provided for each measure reported.

Proven Success

Streamlined Update Process

Since 1998, we have implemented a series of enhancements to improve the run time of our MAR update process. We redesigned the MAR summary and load process to improve the efficiency of the MAR process. These improvements reduced MAR processing time by 80 percent. The processing time saved has greatly increased the state's use of monthly data to evaluate Medicaid programs and make timely decisions. The new streamlined process also allows users to access the MAR data more quickly.

Balancing Procedures

We create automated balancing reports to compare monthly financial and claims paid amounts in the MAR database tables to ensure that all claims data is properly loaded. To substantiate the MAR data, internal dollar and claim data totals are compared at each step of MAR processing to ensure data remains consistent throughout the cycle. We have incorporated processes designed to ensure that each MAR production run includes consistent transaction processing cutoff points. For example, MAR production runs must be consistent with each month's production cycles to ensure the correct financial interface for reporting of medical assistance data.

Enhancements

Improved Reporting

In 2002, we migrated the MAR 4GL windows to the EVAH DB2 database platform and created a series of standard reports to access the MAR database tables. The user controls all elements of this reporting alternative for greater flexibility and access to the tables stored on the EVAH platform. In addition, EVAH offers the flexibility to customize the current standardized reports by tailoring the output of the report to the detail specifications requested by the user.

EVAH can be used to create informational reports that specify reporting elements to monitor financial status, budget/expenditure, category of service, expenditure and utilization by procedure code and date of service, operational statistics and performance, as well as provider and beneficiary participation.

The following are some of the MAR reports currently available in EVAH:

- Provider Ranking
- Provider Participation
- Error Status Code Analysis
- Long Term Care Payments
- Providers by County
- Monthly Expenditure by Age Group
- ECS Statistics by Provider Type

Previously, the 4GL solution was costly and time intensive to modify. Each request for additional columns or reporting elements required technical intervention to incorporate the requested elements or new functionality. **Now with a point and click, users can instantaneously create a unique report designed to meet their specific needs from their desktops.** The capability of the MAR subsystem has been expanded to produce reports on an ad hoc basis, in accordance with a specified schedule.

In addition, MAR reports are processed as needed by the state to provide administrative cost information that is necessary to accurately complete the administrative portion of the HCFA-64 form the state reports to CMS.

To assist the state in its efforts to compile the information necessary for the quarterly CMS-64 wavier report, we created a new MAR reporting process to reduce the intensive manual processing of the claims data requested by CMS. The new process allowed the creation of a specialized report to secure the information required to submit timely and accurate reports to CMS. This process has helped Vermont retain its Section 1115 status. **The quarterly reporting process reduced the time to create the CMS-64 wavier report by 75 percent.**

Ad Hoc (EVAH) Subsystem

RFP Reference: 2.7.10, p. 2-145

The Enhanced Vermont Ad Hoc (EVAH) uses query software from Business Objects to simplify the state's needs for specialty reporting. EVAH offers rapid and efficient access to a majority of the information captured in the MMIS database. EVAH also lets users present geographical data in a map format as a result of its link to the geographical information system MapInfo. Mapping has proven very useful when discussing topics such as the availability of care or distribution of beneficiaries.

State and EDS personnel jointly designed EVAH to ensure it met the most crucial daily reporting needs. EVAH offers access to specially designed data models focusing on the claims, provider, recipient, reference, EPSDT, financial, and TPL components of the MMIS.

Conversion Rewards

With the successful conversion of the EVAH database, the total claims data available was extended from three full years to five full years in all claims-based data models.

User-Friendly, Leading-Edge Technology in a Complicated Industry

Easy and quick access to information is critical in this industry. With EVAH, users can generate specialized reports from their workstations with a simple point and click of the mouse, which eliminates delay and the need for a formal request. Users need not understand SQL or database structures. Report data can be combined with data from outside sources to provide a more comprehensive comparison of—either in data format or graphing. All EVAH reports can be exported to Excel, text, comma delimited, or Dbase format to provide portability to other users and applications.

EVAH helps state personnel analyze the multifaceted approaches to medical coverage for the Vermont beneficiaries. EVAH enables state users to deliver numbers based on program performance, recipient eligibility, claims processing, and any combination of these based on dates of service or paid dates.

Experience Makes a Difference

EVAH support personnel bring more than 35 combined years of EDS MMIS knowledge to the state. Our extensive experience has proven invaluable in supporting the various state agencies that use EVAH. Our EVAH support team consists of two full-time reporting specialists—Louise Brooks and Ann Markle—and one full-time system engineer—Carrie Marchant. All three are specially trained to support the suite of Business Objects products.

Each reporting specialist supports particular departments and is available to provide one-on-one training and to assist users with report development and verification. The focused assignments have helped our staff members develop intimate knowledge of the programs supported by their departments. One reporting specialist is on site at the Waterbury offices for support three days a week.

Much of the success of the EVAH subsystem can be attributed to the dedicated people working on the team. We are pleased that Louise Brooks, Carrie Marchant, and Ann Markle will continue to support the new contract. In the following pages, we provide some highlights of their contributions to Vermont and EVAH.

Louise Brooks: "*An irreplaceable asset for the Department*"

Louise brings 21 years of experience in the analysis of Medicaid data, 14 years of experience with SUR systems and Medicaid fraud review, and 14 years of experience with ad hoc report creation with GQL and BusinessObjects. For the past six years, she has worked on-site at your office, supporting the Vermont Medicaid Program's ad hoc needs. On February 28, Commissioner Patricia House honored Louise with the Commissioner's Award and said of her, "You have become an irreplaceable asset for the Department … your ability to live in two worlds—EDS and the Department of PATH—is remarkable … your ability to educate, to synthesize, and to move at the speed of light is appreciated by all of us … "

The following list provides her additional qualifications for this position:

- During her professional health care career, Louise has manually reviewed more than **1 million** Medicaid claims.
- She brings additional extensive experience with system testing and data verification.
- Most importantly, she believes the customer always comes first.

Louise currently focuses her considerable skills on Vermont's ad hoc reporting needs to produce weekly, monthly, and quarterly reports as well as the critical and highly specialized report needs that a large-scale health care program requires for ongoing, current analysis of program usage and to support program direction. She readily supports the reporting needs of OVHA, Administrative Services, the Medicaid provider fraud unit, the Health Access Eligibility Unit, the Department of Developmental and Mental Health, the Vermont Program for Quality Health Care, the Medicare Advocacy Project, the PATH Commissioner, and CMS. For these state customers, she performs all types of inquiries and ad hoc query reporting.

The Department of PATH formally recognized Louise's dedication and contributions with the 2002 OVHA Speed of Light Award. The Commissioner of PATH presented the award to Louise in February 2003. The award reads:

This award is presented to

Louise Brooks

for her outstanding contributions to the Office of Vermont Health Access. Over the past 15-plus years your job has changed tremendously and you have become an irreplaceable asset for the Department. Your ability to live in two worlds—EDS and the Department of PATH—is remarkable. Your ability to educate, to synthesize, and to move at the speed of light is appreciated by all of us, but especially by the Commissioner! Just as important is your patience and professionalism. This recognition is long overdue. Congratulations!

Ann Markle: Bringing Long-Term Provider and EDS Experience

Ann has been a member of the EDS Vermont team since 1996. Prior to joining EDS, she supported the Medicaid billing operations of a major Vermont provider, Fletcher Allen Health Care. In total, Ann brings 16 years of medical billing and report production experience. This experience includes several years as a Vermont provider representative, active participation in establishing the state's PC*Plus* program (which allowed the state to continue its 1115 Waiver program when the managed care organizations abandoned the program), and—starting in 1999—working with BusinessObjects for Vermont's ad hoc reporting needs.

Ann will continue to support Vermont's specialized reporting needs in the next contract period. She continues her study of the BusinessObjects tool and has become proficient in providing just the information her customers are looking for. In 2002, Ann received certificates of completion for the Business Objects 5i Core Reporting Concepts and the Business Objects 5i Intermediate Reporting Concepts courses. She creates EVAH training manuals, conducts training for all state users, and develops reports required for the Federal Attorney General's Office for nationwide Medicaid fraud cases. She will continue to support all reporting needs for the Office of the Attorney General; the Department of Aging and Disabilities; Vermont Department of Health, including (but not limited to) the AIDS Medical Assistance Program; the Department of Dental Health; and the Division of Vocational Rehabilitation. She will also support EDS EVAH users.

Carrie Marchant: Primary Contact for All Things EVAH

Carrie brings eight years of Vermont Medicaid experience and six years of experience with the EVAH database team. She was one of EVAH's principle designers and has a comprehensive and detailed understanding of the database, its table structure design, and the DB2 update process. She has supplemented this technical know-how with intensive training in the use of BusinessObjects, attends BusinessObjects user conferences, and has completed training offered by both Business Objects and EDS. In fact, Carrie is so accomplished in the use of this tool that she receives frequent requests to teach introductory and advanced courses for both the Vermont customer and EDS staff.

The EVAH project has evolved from a one-department, ad hoc solution to a multidepartment support tool. Currently, the following departments use EVAH for program management decisions:

- Office of Vermont Health Access
- Department of Developmental and Mental Health Services
- Department of Aging and Disabilities
- Department of Health (Healthy Babies, AIDS Medication Assistance Program, Statistical, Alcohol and Drug Abuse Program)
- Division of Dental Health
- Medicaid Fraud and Abuse
- Office of the Attorney General
- Planning and Evaluation Division
- Department of Social and Rehabilitative Services
- Department of Planning and Evaluation

Carrie is the primary EDS contact for all technical questions and works closely with each of the state departments using EVAH. She works directly with Business Objects to obtain information on new products and product upgrades, which ensures Vermont is always using the most current and powerful versions. She has recently been working with the Planning and Evaluation Division to assist it with the design and structure of a new enterprisewide database. Her responsibilities include resolving any user security and access issues, overall universe design, modifications to the weekly update process, requests for new data to be added, implementation of structural changes, and Broadcast Agent (BCA) server issues.

Training Support

EVAH gives users the power to design and run their own data requests. Although our support staff is available to walk through the various considerations when creating a request, it is our goal to give each user the knowledge needed to complete most requests independently. To aid in this, we have designed and sponsored many training classes and will continue to do so in the upcoming contract period.

We have created training courses and material specifically designed for the Vermont EVAH application. These training courses are held in a hands-on laboratory environment with training exercises targeted directly for the users attending the trainings. Since implementation, we have offered a number of courses covering basic BusinessObjects functionality, advanced BusinessObjects training, and training on the data as it is stored in the data warehouse. In addition, each user is required to complete a Claims 101 course that helps users understand the MMIS claims processing steps to ensure query requests are structured accurately to retrieve the desired information. As an added resource, the reporting specialists and the system engineer are available to work one-on-one with any individual user as needed.

Following the recent database conversion, we conducted a two-week series of classroom training sessions to teach new features to existing users and introductory information to new EVAH users. These courses allowed all current and new users to gain the same level of exposure to the new version of EVAH and established the starting point for our quarterly training courses.

We will continue to offer basic and advanced training courses on a quarterly basis to meet your needs for flexible, powerful, and most importantly informational ad hoc reporting.

Meeting the State's Reporting Needs

We have designed each data model within EVAH to address the multiple reporting needs of the state. In the health care industry, data needs to be analyzed from many different perspectives, including the date of payment, dates of service, and program and eligibility groups. These perspectives were all taken into consideration when creating the table structures and data models. The table below lists many of the data models available:

Available Data Models

EVAH Data Model	Description
Archive	Claims data dating back to the origination of the MMIS—1992
Cash Control	Information specifically pertaining to the cash control procedures
Claims Analysis *	Aggregate and detail claims data for all claim types
Drug Claims Only **	Specific information regarding drug claims processed
EPSDT	Specific information used to generate EPSDT letters
EVAH MAR	Aggregated data from the MAR subsystem
Financial	Financial-specific information, nonclaim related, such as accounts payable, accounts receivable, cash transactions, and recoupments
Institutional Claims Only	Detailed information specific to claims submitted on a UB92 claim form—inpatient, outpatient, crossovers, home health, and hospice
Long-Term Care	Recipient placement level information
Nursing Home Only	Specific information regarding nursing home claims

EVAH Data Model	Description
Professional Claims Only	Specific information regarding paid claims—physician, dental, vision
Provider	Eligibility, type, status, and demographic information pertaining to providers
Recipient	Eligibility, aid category, and demographic information pertaining to beneficiaries
Reference	Reference information specific to revenue code, drug codes, procedure codes, and diagnosis codes
Third-Party Liability (TPL)	Information regarding to TPL

* Calendar-year partitions based on claim paid date. Views available for all years.
** Calendar-year partitions based on claim from date of service. Views available for all years.

Frequently, data requests need to be conditioned based on a beneficiary aid category code or various reference information specific to claim types. To meet these needs, we added recipient eligibility information and pertinent reference information in each of the claims data models.

The Business Objects suite of products includes the BCA server. The BCA gives users the flexibility to schedule queries to run during evening hours, over the weekend, or at any designated interval. The BCA also allows queries to run remotely on a server at the EDS site. This frees up desktop resources and lets the server at EDS do the work. When the query finishes, the results are stored on a database until the user is ready to retrieve the results.

The TPL unit at the state uses EVAH on a regular basis to complete casualty and estate research. The queries are scheduled on the BCA and completed in a fraction of the time required for manual research.

Currently, provider representatives use EVAH to track claims from any provider to identify billing problems and offer further education. Our Provider Enrollment unit uses EVAH to assist in the provider recertification process. Verification is completed using EVAH to validate which providers are attached to group—an important consideration for recertifications that are due at the end of the month.

Security

BusinessObjects supervisor security features restrict users to pre-established levels of information by password. Based on a user's need for information, he or she has a different level of access. No user has automatic access to all the data models available or the all data within a data model provided by EVAH. Password access is restricted to the field level. Key personnel at the state must approve all requests for access to the EVAH database.

Subsystem Objectives

There were no specific objectives listed in the RFP for this subsystem, but we have worked with the state to develop EVAH objectives to ensure the solution will continue to meet the needs of all users. Training, upgrades, and enhancements are a few of the areas always under review.

Training time is always available by request. It is our hope that the initial training offered would create the foundation for all users to begin using the EVAH application. We are aware that, in some cases, a review of the initial training is needed. Louise Brooks, Ann Markle, and Carrie Marchant are available to provide one-on-one training as necessary. Just as review is crucial to ensure that some users are proficient in the use of EVAH, others find the need to expand the introductory and advanced training material. In these cases, we are always available for additional training on the latest techniques and features of BusinessObjects. We have held small classes for users ready to expand their expertise in query creation or report manipulation.

BusinessObjects is an ever-evolving application. New releases are created with enhanced features on a regular basis. As new releases are made available, each is downloaded and tested. Once a release is tested and approved by the system engineer, all users are upgraded and notified of any new features used by the reporting functionality.

As new reporting needs are identified, requests are submitted for updates to the database. All enhancements to the MMIS are reviewed to determine whether the changes should be included in the EVAH database. During requirements specifications, we review each project with the customer to determine if the information would be useful in the EVAH application. If so, the modifications are included in the project scope. The recent upgrades to the cash control procedures are a good example of ensuring the affected departments' reporting needs are met. The scope of the project included the addition of all new cash control tables and the creation of a new cash control universe.

Proven Success

BusinessObjects Conversion—One of the most notable successes for the EVAH subsystem was the conversion to the BusinessObjects solution in 1998. Since that time, the state's user base has expanded from 15 to 40 users in twelve departments. The EVAH data model selection has grown from the original 30 universes to a current total of 46 data models.

Within the first two years of using the EVAH application, its power and flexibility proved beneficial in many areas. As such, the decision was made to convert our access to the MARS database from Windows 4GL to EVAH reporting.

Combined Power—Repeatedly, EVAH and the Broadcast Agent Server have proven their versatility and reliability. The state offices, as well as our reporting specialist, use EVAH to estimate the potential impact of the cost savings and expenditures prior to implementing edit or pricing changes. The application is relied upon during legislative sessions to assist in establishing new changes to the pricing schedules for various providers and to determine potential cost saving measures on an annual basis. For example, data is extracted which is then used to summarize

program utilization, demonstrate program growth, and to provide necessary statistics in support of program modifications to receive continued funding.

Frequently a project is requested that requires a query to run multiple iterations but with different criteria, for example NDC, aid category, or procedure code. Our EVAH solution has proven on numerous occasions that the versatility of the application in conjunction with BCA server allows users to schedule multiple queries to run overnight and during weekend hours to complete projects in a timely manner. When a drug research project required that data be extracted for more than 200 individual NDC codes, the queries were scheduled to run all day and overnight on the BCA server—thus freeing up the resources on the users desktop and continuing the work in off hours to complete the project on schedule.

Enhancements

DB2 Conversion

In 2001, we successfully converted the EVAH database from the original Ingres database to a DB2 database. Our conversion project was completed on a database independent of the Ingres database—causing no interruption to users. This conversion has resulted in faster response time for all queries (more than a 50 percent increase in weekly update process time), added functionality within EVAH, and positioned the state to move forward in the future of data warehouse structures. The following table shows the different runtimes between EVAH queries run using the old Ingres database and those using DB2.

Exceptional Performance With DB2

Query Content	Ingres EVAH Run Time	DB2 EVAH Run Time
Dental Eligibility Based on Fiscal Year	44 minutes	2 minutes
Dental Claim Payment Based on Fiscal Year	2 minutes	22 seconds
Specific Drug Data Extract – Multiple Years	27 minutes	1 minute
Program Specific (Based on Procedure Code) – Multiple Years	22 minutes	9 seconds

In conjunction with the conversion of the database, the total claims data available in EVAH was extended from three full years to five full years in all claims-based data models. The oldest year of data is removed from the database at the completion of the sixth year to ensure a full five year's worth of data is always available.

MAR Subsystem Window Conversion

The existing Windows 4GL application of the MARS database had proven itself outdated and inflexible for the state's needs. In a joint effort between the state and EDS, the key windows from the old MARS application were identified for conversion along with any requested enhancements in the window structure. All identified windows were converted to EVAH reports. Each report now has flexibility that was not available in the 4GL application as well as the portability of the data through exporting to Excel or a text file.

Claims Analysis Improvements

In the upgrade to BusinessObjects, we expanded the flexibility to include a specially designed star schema that provides an efficient design for query access and response time. The claims analysis portion of the EVAH database contains aggregated payment and processing information along with detailed claims data for all claim types partitioned by claim paid date. This design provides the ability to drill down to the individual claim level when analyzing data for various programs, funding sources, recipient groups, and locality within the state across all claim types.

We have also created specialized claims data models designed to allow for research and report creation specific to particular claim types. These individual claim-type data models expand the data elements offered in the claims analysis data model providing the opportunity for more analytical research of claim subsets. To further the flexibility of the EVAH application, these individual claim-type models are partitioned based on claim from date of service. Data models designed to meet specific needs include: professional claims, institutional claims, nursing home claims and drug claims.

Random Sampling

In our response to the Amendment 1 (2.8.2.1 c) we are proposing the purchase of Business Objects Set Analyzer application. This product will provide the functionality to meet the state's needs for random sampling in report generation.

Enhanced Report Selection

With the selection and implementation of Amendment 1 (2.8.2.1 c), the existing EVAH application will provide you with additional predefined financial and claim reports. This enhancement will provide approved users with access to:

- Financial information from sources outside the current MMIS
- Expanded eligibility information
- Claim and financial information currently available only in OnDemand

We look forward to the opportunity to expand your current report selection as defined in "Appendix T." We anticipate that once this enhancement has successfully been implemented, the state may determine future requirements for the EVAH application. We look forward to working with you to accommodate new requests through the CSR process.

Fiscal and Budget Application

The implementation of the fiscal and budget application outlined in Amendment 1 (2.8.3.4) will provide a new suite of tools to work in conjunction with your existing EVAH application. Our solution will expand your current functionality from the flexible reporting tool you know today to a Web-enabled analytic suite. The new fiscal and budget application will provide the following to approved users:

- Predefined reports as defined in "Appendix S"
- Predictive analysis
- Personalized dashboards with alerters
- Analytic report templates

We anticipate that after the implementation of this enhancement, the state may determine future requirements for the fiscal and budget application. We welcome the opportunity to further meet your analysis and reporting needs through our current CSR process.

Surveillance and Utilization Review Subsystem

RFP Reference: 2.7.11, p. 2-148

The surveillance and utilization review (SUR) subsystem is a management-reporting tool that assists the state in identifying patterns of inappropriate care and services. The SUR subsystem can be used to detect and substantiate provider and beneficiary fraud and abuse. The SUR subsystem produces statistical profiles of health care services and utilization patterns that identify the potential misutilization of services by the participating provider or beneficiary. This information may also detect problems with the level of care or quality of services provided under the Medicaid program. It provides administrators with information needed to initiate appropriate corrective action.

Reporting to Meet Your Needs

To increase the ease with which the state can access reports, the Vermont team placed quarterly SUR reports dating back to July 1994 on the IBM Content Manager OnDemand where they can be accessed from the user's desktop.

The VermontAIM MMIS provides the state with the capability to extract and electronically exchange specified data needed to monitor provider and beneficiary utilization practices within Vermont medical assistance programs.

SUR reports are based on the detail information from paid claims. The detail information is arranged into categories of similar participants (peer groups). Peer group averages and utilization trends are computed on selected statistical items designed to reflect an overall picture of medical practice and diagnosis treatment. The system then compares medical activity for individual providers and beneficiaries to criteria the peer group has established as "normal" activity for each parameter. Providers and beneficiaries who have deviated above or below a predetermined margin of the peer group average are flagged for the exception. Each statistical item for which an individual participant has an exception is assigned a weight based on the degree of variance. The system then ranks providers and beneficiaries within each peer group according to their total exception weight. Participants with the high exception weights rank high for potential misutilization of the program and are subject to utilization review from the Vermont Fraud and Abuse Department.

The SUR subsystem performs the following high-level functions:

- Update the SUR control files
- Extract paid claims data
- Process quarterly reports
- Interface with other subsystems in the MMIS to receive or provide needed data
- Provide retrospective drug utilization review

To demonstrate our understanding of the SUR subsystem and our ability to work with its data, we have organized our response in the following subsections:

- **Subsystem Objectives**—By responding to RFP objectives, we show our understanding of the role this subsystem plays in MMIS processing.
- **Proven Success**—We demonstrate our ability to work with the subsystem while keeping pace with program growth.
- **Enhancements**—We identify recent and planned enhancements that have notably enhanced the subsystem's functionality and user-friendly capabilities.

Subsystem Objectives

a. Provide:

- **Comprehensive health care delivery profiles and utilization patterns for providers and recipients in various categories, under Vermont's medical assistance programs.**

  The following are the various SUR reports available for provider and beneficiary profiles and the control file required to define the line items to be reviewed.

  - **Summary Line Item Control File (40 Control File)**

    Line items that appear on the summary profiles must be defined for each provider category of service and for the beneficiary subsystem. The line items selected should reflect the needs of the account. Line items and their exception limits can be changed quarterly with no interruption in the continuity of data being reported.

    The report line items are defined by the state and oriented to potential areas of abuse by the providers. The line items can be divided into categories which enhance the appearance of the reports and provide a logical flow of information. Up to 99 different line items can be defined.

  - **Provider Summary Reporting**

    Summary profile reporting summarizes the data for selected report items, compares the individual's activity to the exception limits, assigns a weight for those report items on which the provider has deviated, and then ranks the providers according to their exception weight.

    We produce the following reports:

    - SRGR320V—Provider Exception Summary Profile
    - SRGR321V—All Provider Summary
    - SRGR322V—Selected Provider Summary

- SRGR323V—Provider Group Profile
- SRGR324V—Provider Exception Deselection
- SRGR325V—Provider Peer Group Profile
- SRGR326V—Provider Exception Statistics
- SRGR327V—Provider Forced Exception
- SRGR328V—Referring Provider Summary Profile
- SRGR330V—Provider Summary Profile Exception Ranking
- SRGR331V—Initial Three Percent Investigation List

SRGR325V accumulates and summarizes the activities of all providers in a peer group. The peer group averages for the selected report line items are compared to the individual's activity summary on the SRGR321V report. Line items on which the provider deviates above or below the allowable values are flagged, and an exception weight is assigned. If the provider's exception weight and volume of activity are high enough to place the provider in the user-defined top percentage of exception providers, the system generates the SRGR320V for that provider. From each Provider Exception Summary Profile report, SRGR330V lists the providers in descending weight order. The individual with the highest weight is ranked first indicating that the degree of variance from the peer group average is the greatest for this provider.

We generate a set of reports for each category of service (COS). The report provides activity summaries for each category applicable to the services provided. The line items for COS-Inpatient would be directed at length of stay, accommodation charges and use of ancillary codes. The line items for COS-Drug would apply to the dispensing of certain classes of drugs and narcotics, the percent of refills, average days supply, and so forth. Within category of service, different sets of line items can be established based on provider specialty groups.

The key to effective use of the summary profile is to have appropriate parameters with at least one line item covering every major facet of treatment expected within the category of service. We give special attention to the exception limitations set for each line item. The limits are defined in the 40 Control File above or below the peer group averages so only those providers who have deviated most significantly are flagged. Providers are not flagged on line items that have not been assigned an exception limit. A limit is established for every parameter selected to detect misutilization.

- **Provider Detail Reporting**

The provider detail reports display claim details for a reporting period specified by the user with a maximum of 15 months. Medical services rendered by a provider are displayed for each of that provider's beneficiaries in claim number (ICN) order within provider number order.

The reports in this group are:

- SRGR121V—Periodic Provider Detail
- SRGR130V—Selected Provider Detail
- SRGR135V—Selected Criteria Provider Claim Detail

Once a provider's problem areas are identified through a review of that provider's summary profile and treatment exception reports, it is frequently necessary to research the history details in order to document the specific instances of abuse. The reports identify the beneficiaries who receive the services, when the services are performed, and what other services the beneficiary has received. The claim ICNs are given so the reviewer can obtain copies of the original claims. Often a review of the history detail uncovers certain patterns not detectable with other reports. The most common of these patterns are identical treatment on the same day for which the provider alters the diagnosis and/or procedure codes. Date-of-service patterns for procedure use are also recognizable in claim-detail analysis.

- **Data that aids in the investigation of:**

  - **Misuse of Vermont's medical assistance programs by recipients, and promote corrective action in cases of actual misuse.**

    The following is an outline of the various SUR reports available for beneficiary profiles and the control file required to define the line items to be reviewed:

    - **Summary Line Item Control File (40 Control File)**

      The report line items are defined by the state and should be oriented to potential areas of abuse by the beneficiaries. A different set of line items can be established for each category of assistance, if desired. Up to 99 different line items can be defined.

    - **Beneficiary Summary Reporting**

      The beneficiary summary profile reports are similar to the provider summary profile reports. Any indications of misutilization can be investigated through use of the beneficiary history profiles from the claims system. The report line items for the activity summaries are defined by the user and should be oriented to potential areas of abuse by the beneficiaries. A different set of line items can be established for each category of assistance if desired.

      We produce the following reports:

      - SRGR350V—Beneficiary Summary Profile (Exceptions)
      - SRGR351V—All Beneficiary Summary
      - SRGR352V—Selected Beneficiary Summary
      - SRGR354V—Beneficiary Exception Deselection

- SRGR355V—Beneficiary Peer Group Summary Profile
- SRGR356V—Beneficiary Summary Profile Exceptions Statistics
- SRGR357V—Beneficiary Summary Profile (Forced)
- SRGR360V—Beneficiary Summary Profile Ranking
- SRGR361V—Initial Three Percent List

The beneficiary summary profiles provide a volume analysis of a beneficiary's Medicaid activity in comparison to the activity of that beneficiary's peers as defined by the state. The profiles can be used to detect potential areas of abuse, misutilization, or fraud. In addition, the report can be designed to indicate a lack of care on the part the provider(s) treating the beneficiary. The user determines what aspects of beneficiary activity is monitored according to the types and cost of services covered under various programs. Quality of care, beneficiary abuse, or a combination of the two can be assessed by selection of appropriate line items. Beneficiary summary profiles can be used as additional documentation in a provider case review.

The problems indicated by flags on a beneficiary's summary profile can be researched on the beneficiary history profile from the claims processing system. If drug utilization is the focal point for beneficiary utilization review, there is a special on-request report available SRGR091V (Beneficiary Drug Profile Report).

The report line items are defined by the state and should be oriented to potential areas of abuse by the beneficiaries. A different set of line items can be established for each category of assistance (in the 40 Control File), if desired. Up to 99 different line items can be defined.

Two types of date processing are available to the user:

- Date of Service—Each reporting period reflects the services performed during that time.
- Date of Payment—Each reporting period reflects the services paid during that time regardless of when the services are performed.

We recommend using the same type of date processing for the beneficiary summaries as for the provider summaries.

- **Beneficiary Detail Reporting**

The beneficiary detail reports provide claim details for beneficiaries selected on the 60 Control File for a reporting period specified by the user with a maximum of 15 months based on either date of payment or date of service. The reports in this group are:

- SRGR160V—Selected Beneficiary Claim Detail
- SRGR165V—Selected Criteria Beneficiary Claim Detail

Once a beneficiary's problem areas are identified through a review of the beneficiary's summary profile, it is frequently necessary to research the history details in order to document the specific instances of abuse. The claim ICNs are given so the reviewer can obtain copies of the original claims. Often a review of the history detail uncovers certain patterns not detectable with other reports.

- **Potential defects in the level and quality of care and services provided under the Vermont medical assistance programs.**

  The treatment analysis reports (SRGR430V, SRGR431V, and SRGR432V) present a statistical profile of treatment rendered by individual physicians in response to specific diagnoses. The reports are intended to detect inappropriate utilization of services in the treatment of specified diagnoses, thereby revealing deficiencies or excesses in the level and quality of care being delivered to Medicaid beneficiaries.

  The treatment analysis reports identify the specific diagnoses and specified procedures or procedure categories the provider is apparently misutilizing. Deficiency in the quality of care is also indicated by the provider's nonperformance of required procedures. Once these problem areas are identified, the specific cases can be investigated through use of the history detail reports.

b. Produce reports that are responsive to the changing administrative and management needs of the Vermont medical assistance programs.

SUR reporting is very responsive to the changing administrative and management needs of Vermont medical assistance programs. We can modify control (report parameter) files to select the detail required in the provider and beneficiary reports to be reviewed by the state. The system provides special control file reports, which are monitored each quarter by the state and our SUR coordinator to review the current control file setup and determine what changes to make for the current quarter. Our SUR coordinator also uses them to identify any errors made while making updates, and the OVHA SUR coordinator uses them to approve the control file setup for the current quarter's SUR processing cycle.

In addition, as a supplement to the data generated by the SUR subsystem, EVAH BusinessObjects query software is also available to the state to analyze claims reporting specific to a Vermont medical assistance program.

c. Provide clinical and utilization review of selected services and make referrals as necessary to the Program Integrity Team.

Providing clinical and utilization review of selected services was not originally contracted with the VermontAIM system. However, we have, in the past, assisted the state in references to other sources. The Resolution and Provider Services teams are available to provide this service whenever it is needed.

Proven Success

Our Vermont-based team is always ready and able to provide the level of service needed to meet the state's needs. Even though the state does not have an in-house SUR team dedicated to reviewing SUR reports, we are always willing to provide state employees with the SRGR350V report to assist in the detection of possible beneficiary drug abuse.

Enhancements

Web-Based Reports

To improve report accessibility, we placed all quarterly 350V reports dating back to July 1994 on the IBM Content Manager OnDemand report retrieval system. All 350Vreports are now accessible using a Web browser such as Microsoft Internet Explorer or Netscape. To improve the timeliness of the SRGR091V report, which originally was an on-request paper report, we updated the report to go to OnDemand beginning in the fourth quarter of 2000.

Moving reports to a Web-based system has benefited the state in the following ways:

- Reduction and elimination in supply costs
- Elimination of document storage
- Easier accessibility of reports
- Reduction in time to view reports
- Faster distribution of reports
- Easier research on past documents

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Drug Rebate Subsystem

RFP Reference: 2.7.12, p. 2-153

The Vermont drug rebate subsystem and the Vermont-based team have proven highly effective at maximizing drug rebate collections and minimizing disputes. Our experienced staff is committed to furthering the success of Vermont's drug rebate program in the next contract. For the new contract term, we will continue to build upon the elements that contribute to the successful administration of drug rebate services including:

- Innovative programs for rebate revenue
- Exceptionally high collection rate
- Proactive dispute avoidance
- Award-winning Drug Rebate team
- Established industry relationships
- Thought leadership
- Established relationships with the state, CMS, and drug manufacturers

Key Benefits for Vermont Medicaid

The drug rebate collection rate in Vermont for the last two years exceeds 99.5 percent. The state can rely on EDS' experienced, proactive, and innovative methods to maximize collections and minimize disputes.

To demonstrate this understanding and our ability to work with the drug rebate subsystem, we organized our response in the following subsections:

- **Subsystem Objectives—**by responding to RFP objectives, we show our understanding of the role this subsystem plays in MMIS processing.
- **Proven Success—**we demonstrate our ability to work with the subsystem while keeping pace with program growth.
- **Enhancements—**we describe recent and planned enhancements that have notably enhanced the subsystem's functionality and user-friendly capabilities.

Subsystem Objectives

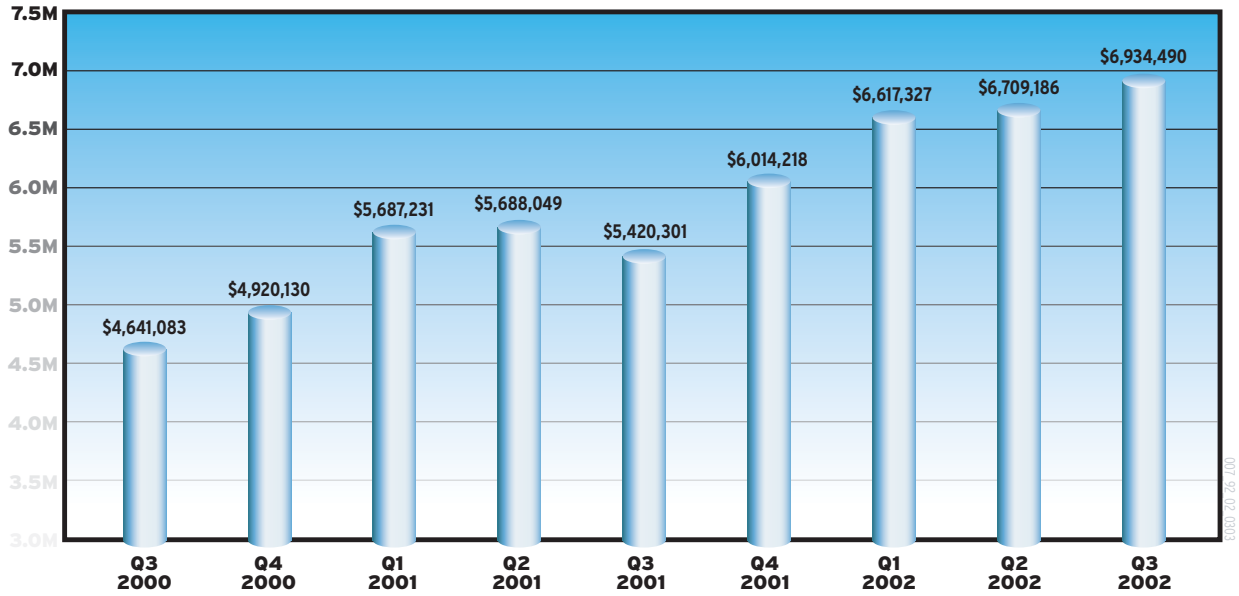
Vermont requires the MMIS to provide automated support to carry out the federal mandates related to drug rebate processing.

The VermontAIM system supports the required processes for both the federal and state-only VScript drug rebate program mandates to maintain the integrity of Vermont's drug rebate data. The VermontAIM drug rebate subsystem combined with our experienced team work to provide accurate and up-to-date rebate information to maximize the state's drug rebate revenue.

Proven Success

The Vermont Medicaid Program has benefited from an established record of proven successes in drug rebate. Drug rebate revenue has grown exponentially during the past two years.

Drug Rebate Revenue: Exponential Growth

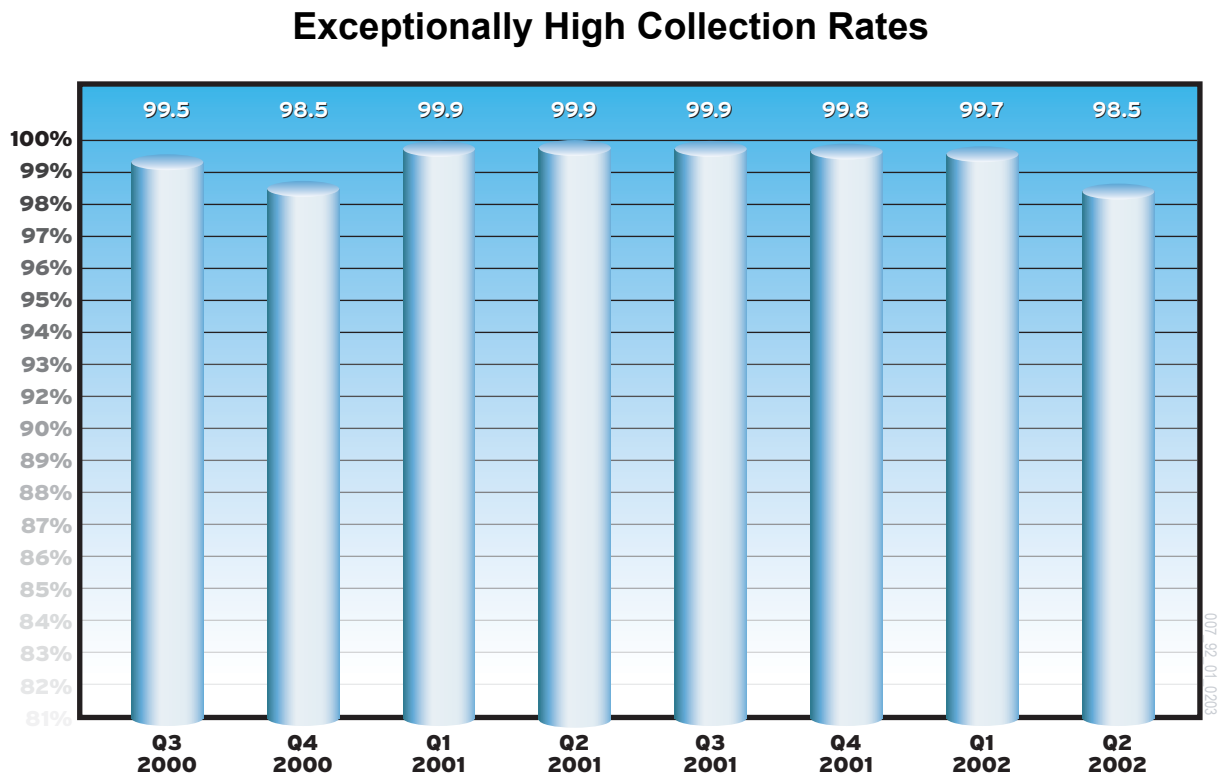


In just two years, revenue has grown from just over $4.6 million during the third quarter of 2000 to more than $6.9 million during the third quarter of 2002.

Innovative Programs for Rebate Revenue. The Vermont Drug Rebate team continually looks for ways to maximize the percentage of rebate billed compared to drug expenditures. One innovative way we increased drug rebate revenue was to modify our drug rebate program to integrate units reimbursed for physician-administered drugs as billed on professional claims within the drug rebate process.

The federal drug rebate program allows for collection of rebates from drug manufacturers for covered outpatient drugs under rebate agreements, but **the Vermont Drug Rebate team went beyond state expectations to analyze the program for additional sources of collection**. With the help of drug rebate teams supporting other Medicaid programs, we determined that federal regulations allowed for inclusion of physician-administered drugs. In the second quarter of 2003, we submitted a retroactive one-time invoice to labelers netting the state an additional $334,090 in revenue for the period first quarter 1999 through first quarter 2002. EDS then enhanced the system to automatically incorporate these units into the existing quarterly drug rebate cycle.

Exceptionally High Collection Rate. Our innovative and proactive methods have positioned Vermont to achieve phenomenal collection rates—the average collection rate for the past two years exceeds 99.5 percent. We have achieved this exceptionally high percentage through aggressive use of past due notices and direct contact with drug labelers. In our next contract, our Drug Rebate team is challenged and committed to achieving this level of success and additional revenue for the state.



The EDS Drug Rebate team successfully achieves high collection rates using innovative and proactive methods.

Proactive Dispute Avoidance. The Vermont Drug Rebate team creates a forum that allows us to collaboratively define new processes to reduce disputes. This program has proven to be very successful and has decreased the number of disputes submitted by labelers. This reduction expedites the amounts collected for the state.

Our solution is comprised of two components. First, the system generates reports to identify invoices containing outliers that may indicate unit of measure errors, drug unit type mismatches, and unit discrepancies. Secondly, experienced Drug Rebate team members review specific drug product invoice line items for anomalies before mailing the invoice. These proactive steps significantly reduce the number of potential invoice disputes.

Award-Winning Drug Rebate Team. Members of the Vermont Drug Rebate team participated in the Region 1 Drug Rebate Dispute Resolution that eventually led to the receipt of former Vice President Al Gore's Hammer Award**.** This award recognizes partnerships that create solutions to reduce wasteful spending and increase revenue to the government. Along with CMS, members of the New England Drug Rebate teams collected more than $440 million in outstanding Medicaid rebates. CMS then published these solutions as *CMS' Best Practices Guidelines for Dispute Resolution* for distribution and use nationwide.

Established Industry Relationships. EDS' presence in the prescription drug industry across the country results in an extensive list of state, government, and drug labeler contacts. EDS manages drug rebate programs in several states, including Rhode Island, Connecticut, Kansas, North Carolina, and California. Members of the Vermont team have been asked to present and attend various conferences to expand our network of resources and gain new ideas for improving the drug rebate process.

Our established relationships with many drug manufacturers result in open communication during rebate invoice processing to resolve questionable line items. These relationships not only help reduce disputes but also increase cash flow by allowing the state to collect rebate monies in a more expedient manner. We will continue to encourage drug manufacturers to work with us each quarter.

Thought Leadership. Members of the Drug Rebate team participate in extensive networks of pharmacists and drug rebate analysts employed by EDS who converge monthly on conference calls to discuss various topics, including rebate issues and policy. EDS has used this forum during the past several years to learn what successes other states experience. The Vermont Drug Rebate team continues to participate in these interstate conference calls to bring innovative approaches and new ideas to Vermont's drug rebate program. The expansion of the drug rebate program to include units reimbursed for physician-administered drugs was a direct result of these networking sessions.

Established Relationships With the State, CMS, and Drug Manufacturers. In addition to the benefits of our relationships within the industry, our relationships with state personnel enable us to work as a team to accomplish state goals quickly and effectively. For example, the Vermont Drug Rebate team worked in conjunction with the OVHA to enhance the cash control procedures for handling checks from receipt to final disposition. These enhanced processes led to better security and tracking of incoming checks.

Enhancements

The Vermont drug rebate subsystem has evolved over the years to allow for program growth and expansion. EDS will work with the state to decide how to best address all of the drug rebate issues. We fully recognize the need to maintain infrastructure and business processes that are sufficiently flexible to respond to legislative changes. We propose using CSR modification hours to implement any required modifications.

VScript State-Only Drug Rebate Program

Using the federal drug rebate program as a model, EDS worked with the OVHA to develop the program to collect rebate funds from drug labelers for the VScript state-only funded program.

The VScript drug rebate solution segregates the VScript and federal drug rebate programs by funding source. Separate invoicing, labeler participation, and accounts receivable allow for program-specific tracking and monitoring. EDS worked with the OVHA in every stage of design and implementation of this program and will continue its success with the next contract.

AIDS Medication Assistance Program (AMAP)

Because the VermontAIM system is a flexible, client/server system, EDS was able to offer an alternative solution for the AMAP. EDS leveraged the existing infrastructure to not only process AIDS claims, but also obtain the data required to obtain drug rebates from the drug manufacturers because the information was not originally captured. The system now automatically generates drug rebate invoices and performs the necessary financial tracking to obtain additional AMAP funds. The rebates produce cost savings, increased productivity, and improved financial forecasting capabilities for this program.

Integration of Physician-Administered Drugs Into Drug Rebate Processes

Because the VermontAIM system is so flexible and customizable, we were able to enhance the existing drug rebate subsystem to integrate units from physician-administered drug claims into the quarterly drug rebate cycle. Additional tables and screens were added to allow for systematic invoicing of physician-administered drugs. This allows for creation of a single invoice for each labeler code. The single invoice allows for streamline processing, payment and reconciliation for both the drug manufacturer and the Vermont-based team.

Added Expertise

In June 2002, we expanded our team to include Pharmacist Julie Ann Allen Simpson R.Ph. Julie has 19 years of pharmacy experience with 11 years in drug rebate and holds a masters degree in business administration. CMS and drug labeler contacts are familiar with Julie's work and have worked with her in the past. She understands billing procedures, is familiar with drug products, and is aware of new drug products entering the market. She can work with drug rebate analysts and providers to educate them on unique package sizes that might cause disputes in the drug rebate program. Julie's skills will help minimize disputes and resolve them faster.

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(e) INFRASTRUCTURE REQUIREMENTS

RFP Reference: 3.2.2.7(e), p. 3-11

EDS recognizes and understands the state's need to identify ways to reduce administrative costs associated with Vermont's Medicaid Program, and we are offering an infrastructure designed to fulfill that need. As part of the state's required enhancements, we will build on the existing architecture by converting the Medicaid Management Information System (MMIS) from the CA Ingres database to the leading-edge IBM DB2 Universal Database (DB2). By using our existing hardware and software configuration, not only will we be able to limit costs, we will be able to continue to provide the excellent support you expect with no disruption to you or the participants.

We will leverage our experience gained from the 2002 implementation of the Delaware MMIS where we successfully implemented their DB2 MMIS system—the first fully certified HIPAA compliant system in the nation. While Ingres has served the state of Vermont well the past 10 years, this is the time to take advantage of the newest in relational database management system (RDBMS) technology. With DB2, we will provide the Department of PATH with a more robust and scalable platform for the future. This decision to utilize DB2 will further reduce state costs by using the same RDBMS currently used by EVAH.

In addition, we will enhance the MMIS to provide the capability to produce and send mass e-mails to the state's provider community. This innovative technology will enable the state to reduce postage costs and reach providers in a much more efficient manner than by using traditional mailings.

As part of our infrastructure upgrade, we will replace the existing microfilm equipment with the latest scanner technology. This capability will allow authorized users to view submitted paper claims through our Web interface. By replacing the current microfilm technology with a Kodak scanner, the state and EDS can retrieve claims information more efficiently by using an internal control number (ICN). With this capability, users can perform their functions quicker and easier. For example, when a provider tells a provider services representative that a submitted claim does not match the remittance advice, the representative will be able to immediately view an image of the submitted claim thereby eliminating the typical research time required today to respond to the provider's inquiry. This will improve productivity in the provider services area, the claims area, and, should a claim copy be needed by the state TPL staff, in this area as well. This approach also will allow multiple users to view the same claims information simultaneously.

The use of scanning technology also allows for the possible future use of Optical Character Recognition (OCR) software for inputting paper claims into the MMIS. However, we believe that with the advent of the HIPAA electronic claim standards, we will likely see far fewer paper claims in the next few years. As a result, we feel that an investment in OCR at this time may not be in the best interest of the state. We leave the door open to future enhancements that could

bring OCR to the VermontAIM system should we see more paper claims in the future than we anticipate at this time.

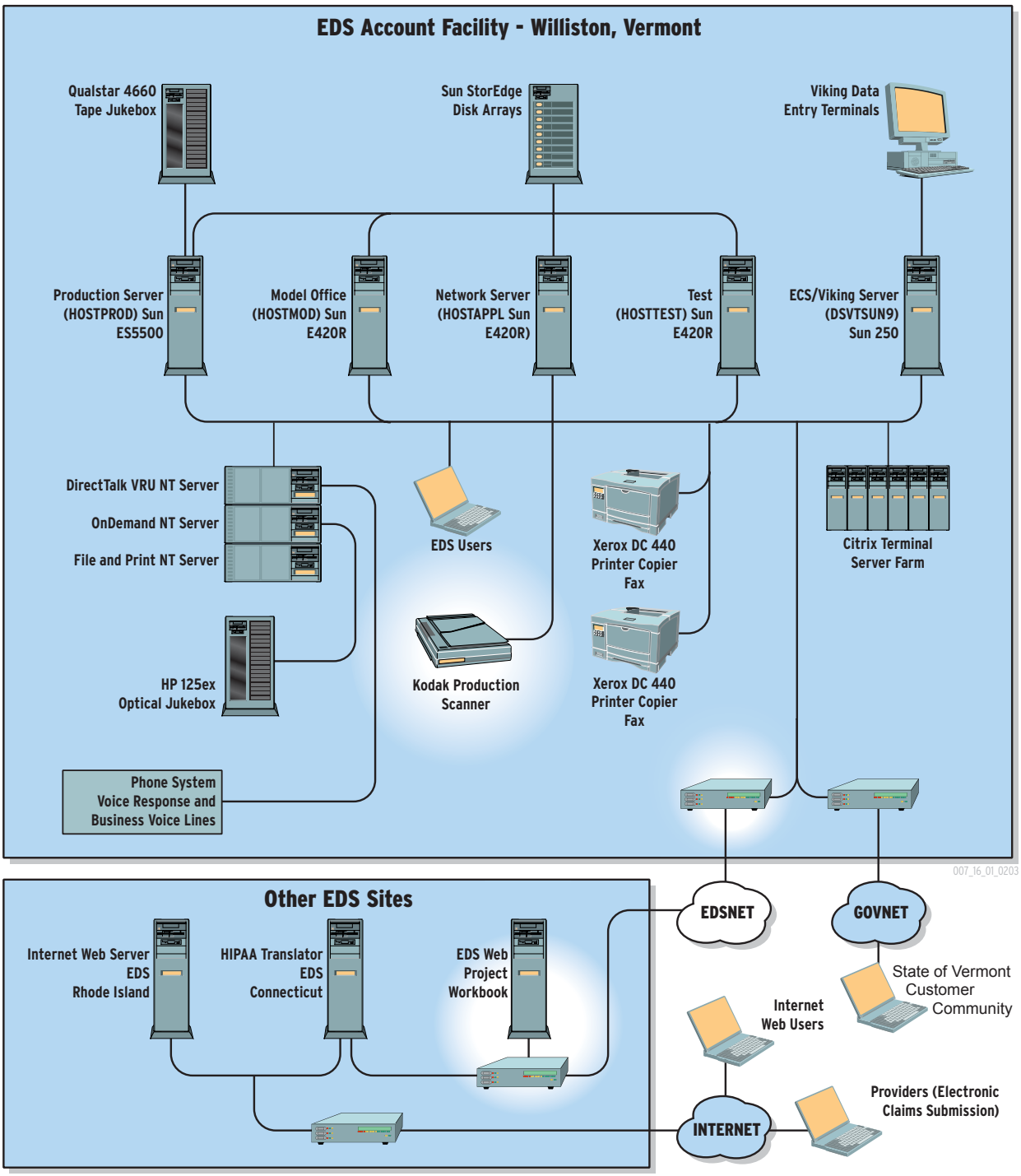
Equipment Purchases/Leases

We will continue to provide the same excellent level of support to the VermontAIM that we are providing today, and we will continue to use a significant amount of the existing infrastructure to provide that level of support. Therefore, we will need to purchase or lease only minimal amount of new equipment to support the Operations Phase.

Overall Architecture

The following diagram depicts the existing architecture (with the Citrix server for the HIPAA implementation occurring in July) and the hardware needed for the mandatory and optional enhancements highlighted.

An Enhanced Architecture Primed for the Future



With the addition of a minimal amount of new hardware, this architecture will provide the state of Vermont with the technology needed to meet its future MMIS needs.

Hardware

We will continue to use the following network servers and configurations to support the production MMIS at the start of the Operations Phase:

- HOSTPROD—SUN ES5500 system running Solaris 9 and Ingres 2.6 supporting the MMIS
- Enhanced Vermont Ad Hoc (uses DB2 UDB) and management and administrative reporting subsystem (MARS)
- HOSTAPPL—SUN e420r system running Solaris 9 and Ingres 2.6 supporting domain name servers (DNS) primary, NIS master, and the backup eligibility database
- DSVTSUN9—SUN 250 system running Solaris 9 and supporting Viking data entry
- HOSTMOD—SUN e420r system running Solaris 9, Ingres 2.6 and DB2 UDB V7.2 supports the model office test environment and application development, DNS Secondary, and NIS Slave. At the start of the Operations Phase, this server will support base systems engineer work.
- HOSTTEST—SUN e420r running Solaris 9, Ingres 2.6 and DB2 UDB V7.2. At the start of the Operations Phase, this server will support enhancement systems engineer work.
- IBM Netfinity 5000 server running NT 4.0 with service pack 6.0A. This server supports automated voice response (AVR).
- SUN Sunfire V880 will be leveraged with three other Northeastern Medicaid account MMISs (New Hampshire, Connecticut, and Rhode Island) to host the HIPAA translator. Additionally, two Compaq and three IBM Netfinity servers will be used as Web servers in support of the HIPAA translator. To most efficiently provide services to the state, we propose installing the optional Internet enhancement from this RFP on the same hardware supporting the HIPAA translator Web sites.
- IBM Netfinity 5600 running Windows NT 4.0 server. This server supports the EDS local area network (LAN) in Williston with local file and print services as well as Dynamic Host Control Process (DHCP) services.
- IBM Netfinity 5600 server, running NT 4.0, is the intranet Web-based content manager OnDemand server.
- IBM xSeries 342, running Microsoft Windows 2000 server, is used as the BusinessObjects Broadcast Agent Server.
- Dell PowerEdge 2650 servers will be used as the Citrix MetaFrame Xpe servers.

Recovery and Disaster Preparedness

We use Legato Networker and a Qualstar 4660 tape jukebox to perform **full network backups each week**. For disaster recovery purposes, we produce a copy of the weekly **tapes for off-site storage**. At any given time, we have three sets of media tapes stored off-site that we update weekly. **We also perform incremental tape backups daily**, which remain on-site at Williston. In January, we will begin taking complete daily backups, which will be stored off-site.

We installed a 20KVA APCC Silicon uninterrupted power supply (UPS) on-site for **additional backup power support in the case of a disaster**. The power to all server, periphery, and telecommunication equipment goes through the UPS. This capability allows us to continue operations for up to one hour in the case of a power surge or short-term power outage. If we experience an extended power outage, the UPS provides us with enough power to shut down the servers in a controlled and graceful manner, which will eliminate the possibility of data corruption.

Software

The Vermont MMIS is based on Ingres 2.6 with an online environment currently written in CA Vision. As part of the HIPAA project, we will replace the existing CA Vision screens with those written in Sybase PowerBuilder effective July this year.

Our facility in Williston currently uses the following software:

- VermontAIM applications
- SUN Solaris 9
- CA Ingres 2.6
- IBM DB2 UDB V7.2
- CA Vision (to be phased out in July)
- PowerBuilder (to be implemented in July)
- Microsoft Windows NT workstation and server edition 4.0, service pack 6.0A
- Windows 2000 server
- Citrix MetaFrame XPe feature release 2. This software facilitates a server-based computing (SBC) environment in support of our new (as of the HIPAA updates in July) PowerBuilder screens. When Metaframe XPe is being used, published Microsoft Windows applications such as PowerBuilder are executed on the Metaframe servers. Users can interface with these applications.

- The Metaframe XPe SBC with three components:
  - A multiuser operation system (We will use a Microsoft Windows 2000 terminal server.)
  - Citrix MetaFrame XPe application server software
  - Citrix client software and devices
- IBM Content Manager OnDemand V7.1. This software interfaces through the Internet Information Server (IIS) to authenticate users and provide reports through any of the common Web browsers. We will extend this capability to also provide images of paper claims and attachments (as well as other documents) by replacing microfilm with electronic document scanning.
- Remote Eligibility Verification System (REVS)
- Business Objects—Enhanced Vermont Ad Hoc (EVAH) query tool. This tool allows authorized users to perform ad hoc queries as well as schedule queries or reports and disassociate them from the workstation.
- BEA Tuxedo 6.5
- Viking Data Entry
- CA-Autosys 4.0 for batch job scheduling
- Microsoft Office 97 and 2000

Interfaces

The foundation of the Vermont MMIS LAN consists primarily of fast Ethernet connectivity with a few Ethernet connections configured in a star-bus topology. The state provides 10MB link point of presence on their wide area network (WAN), commonly known as GOVNET, from Montpelier to Williston. This connectivity makes it possible for us to provide excellent response-time performance of the VermontAIM online screens to the state's users.

Our account site in Williston makes its connection to the EDS corporate intranet through a Cisco 25XX router and a frame relay network. All connections, such as telephone and T1, enter and leave the site through a trunk switch network.

(f) Project Risks and Approach to Monitoring and Managing Such Risks

RFP Reference: 3.2.2.7(f), p. 3-11

Early identification of project risks and contingency planning are key elements of project management. Our team has years of Vermont Medicaid experience and understands how to approach and minimize program risk. We recognize and use a risk management process consistent with the Project Management Institute (PMI) Body of Knowledge. The following graphic illustrates the major risk management components our team employs.

Risk Management Components

Risk Identification

Client Delivery Executive Barbara Davis and her key managers systematically assess the existing Medicaid project risk factors and identify specific risks. We document the characteristics of each identified risk factor.

Risk Quantification

We work with the state to rank risks, determine risk interactions, and document possible project outcomes for each risk factor. We use standard project management tools, such as decision trees, to analyze the risk factors and determine possible outcomes.

Risk Response Development

We manage risk by accepting, transferring, or mitigating exposure and create contingency plans and responses to threats to reduce related uncertainties and consequences. Reducing or eliminating risk increases the probability of a project's success.

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Risk Response Control

Risk management is continual throughout a project. Because project risks increase or decrease their threat throughout the life of a project, the leadership team continually reviews risk factors and their priority. We work with the state to develop plans to reduce the risks or eliminate them.

Our team has years of experience proactively identifying, quantifying, quickly responding to, and successfully controlling risk.

Our project management methodology provides tools, templates, and processes that help identify risk. The process provides an early identification of major obstacles to project success. It helps determine and communicate the degree of risk the project faces and details plans to handle that risk. The risk identification process and the resulting table also provide the state with the opportunity to discuss the consequences of doing or not doing specific project activities. We identify major obstacles in a timely, objective manner. This identification provides the state and us with the opportunity to identify an action plan to resolve risk issues and increase the success of the project. The management team plans a detailed review of all identified risks with the state so we can resolve risk issues timely and effectively.

The risk identification table includes the following information:

- **Risk Item No.—**The identification number assigned to the risk
- **Responsible Team/Person—**The person ultimately responsible for resolving the risk
- **Risk Description—**Type of risk
- **Risk Status—**The current status of the risk
  - "O" indicates the risk is open.
  - "C" indicates the risk is closed.
- **Risk Level—**The magnitude of the impact of the risk
  - "L" indicates a low level of risk.
  - "M" indicates a medium level of risk.
  - "H" indicates a high level of risk.
- **Probability—**The probability that the risk will occur
  - "L" indicates a low probability.
  - "M" indicates a medium probability.
  - "H" indicates a high probability.
- **Potential Impact—**The impact to the project if the risk should occur
- **Approach—**The suggested approach to be taken. The state will review and approve all approaches before we take action.
  - "E" indicates eliminate: Immediately act upon the risk based on the cost of eliminating the risk compared to the cost of potential impact and the likelihood that it will occur
  - "A" indicates accept: Accept the consequences of the risk occurring (an appropriate strategy for risks with low possibilities of occurring or little effect if they do occur)

— "T" indicates transfer: The authority and accountability to actually address the risk lies elsewhere and has been transferred to the accountable entity

— "M" indicates mitigate: Reduce the effect of the risk and the likelihood that the risk will occur to an acceptable level

— "S" indicates study: Need resources to further investigate the risk to better determine its characteristics and to make more knowledgeable decisions

- **Anticipated Mitigation**—How we will address the probability or the effect of the risk. The mitigation process allows us to reduce the effect of the risk, thus reducing the risk event value.

We will provide the state with a risk mitigation plan that describes potential technical obstacles and business issues associated with day-to-day operations. The table on the following page is an example of the type of information we will provide the state concerning project risk management.

Our proactive approach to project risk management helps us keep projects on track for implementation. Based on our unmatched knowledge of the Vermont environment, we have allocated adequate time to respond to unanticipated risk situations that may arise or have developed a mitigation plan to address possible risk areas. In addition, our broad health care experience across numerous clients allows us to effectively handle risk issues specific to health care because we have worked with similar systems.

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Potential Risks for Vermont Medicaid and Other PATH Programs—Example

Risk Item No.	Responsible Team/Person	Risk Description	Risk Status (O, C)	Risk Level (L, M, H)	Probability (L, M, H)	Potential Impact	Approach (E, A, T, M, S)	Anticipated Mitigation
R1	Client Delivery Executive	Experienced EDS staff cannot be assigned according to project schedule	O	H	L	Work tasks are not assigned or scoped according to schedule and tasks begin to slip.	A	We have an experienced and successful team in place today. Additionally, we are the largest provider of services to Medicaid agencies across the country. We will draw upon corporate resources to identify and recruit the best possible staff to backfill for required positions as necessary.
R2	Client Delivery Executive	Inaccurate or unclear RFP requirements	O	M	L	Project scope is increased, which expands the demands on the state and us and jeopardizes our ability to deliver on schedule.	M	Our understanding of the existing system validates our assumption that the RFP is thorough and represents a good faith effort to fully document the requirements of the replacement system/operations. The requirement validation meetings will enable the state and us to finalize requirements and document results of our meetings. We will mitigate this risk by thoroughly mapping the RFP requirements to system objects to ensure that we are performing the right tasks and cooperating with the state to efficiently plan activities and resources to meet RFP requirements.

Risk Item No.	Responsible Team/Person	Risk Description	Risk Status (O, C)	Risk Level (L, M, H)	Probability (L, M, H)	Potential Impact	Approach (E, A, T, M, S)	Anticipated Mitigation
R3	Client Delivery Executive; Systems Manager	The availability of full-time dedicated state staff with the necessary decision-making authority to provide thorough and timely review of all project deliverables	O	H	M	Lack of state staff participation in the review of the schedule, work plans, project status reports, associated project records, and deliverables within the established time frames may negatively affect the overall project. Potential problems include project task end-date slippage, cost overruns, and rescue availability.	M	We will work with the state to meet requirements in a timely manner. We will use status meetings to review and identify potential threats to the work plan before they affect the dates, cost, and resources. To ensure timely completion of all deliverables and project goals within required time frames, we recommend that the state provide us written approval of deliverables within 10 calendar days of the submission of a deliverable. If written notification is not provided within the 10 calendar-day period, we will assume the state has approved the deliverable.
R4	Client Delivery Executive	Insufficient program experience and system proficiency to address problems or questions	O	M	L	We are unable to retain personnel with the necessary qualifications to operate the Vermont MMIS.	A	We have access to sufficient staff and will be able to use them if this risk event occurs. EDS currently provides similar services to 15 Medicaid clients and more than 150 health care clients. Moreover, we operate versions of the system in place for several clients and have more than 20 other health care system solutions.
R5	Systems Manager	Equipment delivery delayed, causing delays in installation and operations	O	M	L	Because of unanticipated manufacturing, inventory, or transportation delays, required equipment may not arrive as scheduled.	M	The draft work plan allows for appropriate lead-time to minimize the possibility of manufacturing, inventory, and transportation delays, having a negative effect on the project schedule. We will work with the state to finalize schedules presented in the final work plan. Our work plan mitigates this risk.

Risk Item No.	Responsible Team/Person	Risk Description	Risk Status (O, C)	Risk Level (L, M, H)	Probability (L, M, H)	Potential Impact	Approach (E, A, T, M, S)	Anticipated Mitigation
R6	Systems Manager	Implementation schedule affected	O	M	L	Through the addition of features, Medicaid change requests, Vermont legislation, or CMS directive, project scope could expand to exceed the available implementation schedule.	A	Our project plan incorporates methods to identify issues, risks, assumptions, and project constraints early in the project, allowing us to be proactive and work with the state to resolve and avoid problems that affect the schedule, therefore minimizing impact to scope.
R7	Client Delivery Executive	The state and EDS have different definitions of "acceptable performance" of contract requirements	O	M	L	Variation in performance and deliverables occurs because the state and EDS use different operational definitions for performance, deliverables, or sign-off.	A	As part of the quality management process, the state and EDS will jointly define performance requirements and methods for measuring and reporting results.
R8	Client Delivery Executive	Hardware downtime	O	H	L	We are unable to process claims through the MMIS because of unanticipated hardware downtime or lack of hardware reliability.	M	We will work with the state to develop a finalized disaster recovery plan that includes the ability to continue processing at an alternate state site or EDS facility in the event of an unexpected system outage.

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(g) Interaction With State Personnel

RFP Reference: 3.2.2.7(g), p. 3-11

A practice of open and regular interaction with state personnel is a key ingredient for us to maintain the solid foundation on which the MMIS operates and allows us to continue to grow to meet the business needs of the state. The members of our Vermont-based team consider themselves part of your team and are committed to maintaining both structured and informal interactions with the Department of PATH to ensure smooth policy implementations and enhancements to support the evolution of the Vermont Medicaid Program.

Easily Accessible Staff

Our team is accessible 24 hours a day, 7 days a week. Barbara Davis, our client delivery executive, is always on call and can be reached by telephone. During the past 21 years, only a handful of occasions have occurred when after-hours contact was needed—but it is always available.

During business hours, our employees have e-mail capability as well as a current Vermont State Government Telephone and E-mail Directory. Every employee is encouraged to check e-mail on a regular basis but not less than three times each workday. By maintaining this open form of communication, the state is assured of reaching all personnel when needed.

We also use our courier to deliver nonelectronic, written correspondence and paper documents sent between our two offices. In 1993, we developed the S-log system as a tracking mechanism for written correspondence from the state that requires our action. When we receive correspondence, we enter the document into the S-log system and assign a sequential number. We photocopy the document and file the original with the S-log documentation. The S-log sign-in sheet lists the person to whom the document was sent, the date received at our facility in Williston, the date on the document itself, the sender, a brief description of the document (for example, rate changes and procedure code additions and deletions), and a response date if required. We then distribute copies of the document to the appropriate managers and team member responsible for completing the request.

As we continue to move forward in our efforts to increase accessibility, we will upgrade the telephone system at the account to provide direct lines and voice mail to all staff members as required in this RFP.

On-Site Staff

To assure accessibility to information on a timely basis, Louise Brooks, one of our reporting specialists, works at your office in Waterbury three days each week. Louise, a 21-year veteran of the Vermont-based team, is available to assist state employees with questions ranging from the way a claim is processed to designing and running queries in EVAH. In addition, Ramona Godfrey, R.N., who has almost 18 years of clinical review experience with EDS, works at the state offices in Waterbury one day each week. Ramona works with the nursing staff at the OVHA to address coding and review issues.

We also provide a dedicated office at our Williston site for use by state employees. The acting deputy director and school-based health services coordinator use this office on a regular basis.

Regular Meetings

The Vermont-based team welcomes the opportunity to meet with the state on a regular basis to keep information flowing between the many parties committed to caring for Vermont's Medicaid population.

On a monthly basis, Paul Wallace-Brodeur, the director of the OVHA, and Barbara Davis meet to discuss upcoming changes to programs and possible implementation issues that may occur. These meetings also focus on provider items that the OVHA received. We take meeting minutes and distribute copies to the appropriate managers for follow up.

Twice a month, Pat House, Barbara Davis, and Judy Higgins, the director of computer services and IT manager, meet to discuss the oversight of HIPAA, the vision for the MMIS, and the EDS corporate capabilities needed to meet this vision.

Each week, the fiscal agent meeting provides a structured forum for the Vermont-based management team and the state to communicate directives related to policy changes, system modifications or enhancements, provider correspondence, training or billing concerns, and claims processing statistics. The claims processing statistics are broken down by claims to be keyed and claims awaiting resolution. We update and post these numbers on the bulletin board in the claims processing area each day. All account employees and visitors to the account can monitor these numbers. The administrative assistant takes fiscal agent meeting minutes and distributes the minutes as appropriate. These minutes act as the official record for documenting changes to claim processing procedures and billing instructions to providers.

In addition, several operational meetings occur on a regular basis. For example, in an ongoing effort to help Vermont achieve its fiscal goals, the state's third-party liability (TPL) staff and our TPL staff meet every other week to discuss the current status of TPL recoveries and identify enhancement possibilities or processing improvements. Meeting minutes are taken and distributed so follow up and progress continue. With the joint effort of the Vermont-based team and the state, we have consistently exceeded the monetary goals for TPL recoveries.

Cherie Bergeron, our systems manager, is also active on the Vermont Health Access Team (VHAT), which meets monthly at the state offices in Waterbury. VHAT includes members from the Department of PATH, EDS, and other stakeholders as necessary. The goal of this meeting is to determine the impact of proposed legislative or state plan changes to the Vermont Health Access Program systems. The dialog between the Vermont-based team and other stakeholders at these meetings is critical to providing uninterrupted service to all programs.

Provider Support

The Vermont-based team works very closely with the state to provide continued support to and communication with providers. The *Vermont Health Access Advisory* newsletter, which is produced every other month, is a joint effort between the state and EDS. It is an important link between the providers enrolled in Vermont Medicaid and the programs administered by the OVHA. The *Advisory* is used to convey information about the most common billing errors and how to resolve these errors to improve the providers' payment turnaround time. It also serves as a source of advice and clarification on state or federal policies and procedures. State personnel and EDS employees submit articles for review by the state and provider services representatives and managers. Once the articles are selected, key personnel at the state and EDS, including Paul Wallace-Brodeur, Roger Tremblay, the nursing staff, Testing Coordinator Judy Isham, Barbara Davis, and Cherie Bergeron, review a rough draft of the *Advisory*. Paul and Barbara give final approval prior to the *Advisory* being published and sent to the providers.

As we strive to provide the most accurate information to the providers about the OVHA policies, we hold ongoing meetings with John Dick, the policy and planning chief, and the provider representatives to clarify and update the provider manuals. Recently, we have begun putting the manuals on the Web for those providers who have Web access, thus further automating the communications process between our office and the provider offices.

Training Forums

We consider continued training an integral part of our fiscal agent responsibilities. We fully recognize the necessity of training for new staff and ongoing training for all team members about updates to the MMIS. Chris Haskins is available upon request to train any person granted access to the VermontAIM system. Ann Markle and Louise Brooks coordinate the training for all EVAH users.

In 2002, we converted our platform for EVAH from Ingres to DB2 and upgraded to the most recent version of BusinessObjects. At the completion of the conversion, we conducted two weeks of refresher courses and full-day hands-on training workshops for all state and EDS personnel with EVAH access. We provided an overview of how we process a claim in our system to better prepare the users to achieve the most accurate reporting. We required all authorized users to attend this training in order to receive the updated version of software.

We will take the same hands-on, dedicated approach to meeting all training needs surrounding the operation of the MMIS so the state can feel confident that the individuals entrusted with the fiscal agent responsibilities for Vermont's Medicaid Program have the skills required.

(h) USE OF SUBCONTRACTORS

RFP Reference: 3.2.2.7(h), p. 3-11

EDS has served as prime contractor on many large-scale, multiple-subcontractor Medicaid projects, and we have the local experience necessary to manage subcontracts. Client Delivery Executive Barbara Davis will serve as focal point for all work performed by subcontractors. **EDS accepts full responsibility for subcontractor activities and will be the state's single point of contact.** We will measure quality and reimburse subcontractors only upon satisfactory delivery of a product. We measure quality by providing timely deliverables, exceeding expectations, and satisfying the state with the work we perform. In addition, we will ensure that any subcontractors with access to data strictly adhere to the privacy standards established by HIPAA for the performance of business associates. Barbara will meet with the state to share status on subcontractor work as needed and will meet regularly with each subcontractor partner to discuss tasks, performance, and any issues identified by the state or EDS.

The subcontracts we sign with our partners state that we will monitor their performance on a regular basis and terminate the contract if the subcontractor does not meet deliverable requirements or does not deliver quality products and services. For example, we will ensure that we have in place a process whereby Barbara and the EDS leadership team will review the weekly and monthly third-party liability (TPL) data matching reports for accuracy and completeness of all reporting. During a monthly status call with the subcontractor, we will review the results and discuss any open issues or concerns. We also will use the meeting as an opportunity to advise the TPL subcontractor about any state or legislative changes that may affect the TPL data matching process. We give a 30-day termination notice to noncompliant subcontractors that are unable to correct deficiencies. EDS ensures that the vacancy will not affect the state and the provider and client communities by carefully managing the selection of a new subcontractor and managing the transition period if we ever find it necessary to terminate a subcontractor for performance reasons.

Our relationship with Eagle Managed Care (EMC) is one example of our commitment to quality performance by our subcontractors and our ability to address the issue of substandard delivery. Originally, EDS contracted with Medco to assist in the implementation of the prospective and retrospective drug utilization review (DUR) process. Medco attended all of the scheduled meetings and produced the required results, but we believed Medco was failing to provide the value we had envisioned for the state. In our opinion, they were not innovative or proactive. At that point, Barbara talked to client delivery executives (CDEs) at other EDS Medicaid accounts and found that several accounts used EMC, a company they found to be flexible, nimble, and able to deliver high customer service levels. We terminated Medco and cancelled our contract with them when we determined that they could not meet the performance deliverables of our selected vendor EMC.

The results substantiated the CDEs' recommendations—EMC was significantly better from the contract start. While we no longer provide DUR subcontracting, EMC is viewed as a true partner who helped the OVHA improve its drug utilization review program.

A subcontractor may not terminate or change its relationship with EDS without prior and expressed approval as specified in the contract. To avoid unnecessary project interruption, we will work with the state's legal and contracting staff to obtain all necessary approvals before replacing the subcontractor.

(i) ASSUMPTIONS AND CONSTRAINTS

RFP Reference: 3.2.2.7(i), p. 3-11

Our continuing partnership with the Department of PATH allows us to be in the best position of any vendor to discuss the assumptions and constraints that may affect the state of Vermont and EDS. As your fiscal agent since 1981, we assume the following:

- We will continue to employ the same knowledgeable personnel currently serving the Vermont Medicaid Program. They will continue to provide you with their experience and Vermont-specific program knowledge as they serve the program.
- We are knowledgeable in the Vermont Medicaid Program and its complexities, including the unique needs of the provider recipient communities.
- We will remain focused on our current delivery of exceptional services rather than having to focus intensely on the Takeover tasks required of a new fiscal agent.
- Our project management methodology will allow us to approach the Enhancements/Modifications Phase of the project with a systematic process of planning, monitoring, adjusting, and controlling work activities that will limit or mitigate any potential disruption of current operations.

The constraints that may affect the Department of PATH and EDS remain the same ones that we currently face together:

- Any delay to contract signing may impact the dates noted in your RFP and adhered to in this proposal and its associated work plans.
- Any replacement of state or EDS staff is unexpected and unplanned.
- Changing priorities due to new state or federal regulations can affect the Vermont Medicaid Program.

Please refer to the "Assumptions or Constraints in Developing and Completing the Work Plan and Schedule" subsection in the "Work Plan and Schedule (Operations)" section and the "Assumptions or Constraints in Developing and Completing the Work Plan and Schedule" subsection in the "Work Plan and Schedule (Enhancements/Modifications)" section for more information about the assumptions and constraints related to the specific work plans.

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H. Takeover Narrative

RFP Reference: 2.5, p. 2-8

Takeover of the VermontAIM is a tremendous undertaking for a new contractor. Tackling a complex technical environment is further complicated by the need to continue services to more than 135,000 beneficiaries and 8,000 providers. Beyond the system issues are staffing, facilities, and ongoing support for the other programs supported by the VermontAIM. These programs include Dr. Dynasaur, Primary Care Plus (PC*Plus*), Vermont Health Access Program Pharmacy, VScript, School-Based Health Services, General Assistance, in addition to waiver programs for Traumatic Brain Injury, Home-Based Care for the Elderly, Enhanced Residential Care, Children's Mental Illness, and Developmental Services.

While other vendors are focused on the multitude of tasks associated with takeover, EDS can accomplish takeover without disrupting services to providers, beneficiaries, and other stakeholders. With EDS, the state has the luxury of time: four months in late 2003 when, instead of managing the transfer of fiscal agent services to another vendor, the state can actually get an early start on implementing desired enhancements and cost-containment services.

We represent low risk of disruption of normal business processes for the state. The takeover effort will be simplified because all functions are in place today, and they are working. We know the importance of keeping our operations running smoothly. Vermont's takeover responsibilities will be simpler because the state will not have to spend the time training us that would be required for a new contractor. Retaining EDS also means the on-site state staff will not have the disruption of a move to different facilities.

A takeover with EDS means the Department of Prevention, Assistance, Transition, and Health Access (PATH) team will be sitting down with someone they know and trust. You will spend less time clarifying roles and responsibilities and verifying that the system will operate properly. Instead, you can devote more time to pressing priorities like fiscal budget issues.

In turn, we can accelerate the enhancements or help you adopt proactive cost-saving mechanisms. In fact, if the state so desires, we will be ready to implement cost-saving enhancements as soon as the new contract is signed.

In addition to the Claim Check/Claim Review and third-party liability (TPL) upgrade enhancements that we can start to implement in September 2003, there are a number of additional cost-saving mechanisms that our nationwide Medicaid account leadership team has recommended. These ideas were collected from EDS health care experts across the country and examined as they pertain to Vermont. From these cost-saving ideas, the Vermont Medicaid team selected two that we believe are most relevant to Vermont and will save state dollars. Vermont can select one or both of the following cost-saving mechanisms. If you wish, we will start to implement either or both of them during takeover.

Vermont-Specific Cost-Saving Mechanisms

The cost-containment mechanisms that we believe would provide the greatest benefit to Vermont are in the areas of pharmacy benefits management and disease management. EDS proposes the services of two best-in-class subcontractors to achieve quantifiable cost savings for Vermont:

- Heritage Information Systems (Heritage), a pharmacy benefits management company that performs clinical management services and pharmacy auditing services for some of the largest payors in the country, including 13 Medicaid states.

Sample Cost-Containment Benefits Provided by Heritage
Identification of fraud, abuse, and waste in the drug program
Support for the recovery of fraudulent payments
Reduction of future fraud, abuse, and waste via sentinel effect of pharmacy audits
Identification of overpayments relating to infused and injectible medications
Automated pharmacy prior authorization (PA) for streamlined PA processing
Faster PA approval and real-time pharmacy claims adjudication, resulting in enhanced provider relations

Sample Cost-Containment Benefits Provided by Heritage
Improved provider education resulting from immediate feedback on specific criteria, claim, and clinical issues that result in a recommendation for approval or denial of a drug
Reduced administrative costs in the PA arena resulting from reduced need for manual support
Ability to place more drug classes on PA and to screen for more clinical issues while handling only denials at the state/fiscal agent help desk

- Trestle Tree, a privately owned company developed to provide a fresh approach to disease management. Trestle Tree reduces costs of care by identifying target populations with laser accuracy, investing the time of health professionals, documenting the individual history of each person identified with a particular disease state, and providing focused intervention to influence the pharmaceutical choices made by the patient

Sample Cost-Containment Benefits Provided by Trestle Tree
Intervention alternatives that result in the improved health of Vermont beneficiaries
Clinical monitoring, program trending, and financial analysis
Reduced benefit expenditures for pilot participants

Our approach to takeover gives the state choices that you can exercise or not—at your discretion. You can choose not to implement cost-containment recommendations or enhancements early during the Takeover Phase, or you can choose to implement any of these early. The choices you make will determine our activities during takeover. Having the flexibility to please our customer is a point in which we take great pride.

Taking into consideration your opportunity to choose, we present our response to the RFP-required takeover plans and schedules in the following subsections:

- Project Organization and Staffing (Takeover)
- Project Management and Control (Takeover)
- Work Plan and Schedule (Takeover)

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PROJECT ORGANIZATION AND STAFFING (TAKEOVER)

RFP Reference: 3.2.2.8, p. 3-11

EDS offers the Department of PATH **a management team that brings proven leadership and extensive Vermont-specific experience**. No other contractor offers the Department of PATH the assurance of stability and continuity in support of the programs that we worked side-by-side with you to implement during the past 21 years.

We will retain our current staff of leaders, making minor changes in responsibility where appropriate and supplementing with additional expertise to meet the state's goals, objectives, and performance standards. Our plan is logical and reasonable and reflects our proven performance, experience, and commitment to Vermont. The Department of PATH knows EDS as a reputable company with dependable individuals. We do not make promises in proposals; we deliver. We have a superior track record in operating the VermontAIM. While other contractors will say they will do whatever is necessary, Vermont knows firsthand that we have what it takes to meet expectations.

We bring the right people, resources, and organization to support Vermont's health care needs now and in the future. The Department knows our people. From the leadership of Barbara Davis and long-term members of our Vermont team—Cherie Bergeron, Chrissie Racicot, Cindy Littlefield, Judy Isham, Carrie Marchant, and many more, including our provider representatives and systems engineers—we demonstrate our commitment to the state, providers, and beneficiaries on a daily basis.

The Department of PATH trusts our knowledge and experience and depends on us to answer questions, research a claim, or resolve an issue. The relationships forged among EDS, state employees, providers, and beneficiaries will continue with EDS as the fiscal agent. During the four-month Takeover Phase, the current EDS staff will continue to manage day-to-day operations. EDS Vermont Medicaid staff resumes, experience, and responsibilities are described in detail in the "Project Organization and Staffing (Operations)" section of this proposal.

You gain another advantage with EDS in that the Department of PATH will not have to spend time training or developing critical relationships with new vendor personnel. If desired, the state can spend this time implementing enhancements and modifications or new cost-containment mechanisms early. If Vermont chooses to implement any of these services during takeover, we will discuss the enhancements and their time frames during contract negotiations, we will create a plan to help Vermont realize the benefits of these services early.

We are prepared to bring in Enhancements/Modifications Manager Sean Daly and his team before the Enhancement/Modifications Phase if needed. For a detailed description of the experience and responsibilities of the Enhancements/Modifications team, please see the "Project Organization and Staffing (Enhancements/Modifications)" section of our proposal. Sean's resume is also located in that part of the proposal.

PROJECT MANAGEMENT AND CONTROL (TAKEOVER)

RFP Reference: 3.2.2.9, p. 3-14

The daily tasks of the Vermont Medicaid Program and other Department of PATH programs will not diminish during the takeover. By retaining EDS as its fiscal agent, the state can greatly reduce overall effort resulting from takeover-related tasks. The state will not spend hours in meetings monitoring an unproven contractor's performance or training inexperienced contractor staff on the unique policies and procedures of the Vermont Medicaid Program.

The four months of the Takeover Phase provide an opportunity for you to get an early start on enhancements and modifications, if desired. Experienced EDS leaders and highly trained and knowledgeable technical support staff will be available to implement innovative solutions to meet the state's objectives on the first day of the new contract. This gives Vermont the choice of an early implementation of EDS-recommended cost containment mechanisms or any of the mandatory or optional enhancements/modifications during takeover.

Getting An Early Start

If Vermont decides to implement EDS' recommended cost containment mechanisms or any of the mandatory or optional enhancements/modifications during Takeover, our approach to project management and control is the same approach that we describe in the "Project Management and Control (Enhancements/Modifications)" section of our proposal. Our approach for managing enhancements as described in this section will apply to any enhancements or modifications that Vermont chooses to implement during the Takeover Phase.

In support of the complex changes that may occur should Vermont choose early implementation of cost containment mechanisms or the enhancements and modifications, EDS will apply the latest generation methodology for project management and systems life cycle development. We will use the Global Solutions Management Systems (GSMS) to manage our software development processes and Project Management Institute (PMI) fundamentals for scheduling, control, milestones, and deliverables. State and EDS personnel will also have immediate access to all project communication and documentation through our Web-based Project Workbook.

Starting Change in January 2004

Should Vermont decide to not implement cost containment mechanisms or enhancements and modifications during the takeover period, our approach to project management and control during this four-month period will be the same as that which is detailed in the "Project Management and Control (Operations)" section of our proposal.

We will continue to provide thorough and effective project management through the use of disciplined, controlled processes that are based on GSMS and PMI fundamentals. Vermont can rest assured that all project planning will continue to be iterative and that assumptions, risks, and estimates in our proposal will be re-evaluated at regular intervals to ensure initial planning is still valid. When necessary, we will incorporate changes to keep day-to-day operations running smoothly and on schedule, and we will continue to deliver products on time and within budget.

WORK PLAN AND SCHEDULE (TAKEOVER)

RFP Reference: 3.2.2.10, p. 3-15

A smooth takeover of Vermont Medicaid operations is critical to a seamless and transparent transition for providers, beneficiaries, other stakeholders, and the state. EDS understands the significant effort that is required to implement and manage the VermontAIM. Because the Vermont Medicaid fiscal agent contract is primarily a services contract, it encompasses much more than the technology to process claims. While the takeover of hardware and software is in itself a complex and demanding task, **the takeover of the Vermont-specific knowledge-based items is most critical to success**.

An incomplete or superficial understanding of the requirements, procedures, processes, and driving forces of the Vermont Medicaid Program guarantees disruption in service to providers, beneficiaries, and other stakeholders. Preventing this disruption will require state staff to allocate a disproportionate share of their time and effort to resolve problems and educate the new contractor.

A contractor requires both knowledge of the VermontAIM and experience in takeover and implementation of complex systems to ensure a successful takeover. EDS offers experienced and knowledgeable staff—realistically prepared for the Vermont environment—to provide a successful and low-risk takeover. We bring this knowledge and understanding to the state on the very first day of the contract, allowing no need to use the Takeover Phase to get up to speed. This benefit gives Vermont the choice of implementing cost containment mechanisms or the mandatory and optional enhancements/modifications early during the Takeover Phase.

Getting An Early Start

If the state decides to implement cost containment or enhancements and modifications early, we will develop work plans and schedules for the implementation of any selected cost containment mechanisms that will follow the approach described under the "Work Plan and Schedule (Enhancements/Modifications)" subsection of this proposal.

As the incumbent and the most experienced Medicaid contractor, we have an in-depth understanding of both the Vermont Operations scope of work and the Enhancements/Modifications and cost containment scope of work. This advantage, coupled with our knowledgeable staff and established relationships with providers and the Department of PATH, give Vermont reliability they can depend on. The implementation plans for any early starts will be based on our knowledge, understanding, quality management practices, and VermontAIM management expertise.

We will apply this understanding and logically identify the necessary tasks, subtasks, and milestones necessary to complete the scope of work for whatever Vermont chooses to do during the Takeover Phase. Assurance that deadlines will be met and deliverables will be produced puts Vermont in the unique position of being able to analyze its programs and project its needs for the future of Medicaid. EDS will be there to support you in the execution of your plans.

Starting Change in January 2004

Alternatively, Vermont may also choose to not implement cost containment mechanisms or enhancements and modifications early. In this case, our work plan and schedule will be the same as described in the "Work Plan and Schedule (Operations)" section of this proposal. This ensures that day-to-day operations will continue without interruption through the last four months of 2003 into January 2004 and the beginning of the next contract period.

I. Operations Narrative

RFP Reference: 2.5, p. 2-15

In our response to the Operations Narrative, we provide a comprehensive look at the people, processes, and services that we provide for the Vermont Medicaid Program.

We have organized the material to match RFP response requirements in the tabbed sections described below:

- **Project Organization and Staffing—**The state benefits by maintaining EDS staff in the existing Williston office and augmenting that staff with members of our extended family at the central support centres in Vancouver, Washington, and Richmond, Virginia. The established staff brings 410 years of Vermont Medicaid program understanding, which represents an unmatched investment in program support. Medicaid program operations will benefit from the continued leadership of Client Delivery Executive Barbara Davis and her management team: Systems Manager Cherie Bergeron and Program Services Manager Valerie Lewis.
- **Project Management and Control—**The state gains stability and uninterrupted services as a result of EDS' ability to leverage proven, Vermont-specific procedures for project management and control in the Operations Phase. Based on Carnegie-Mellon University's Software Engineering Institute (SEI) practices and Project Management Institute (PMI) fundamentals, these customized processes will ensure projects are implemented on time. **EDS will enhance established practices by adopting additional best practices for systems support and development that will be applied in the Enhancements/Modifications Phase. Among these new best practices will be instant,**

online access to all project documentation, including status reports and work plans, through EDS' exclusive Web-based Project Workbook.

- **Work Plan and Schedule—**Our work plan and schedule provide a comprehensive look at all aspects of our operations. To make sure we have answered all of your questions, we are responding to each of the lettered requirements in 3.2.2.10 and, in addition, we are responding to the operations requirements found in Section 2.6 of the RFP.

Overall, our Operations Narrative provides the following assurances:

- **A solid platform for continued program growth—**The client/server Advanced Information Management (AIM) Medicaid Management Information System (MMIS) and the established operations in Williston work together to create a firm base for the program's continued evolution.
- **No disruption to the program or the providers—**Without the disruption of takeover, operations will continue without disturbance to the providers or the state.
- **Continued, reliable support from your local program support site—**The state, providers, and beneficiaries benefit from the Vermont team's institutional knowledge.

PROJECT ORGANIZATION AND STAFFING (OPERATIONS)

RFP Reference: 3.2.2.8, p. 3-11
2.6.14, p. 2-43

You have a plan for the Vermont Medicaid Program. You know where you are headed, and you are looking for the best partner to help you get there. We can offer you what no other vendor can—a team with more than 410 years of Vermont-specific institutional knowledge that is committed to helping you turn your vision into reality.

Best Team to Support Vermont Medicaid

- Most Vermont knowledge and experience
- Established relationships
- No learning curve
- Continuity and stability to support growth

We have the most knowledge and experience with Vermont Medicaid Program operations and the VermontAIM. Since 1981, we have been through many transitions with the Department of Prevention, Assistance, Transition, and Health Access (PATH). We have helped the state transition from a legacy Medicaid Management Information System (MMIS) to the most advanced MMIS in the nation—the client/server VermontAIM. This transition significantly improved operational and technical processes, making the VermontAIM a model MMIS for other states.

We also helped the state integrate other health care programs into the MMIS as legislators and the governor expanded benefits for beneficiaries. Examples of these new program additions include the General Assistance Program, Department of Corrections Program, the State Children's Health Insurance Program (SCHIP), and the PC*Plus* managed care program. By leveraging the VermontAIM, we implemented these programs with maximization of federal funding and minimal cost to the Department of PATH.

With this history of Vermont-specific knowledge and experience, our team is the perfect complement to achieving your clear vision for the future. We are committed to taking the Vermont Medicaid program, once again, to the next level. We have grown with you as your program has grown. We built the infrastructure and business processes with the future in mind, and we look forward to making your vision become reality.

We have established relationships with Vermont Medicaid state agency stakeholders. Because your success is our primary goal, we work with you to accomplish your objectives. We have listened to your needs and responded, remaining open to new ways of ensuring your success. For example, we work with your pharmacy benefits manager to maximize drug rebate recoveries and drug transaction processing. We set aside the time of our most knowledgeable staff to help your new vendor learn the Vermont program, the file layouts, and the providers. Our common goal: increased drug rebate revenue for the state. Another example is our relationship with the global clinical record vendor. We are currently working with this vendor to successfully

transition the early and periodic screening, diagnosis, and treatment (EPSDT) processing to them. Our common goal: accurate transition without disruption of service.

These examples illustrate our ability to develop open communication and effective working relationships with both the state and other Medicaid program stakeholders. You know our staff, our commitment to service excellence, and our history of going the extra mile for your success. We offer you a unique benefit—peace of mind that comes with the underlying element of trust to provide stability, continuity, and uninterrupted service to providers and beneficiaries.

With EDS, there is no learning curve. It takes time for a new vendor to get up to speed. Learning the intricacies of the system and the program while developing critical relationships with key state staff and other stakeholders leaves little time for anything else. If you could avoid the time and effort required during a takeover, what would you do? You would spend that time improving productivity, increasing provider satisfaction, or implementing new cost-containment measures, which are some of the benefits you will receive from the mandatory and optional enhancements. If you want to implement any of the enhancements early, we will work with you to make it happen. We will discuss the enhancements and their timing during contract negotiations and create a plan to help you realize these benefits early. You will not have to wait until January to get started.

Retaining EDS and avoiding a takeover has another benefit. State program leaders can restructure their budget, and monies set aside for takeover-related activities can be allocated to future program initiatives, which will benefit Vermont citizens.

Our proposed Vermont-based team offers continuity of leadership, operational, and technical staff with a commitment to excellence and growth. Our proposed team remains largely the same as today; however, this staff will be supplemented with additional expertise to meet the state's goals, objectives, and performance standards. For example, the state's vision for expanded drug rebate services will be supported by the formal addition of a pharmacy consultant. To ensure continued compliance with federal regulations, a Health Insurance Portability and Accountability Act (HIPAA) compliance officer will be dedicated to support the Vermont program. With the stringent requirements of the new HIPAA Privacy and Security regulations, it would not be enough to assign the HIPAA compliance officer responsibilities to an employee as additional duties. We intend to provide a full-time employee to handle the Chain of Trust Partner agreements, monitoring the Business Partner agreements and working with the Department of PATH compliance officer to ensure that Medicaid and other health program data is secure and properly protected.

To provide the road map to your vision, Client Delivery Executive Barbara Davis and Systems Manager Cherie Bergeron will lead our team as we help the state move toward its vision. In addition, the expertise of Program Services Manager Valerie Lewis will bring a fresh perspective to enhance our operational processes and ultimately achieve an even higher level of service to the provider community. Our team is committed to excellence in all areas. We will always strive to exceed the state's expectations, remaining responsive and flexible as the program grows and your vision continues to evolve.

Our proposed key leaders offer significant strength and experience:

- **Barbara Davis, client delivery executive**—Barbara's 26 years of Vermont Medicaid experience, along with her ability to focus her team on supporting the agency goals and the Department of PATH vision, demonstrates her full commitment to the Vermont Medicaid program.
- **Cherie Bergeron, systems manager**—Cherie's extensive system and program experience provides the institutional knowledge that is required when making modifications and enhancements to a program as complex as the Vermont Medicaid program.
- **Valerie Lewis, program services manager**—Val's extensive experience in leadership, human resources, consulting, and organizational development provides a strong background for leading Program Services in her home state of Vermont.
- **Sean Daly, enhancements/modifications manager**—Sean's thorough knowledge of the AIM system and strong project management experience will support the timely and accurate implementation of enhancements and modifications.

We discuss our staffing approach and organization in the following sections:

- EDS Compliance With Contractor Staff Requirements
- Organizational Charts
- Management and Key Staff References
- Resumes or Vitae
- Staff Responsibilities
- Additional Staff

EDS Compliance With Contractor Staff Requirements

The following chart indicates our full compliance with the RFP requirements specified in Section 2.6.14.2.

Contractor Staff Requirements— 2.6.14.2 Contractor Responsibilities	EDS Compliance
a. Comply with staffing commitments made in Contractor's proposal, or in a subsequent State-approved staffing plan.	Yes

Contractor Staff Requirements— 2.6.14.2 Contractor Responsibilities	EDS Compliance
b. Warrant that all staff assigned to the performance of this contract are: • Employees of the Contractor (or specified subcontractor). • Fully qualified to perform the work required herein. *The provisions of section 2.6.14.2(b) must be incorporated into any subcontract.*	Yes
c. Provide the State with a resumé of any of its staff or subcontractor's staff assigned to or proposed-to-be-assigned to this contract, upon request.	Yes
d. Fill vacant positions with staff of equal ability and qualifications within 30 calendar days of initial vacancy.	Yes
e. Confirm all management and key staff commitments to this contract for the entire contract term unless the State exercises its option to have a staff person removed.	Yes
f. Notify the State immediately upon notification that a management or key staff positions may be vacant.	Yes
g. Obtain prior written approval from the State for: • Staff assigned to this contract. • Staff changes, including permanent or temporary changes to or deletions from Contractor's management, and key staff if the change is within the Contractor's control. • Diversion of management and key staff to other Contractor duties, either internal or external to the Vermont account. • Job descriptions. • Definition of positions that qualify as "key staff." • Organizational structure or re-structuring as determined by business needs.	Yes
h. Maintain a staffing structure, of sufficient background, expertise, training, size, scope, and authority to perform Contractor Responsibilities to the satisfaction of the State.	Yes

Contractor Staff Requirements— 2.6.14.2 Contractor Responsibilities	EDS Compliance
i. Retain Existing Staff: The following positions are mandatory throughout the length of the contract and any contract extensions. The EDS staff currently employed in these positions with existing job descriptions shall be retained by the new Contractor. *The salary and benefit costs associated with these positions are fixed throughout the contract term and already accounted for in the Total Price Proposal Worksheet.* • School-based Health Program Field Representative – 4 FTEs (as utilized) • School-based Health Program Lead – 1 FTE (as utilized) • OVHA/TPL Cash Coordinator – 1 FTE • Physical Therapist – 1 FTE • Self-Managed Nursing Coordinator – .5 FTE The OVHA/TPL Cash Coordinator and Physical Therapist are located at the State of Vermont Office Complex in Waterbury and do not require equipment under this RFP. However, the School-based Health Program Field Representatives and Lead will require workspace and all necessary equipment.	Yes

Organizational Charts

RFP Reference: 3.2.2.8.1, p. 3-12

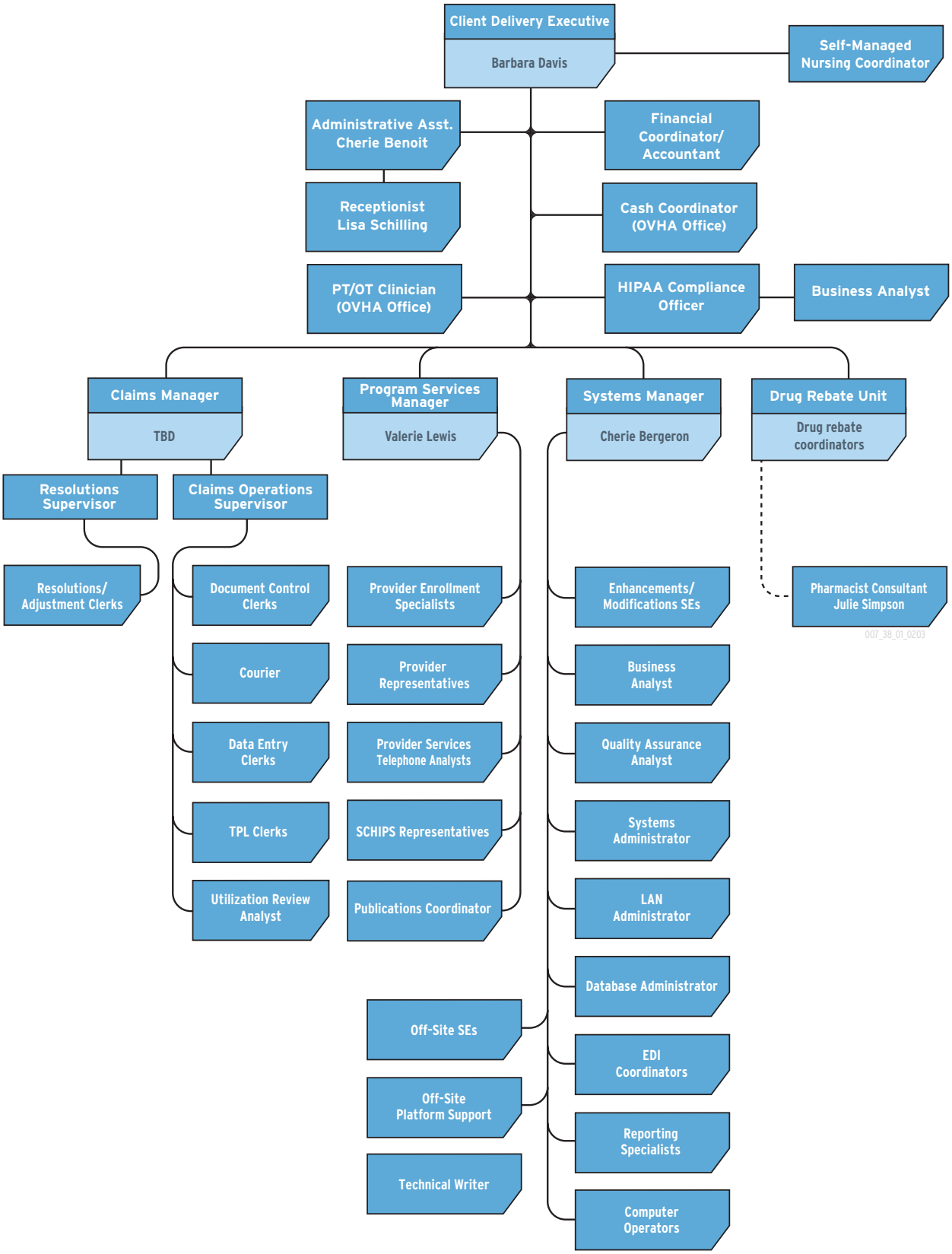
Our team brings unparalleled expertise to Vermont with a reliable operations organization and staffing plan. We offer the state an organization with established reporting relationships and open lines of communication. All functional areas have dedicated leadership to ensure appropriate oversight, accountability, and service excellence.

Barbara Davis will continue in her role as client delivery executive and remain dedicated to achieving outstanding results for Vermont. EDS' philosophy of providing leaders with the right degree of autonomy allows Barbara to make the appropriate decisions to support the Vermont program while relying on a strong corporate infrastructure to back those decisions.

Barbara will continue to apply her leadership skills to manage all phases of this contract, emphasizing that all levels of the organization operate as a quality-driven team focused on responding to customer requests in a timely, courteous, and informative manner. The team will continue efforts to sustain a beneficial, trust-based working relationship with the state.

The Operations Phase organization depicted in the chart on the following page will be in place in January 2004.

Operations Phase Organizational Chart



Each functional area shown in the Operations Phase organizational chart above is responsible for specific areas of the contract as outlined in the following table.

Functional Area	Responsibilities
Administrative	• Management staff members are responsible for oversight of their area of responsibility, ensuring all contractual obligations are met, providing innovation and "best practices" to the Department of PATH, obtaining staff and providing resources necessary to perform fiscal agent responsibilities, identifying issues, creating action plans and reporting status to the Department of PATH, complying with federal and state rules and regulations, performing facilities management, and serving as the single point of contact for the Department of PATH. • Accounting is responsible for performing bank reconciliation, procuring the service of an annual SAS-70 audit with an outside accounting firm, submitting weekly draw requests, monitoring all financial transactions, providing data for all financial requests from the Department of PATH, and following generally accepted accounting principles (GAAP) in financial responsibilities. • HIPAA Compliance is responsible for account training and orientation on HIPAA privacy and security regulations, facilitating chain of trust and business partner agreement processing, reviewing all privacy or security issues, and reporting any noncompliance to management and the Department of PATH. • Administration is responsible for attending and creating minutes of the weekly fiscal agent meetings, handling confidential employee paperwork, submitting all corporate documentation, serving as the liaison with corporate human resources, completing biweekly timecards, generating the Department of PATH billings, and paying sundry invoices. • Reception is responsible for greeting visitors, ensuring visitors sign in and out of the building, answering telephones, monitoring supplies, handling employee supply requests, and addressing general facility issues.

Functional Area	Responsibilities
Claims	• The mail room is responsible for opening, sorting, batching, and scanning incoming mail, and for sending out weekly remittance advices (RAs) and other mailings. • The data entry group is responsible for keying all the incoming claims in a timely manner. • The resolutions group is responsible for making final resolution on claims to pay or deny; forwarding claims to utilization review (UR) or the third-party liability (TPL) unit; and claim archiving, refilming, and recycling. This group is also responsible for updating the resolutions manual. • The adjustment unit is responsible for processing adjustments that can be initiated from a provider, the state, or EDS. • The TPL unit is responsible for retroactive insurance billing, casualty recoveries, and follow-up on TPL referrals. • UR is responsible for reviewing medical necessity and appropriateness, and reference files maintenance.
Program Services	• Provider Relations is responsible for educating the provider community on Medicaid billing procedures, providing outreach to new providers, communicating new billing instructions to the provider community, creating provider billing manuals for Department of PATH approval, presenting at billing workshops, answering provider questions, and monitoring provider billing practices to set up provider visits for additional training as needed. • Provider Services is responsible for providing help desk support to providers on eligibility, payment, or claim submission questions; providing full 8 a.m. to 5 p.m. telephone coverage; documenting telephone call information in the automated telephone tracking system; and ensuring short wait times on the telephones. • Provider Enrollment is responsible for enrolling Medicaid and other health program providers, ensuring the proper licensing and credentialing documentation is present, entering provider changes and bank information, maintaining the provider files for audit purposes, and verifying provider information is on file and accurate. • SCHIP is responsible for the on-site review of Individual Education Plan (IEP) records, visiting schools and supervisory unions and instructing on proper billing practices, setting up billers on electronic billing, developing the SCHIP manual and updates, providing help desk support to schools and supervisory unions, and reporting on SCHIP activities on a weekly basis. • The self-managed nursing care coordinator is responsible for the help desk support provided to families in the program, entering time cards for payment purposes, and assisting families and personal care attendants with billing issues.

Functional Area	Responsibilities
Systems	• Developing, distributing, and supporting the EDS Provider Electronic Solutions (PES) Billing software • Procuring, installing, and testing all hardware and software • Performing security administration • Performing network administration • Maintaining asset inventory • Maintaining system documentation and user documentation • Performing system modifications to include requirements definition, code modification, testing, and implementation • Monitoring production/model office cycles • Monitoring system performance • Performing print distribution
Drug Rebate Unit	• Carrying out federal mandates related to drug rebate processing • Carrying out state mandates as related to state-only program drug rebate processing • Generating drug rebate invoices • Reconciling drug rebate receipts • Generating AIDS Medication Assistance Program (AMAP) drug rebate invoices • Resolving disputes with drug labelers • Working with the Centers for Medicare and Medicaid Services (CMS) regarding drug rebate policy, rules, and regulations.

Our proposed organization for the Operations Phase combines a solid organizational reporting structure that has successfully served the program's many stakeholders. This foundation will be expanded with the technical and operation expertise necessary to maintain a consistent, uninterrupted operational environment and provide the thought leadership necessary to continually evaluate process improvements, technical advancements, and health care trends that align with your goals.

Staff Loading Charts

The following chart shows estimates of staff effort by month for one representative year of the Operations Phase. The positions listed are staffed with full-time employees working 40 hours a week, with the following exceptions:

- Self-managed nursing coordinator—.5 full-time equivalent
- Pharmacist consultant—.33 full-time equivalent

Staff Effort—Operations Phase
Representative Staffing for Year One

Job Titles	2004 (Operations Phase)											
	Jan-04	Feb-04	Mar-04	Apr-04	May-04	Jun-04	Jul-04	Aug-04	Sep-04	Oct-04	Nov-04	Dec-04
Client delivery executive	1	1	1	1	1	1	1	1	1	1	1	1
Administrative assistant	1	1	1	1	1	1	1	1	1	1	1	1
Receptionist	1	1	1	1	1	1	1	1	1	1	1	1
PT/OT clinician (OVHA Office)	1	1	1	1	1	1	1	1	1	1	1	1
Financial coordinator/accountant	1	1	1	1	1	1	1	1	1	1	1	1
HMS subcontractor	1	1	1	1	1	1	1	1	1	1	1	1
Cash coordinator (OVHA Office)	1	1	1	1	1	1	1	1	1	1	1	1
HIPAA compliance officer	1	1	1	1	1	1	1	1	1	1	1	1
Business analyst	1	1	1	1	1	1	1	1	1	1	1	1
Self-managed nursing coordinator	.5	.5	.5	.5	.5	.5	.5	.5	.5	.5	.5	.5
Claims												
Claims manager	1	1	1	1	1	1	1	1	1	1	1	1
Resolutions supervisor	1	1	1	1	1	1	1	1	1	1	1	1
Resolutions/adjustment clerks	10	10	10	10	10	10	10	10	10	10	10	10
Claims operations supervisor	1	1	1	1	1	1	1	1	1	1	1	1
Document control clerks	3	3	3	3	3	3	3	3	3	3	3	3
Courier	1	1	1	1	1	1	1	1	1	1	1	1
Data entry clerks	4	4	4	4	4	4	4	4	4	4	4	4
TPL clerks	3	3	3	3	3	3	3	3	3	3	3	3
Utilization review analyst	1	1	1	1	1	1	1	1	1	1	1	1
Program Services												
Program Services manager	1	1	1	1	1	1	1	1	1	1	1	1
Provider enrollment specialists	3	3	3	3	3	3	3	3	3	3	3	3
Provider representatives	5	5	5	5	5	5	5	5	5	5	5	5
Provider services telephone analysts	7	7	7	7	7	7	7	7	7	7	7	7
SCHIP representatives	5	5	5	5	5	5	5	5	5	5	5	5
Publications coordinator	1	1	1	1	1	1	1	1	1	1	1	1

Job Titles	2004 (Operations Phase)											
	Jan-04	Feb-04	Mar-04	Apr-04	May-04	Jun-04	Jul-04	Aug-04	Sep-04	Oct-04	Nov-04	Dec-04
Systems												
Systems manager	1	1	1	1	1	1	1	1	1	1	1	1
Enhancements/modifications systems engineers	5	5	5	5	5	5	5	5	5	5	5	5
Business analyst	1	1	1	1	1	1	1	1	1	1	1	1
Quality assurance analyst	1	1	1	1	1	1	1	1	1	1	1	1
Systems administrator	1	1	1	1	1	1	1	1	1	1	1	1
LAN administrator	1	1	1	1	1	1	1	1	1	1	1	1
Database administrator	1	1	1	1	1	1	1	1	1	1	1	1
EDI coordinators	2	2	2	2	2	2	2	2	2	2	2	2
Reporting specialists	2	2	2	2	2	2	2	2	2	2	2	2
Computer operators	2	2	2	2	2	2	2	2	2	2	2	2
Off-site systems engineers	5	5	5	5	5	5	5	5	5	5	5	5
Off-site platform support	2	2	2	2	2	2	2	2	2	2	2	2
Technical writer	1	1	1	1	1	1	1	1	1	1	1	1
Drug Rebate Unit												
Drug Rebate coordinators	2	2	2	2	2	2	2	2	2	2	2	2
Pharmacist consultant	.33	.33	.33	.33	.33	.33	.33	.33	.33	.33	.33	.33

Management and Key Staff References

RFP Reference: 3.2.2.8.2, p. 3-12
2.6.14, p. 2-45

Client Delivery Executive Barbara Davis and Systems Manager Cherie Bergeron bring Vermont-specific experience to serve the state, providers, and beneficiaries in the new contract. We also present Program Services Manager Valerie Lewis, a native Vermonter who is eager to bring her experience home to serve the program's providers.

Client Delivery Executive **Barbara Davis**	
During her 21-year relationship with the Office of Vermont Health Access (OVHA), Barbara has served four Medicaid directors and three separate administrations. Her 26 years of Vermont Medicaid experience, along with her ability to focus her team on supporting the Agency goals and the Department of PATH vision, fully demonstrates her commitment to Vermont. Barbara led the successful implementation of the VermontAIM MMIS. Barbara's business transformation leadership resulted in successfully transitioning OVHA from a legacy mainframe system to a new state-of-the-art, client/server MMIS. She later oversaw her team's completion of a full MMIS platform upgrade, including both hardware and software, improving system performance by more than 36 percent. Barbara's efforts at maximizing the state's federal dollars have resulted in significant cost savings for the state. Barbara led a team of drug rebate recovery specialists in recovering more than $27 million dollars from the drug manufacturers in 2002 and collections of more than $81 million dollars in the past six years. She initiated a multistate cost containment forum that resulted in the implementation of cost savings initiatives such as J-code rebates and bi-annual provider recertification, saving the state an additional $504,000 dollars during the past year. Barbara's continuous focus on client satisfaction and service excellence is exemplified by her design and implementation of the Quality Improvement Process (QIP) that has led to improved account productivity and higher client satisfaction. In 2002, the QIP program improvements in all areas of account performance culminated in the account receiving one of the highest provider satisfaction survey ratings in its 21-year history.	Barbara's responsibilities as client delivery executive include: • Overseeing the entire fiscal agent management services contract during all project phases • Ensuring all contractual requirements are met • Emphasizing the importance of all levels of the organization operating as a quality-driven unit • Serving as the primary contact for Department of PATH and EDS corporate leadership • Communicating Department of PATH goals and vision to the account staff • Establishing and communicating the account vision and goals to all project staff • Acquiring the personnel resources required to fully deliver on contractual obligations • Conducting weekly fiscal agent meetings with state staff • Directly mentoring management staff

Client Delivery Executive **Barbara Davis**		
Experience with system development and consultation. Barbara's experience with system development and consultation spans a period of more than 26 years. Barbara first worked with the Blue Cross and Blue Shield Medicaid account in 1976 when they established their first Vermont Medicaid office. She transitioned to EDS in 1981 and has been responsible for multiple MMIS system development projects during her EDS career. These projects include transitioning EDS' first Vermont Medicaid claims processing system from Missouri in 1981, overseeing the implementation of the new client/server VermontAIM in 1993, the Enhanced Vermont Ad Hoc (EVAH), the PC*Plus* implementation, and the complete system upgrade.		
Experience with project implementation (time lines and costs). Barbara's project implementation experience encompasses the projects implemented since 1986, when she was first promoted to client delivery executive of the Vermont Medicaid account. Each project implemented under the fixed price contract model has been implemented at the cost, and in the time frame, established in the contract.		
Ability to provide staff development and education. EDS strongly believes in the concept of promotion from within, and Barbara ensures that her staff receives every opportunity to expand their careers through multiple training methodologies. Her staff may take advantage of training resources such as EDS University training, on-site training, off-site outside vendor training, on-the-job training, and computer-based training (CBT) to reach their goals and expand their careers. Several of the Vermont account staff members have been promoted into administrative, systems engineering, professional, and management positions on the account. Barbara ensures that all staff receive the mandatory security training and the required 30 hours of annual training offered by EDS.		
Depth and breadth of knowledge of provider relations, health care policy and politics, government technology, and information management. Barbara has extensive experience in provider relations, health care policy and politics, government technology, and information management. Her 30 years of experience as a health insurance professional comprises 26 years of Medicaid leadership experience, including project management, account leadership, staff development, financial management, audit review, quality assessment, cost containment, provider liaison, legislative liaison, community service, and information management responsibilities. Barbara's ability to understand and assess the business needs of the customer results in quality deliverables that align with corporate directives and meet or exceed the state's expectations. Barbara's experience in successful Medicaid account operations is well documented, and she is considered a valued EDS resource. She is often called upon to mentor new EDS account leaders and to perform financial reviews with start-up accounts. EDS accounts in Arkansas, New Hampshire, Idaho, and Iowa all benefited from her experience when they called on her to review their Medicaid account operations, financial accounting, and quality programs. Barbara recently participated in the 2002 EDS Technical Grant awards with Governor James Douglas officiating and has built positive relationships with the legislative body. She is able to meet directly with the appropriate legislators when called upon to do so at the request of Department of PATH staff.		
Office of Vermont Health Access Mr. Paul Wallace-Brodeur Medicaid Director 103 South Main Street Waterbury, Vermont 05676 802 241 2156 paulw@wpgate1.ahs.state.vt.us October 1981 to Present	Office of Vermont Health Access Mr. Robert Butts Contracts Director 103 South Main Street Waterbury, Vermont 05676 802 241 3897 bobbutts@wpgate1.ahs.state.vt.us October 1981 to Present	FOUR**THOUGHT**GROUP Barbera Bridgewater Chief Executive Officer 112 North Central Avenue Suite 450 Phoenix, Arizona 85004 602 340 8450 Barberab2@aol.com January 1998 to July 1999

Systems Manager **Cherie Bergeron**	
Cherie's Vermont Medicaid Program knowledge combined with her extensive systems knowledge has served the state well as she assisted the Department of PATH in the transition from a legacy mainframe MMIS environment to the new client/server VermontAIM. Cherie is a prime example of the career opportunities provided by EDS. She joined the Vermont account staff in 1985 as a data entry operator. Excellent work and team spirit brought continuous opportunities for professional growth. Cherie has served as the systems manager for EDS' Medicaid account for the past 8 years and has supported the Vermont account during the past 17 years in a variety of roles, including claims operations management, provider services management, supervisory, and administrative functions. She currently oversees an EDS team of 13 on-site and 9 off-site systems staff, who maintain and enhance the VermontAIM. Her systems team comprises systems engineers (SEs), systems administrators, database administrators, system operators, local area network (LAN)/desktop administrators, electronic claims submission (ECS) coordinators, and systems test coordinators. Together, they provide maintenance and modification support of all MMIS applications. Cherie's Vermont-specific systems knowledge was responsible for EDS' successful Year 2000 (Y2K) transition, resulting in an award from CMS for our diligent performance. She most recently led the team in the full MMIS HIPAA assessment and is currently overseeing the on-time HIPAA remediation of the MMIS. Cherie's dedication to client satisfaction is genuine, and her successful implementation of multiple large-scale projects throughout the years further demonstrates her commitment to Vermont.	Cherie's responsibilities as the systems manager include: • Providing overall leadership and direction to the systems team to ensure that the MMIS is operational and meets contractual performance standards • Coordinating priorities and scheduling with systems staff regarding requests for maintenance/user support and enhancements/modifications teams • Maintaining appropriate staffing levels to successfully support operations • Providing ongoing technical training in database administration and client/server methodologies • Overseeing computer operations, network administration, systems administration, and database administration • Serving as a liaison to state technical, management, and program staff • Controlling project scope and providing oversight of system changes • Ensuring system enhancements and modifications are completed on time and within budget • Developing project control and reporting procedures and managing changes in project work plans
Experience with system development and consultation. Cherie is often called upon by the state to attend business design meetings when the Department of PATH is looking to add a new program or service. Her extensive system and Vermont program knowledge provides the institutional knowledge that is required when making modifications and enhancements to a program as complex as the Vermont Medicaid program. Her knowledge of the VermontAIM allows her to offer consultation support that presents the most economical and beneficial method of implementing the desired change. Cherie provides oversight/approval of all proposed VermontAIM development/modifications and ensures that all requests are entered into the tracking system for documentation and audit purposes. Under her guidance, the Systems team has completed 1,971 modifications/enhancements to the system since 1995. Cherie is a member of the Vermont Health Access Transition Team (VHAT), which reviews all proposed budget/legislative changes for impact to the MMIS and provides suggestions for implementation. Most recently, Cherie has been working with the Global Clinical Record (GCR) project requirements team to assist in the definition of that project for the Department of PATH.	

Systems Manager **Cherie Bergeron**		
Experience with project implementation (timelines and costs). The following list provides you with an overview of Cherie's successful project implementation experience: • 1998 BusinessObjects Implementation, 20 manmonths, duration 9 months • 1999 Platform Upgrade Project, 35 manmonths, duration 13 months • 1999 Y2K Readiness, 30 manmonths, duration 8 months • 1999 PC*Plus* Implementation, 19 manmonths, duration 4 months • 2001 HIPAA Assessment, 23 manmonths, duration 6 months • 2001 General Assistance Program Implementation, 16 manmonths, duration 12 months • 2002 HIPAA Remediation, 195 manmonths, duration 10 months		
Ability to provide staff development and education. Cherie uses EDS' Individual Development Plan (IDP) career path program established for all technical staff, which includes the use of job family matrices to ensure consistency in promotion procedures and Systems team members' career growth. Several members of our Systems team have attended systems certification courses and are working towards full certification. In addition, Cherie ensures that all team members receive the 30 hours of mandatory EDS training in topics such as security, privacy, diversity, and leadership.		
Depth and breadth of knowledge of provider relations, health care policy and politics, government technology, and information management. Cherie has more than 17 years of Vermont Medicaid experience. She is well known by the Department of PATH partners and stakeholders for her attention to detail and intimate knowledge of both the MMIS and the Medicaid program. She has served as the provider manager, the claims manager, and the systems manager for the Vermont Medicaid account. Her well-rounded background in all facets of the MMIS and operations provides the Department of PATH with a most qualified and knowledgeable team member.		
Office of Vermont Health Access Mr. Robert Butts, Contracts Director 103 South Main Street Waterbury, Vermont 05676 802 241 3897 bobbutts@wpgate1.ahs.state.vt.us 2000 to Present	Office of Vermont Health Access Mrs. Gloria Jacobs, School-Based Health Services Supervisor 103 South Main Street Waterbury, Vermont 05676 802 241 2763 gloriaj@wpgate1.ahs.state.vt.us 1993 to Present	U.S. Department of Health and Human Services/ Office of Inspector General Mr. Frank M. Puleo, Special Agent Office of Investigation P.O. Box 1210 Burlington, Vermont 802 651 9622 fpuleo@oig.hhs.gov 1999 to Present

Program Services Manager **Valerie Lewis**	
Valerie has more than 20 years of experience in leadership, human resources, consulting, and organizational development. In addition, she has extensive experience in developing and providing services to state and local governments. She is highly skilled in identifying key customer needs and designing value-added solutions and services. Valerie continually demonstrates her strong business perspective and applies systemic thinking and creative solutions to business problems and opportunities. This experience and skill set, combined with her ability to successfully manage a wide array of personnel, best positions Valerie to manage the Program Services unit. In her work with organizational change, Valerie has created change strategies and practices that have assisted her customers in implementing large-scale business and system changes. With the support of a detailed change readiness assessment and project plan developed by Valerie's team, individual companies within a large United States utility holding company were able to successfully install and execute multiple new software applications on or before schedule with minimal transition problems. Valerie worked with one of the largest agencies of the United Kingdom government on a plan for improving process and technical efficiencies and enhancing leadership capabilities. Key objectives of the plan were to avoid a potential 25 percent staff layoff and demonstrate more effective leadership to avoid privatization of the agency. Both objectives were achieved.	Valerie's responsibilities as program services manager include: • Overseeing the provider help desk, provider enrollment, and provider representative teams • Educating the health care community on Medicaid policy, programs, and billing issues • Coordinating all written and verbal communications to providers, including letters, provider manuals, and newsletters • Developing annual provider training plans • Ensuring excellent customer service to Medicaid providers in a timely and efficient manner • Promoting education and outreach initiatives to the provider community • Representing EDS at the provider association meetings
Experience with system development and consultation. Valerie brings extensive consulting experience to her position as program services manager. In her most recent endeavor, Valerie consulted with information technology and business leadership on human and cultural aspects of change. She is experienced in developing strategic and operational plans to successfully manage change and achieve business goals.	
Experience with project implementation (time lines and costs). Valerie has many years of experience in implementing and integrating human performance into EDS strategic business units. She has served on the Competency Integration Steering Committee to ensure integration of all corporate human resource processes, practices, and tools. She played a key role in the creation of the EDS Asia Pacific Education and Training Centre. Additionally, Valerie has served as a project manager for the development and integration of human resource processes and tools.	

Program Services Manager **Valerie Lewis**		
Ability to provide staff development and education. Throughout her EDS career, Valerie has been dedicated to assisting EDS customers and internal business units with their human resource performance issues. She develops strategic and operational plans to help her customers manage change and obtain their goals and objectives. She has years of experience managing people, processes, and procedures. She is skilled at evaluating these procedures and processes and making recommendations on improvements. As an experienced practitioner in managing change and enabling organization transformation, Valerie has helped customers engage all stakeholders in enacting and supporting business and service improvements for their customers. In her role as director of Staff Development and Training for the Department of Social Welfare, Valerie was responsible for the training of all Department and related Agency staff in health and welfare program requirements and practices, technology applications, and business management and leadership skills.		
Depth and breadth of knowledge of provider relations, health care policy and politics, government technology, and information management. Valerie brings a unique blend of State of Vermont and EDS experience to her role as program services manager. She began her career with the Vermont Agency of Human Services, providing strategic planning support to Agency departments and programs and to the Office of the Governor. She then moved to the Department of Social Welfare, first as training specialist, and then as the director of Staff Development and Training. Valerie followed her experience in Vermont with health and welfare program service at the national level as a research analyst for the American Public Welfare Association. She analyzed government legislation and assessed its impact on state and local program operations. At EDS, Valerie continued her support for health and welfare programs through the development and provision of systems for Medicaid; Women, Infants, and Children (WIC); Child Support Enforcement; Mental Health; and related programs.		
State of Vermont Agency of Human Services Jane Kitchel, former Secretary P.O. Box 82 Danville, Vermont 05828 802 684 3482 janek45@hotmail.com April 1974 to December 1987	State of Vermont House of Representatives, Government Operations Cola Hudson, Chairman Box 511 Lyndonville, Vermont 05851 802 626 9428 January 1974 to present	State of Vermont Agency of Human Resources Department of Social Welfare Jennifer Trombley, former Training Director, Systems Manager N7375 910 Street River Falls, Wisconsin 54022 715 425 0774 jtromb1@aol.com January 1977 to December 1987

Resumes or Vitae

RFP Reference: 3.2.2.8.3, p. 3-12

The Department of PATH will benefit from our experienced operations staff. Our proposed management and key staff have strongly demonstrated the motivation, experience, and vision that enable them to successfully lead the Operations Phase of the MMIS. We are the most qualified vendor to strategically align the current organizational structure with the Takeover, Operations, and Enhancements/Modifications Phases of the new contract.

The subsequent pages contain the resumes for the following proposed key management staff based on the relationship of their past experience to their proposed responsibilities under this contract for the Operations Phase:

- Client Delivery Executive Barbara Davis—26 years of Vermont Medicaid experience, including significant cost containment and quality management activities
- Systems Manager Cherie Bergeron—17 years of Vermont Medicaid experience, including extensive systems management activities
- Program Services Manager Valerie Lewis—More than 20 years of leadership, human resources, consulting, and organizational development experience

We included a representative resume for the claims manager position. Barbara Davis is currently interviewing candidates for this position and expects to fill it by contract signing.

The resume for Enhancements/Modifications Manager Sean Daly is located in the "Resumes or Vitae" subsection of the "Project Organization and Staffing (Enhancements/Modifications)" section. The chart on the following page illustrates the key leaders' collective years of experience in the categories that the RFP requires.

Key Personnel Years of Required Experience

Required Experience	Barbara Davis	Cherie Bergeron	Valerie Lewis	**Sean Daly	All Key Personnel
EDS	22	17	20	13	**72**
Management	30	15	15	5	**65**
Medicaid claims processing systems	27	17	8	7	**59**
Client/server non-mainframe systems	12	10	10	12	**44**
Table- and Web-based applications	12	10	6	12	**40**
Application interface design and implementation	22	7*	NA	12	**41**
Transfer, modification, and implementation of an MMIS	28	7*	5	7	**47**
Medicaid provider relations	18	6	8	NA	**32**
Other medical claims processing systems	9	NA	9	1	**19**
Governmental information technology projects	27	NA	12	7	**46**

* In management oversight capacity only
** See the Enhancements/Modifications Project Organization and Staffing section for Sean's resume and career summary.

Barbara Davis

Client Delivery Executive

In supporting The Department of PATH in its vision for the future, my objective is to integrate all new functions and technologies without disruption of service to beneficiaries, providers, or the state. I will coordinate the leadership team's skills and energy to meet the state's objectives and ensure a successful implementation of the new enhancements.

I will continue to build on our established project, change, and operational management processes in three ways:

- *Enhanced customer interaction and communication to mirror the Department of PATH's program management objectives*
- *Managing teams with unsurpassed knowledge and experience of the Vermont program to focus on quality service to providers and clients*
- *Strong program management methods and tools for consistent, repeatable processes and responses*

Barbara Davis is the client delivery executive for EDS' contract to provide Medicaid fiscal agent services for Vermont. Barbara has supported the Vermont account for more than 20 years, leading the initiative for the last 14 of those years. As the client delivery executive, she currently oversees the EDS team of 65 on-site and 9 off-site staff supporting the VermontAIM. In addition to being a valued resource to OVHA, Barbara's program and MMIS knowledge has enabled her to provide program management assistance and consulting expertise to other EDS Medicaid and Medicare projects and to the Canadian health care system.

Key Medicaid Experience

During her 21-year relationship with OVHA, Barbara led the successful implementation of the MMIS' client/server open system. This system was the first of its kind in the nation. In addition, she later oversaw a complete platform upgrade, including both hardware and software, that improved overall system performance by more than 36 percent. Barbara's program management career spans the implementation of three separate MMIS systems for OVHA. The first system implementation was with Blue Cross and Blue Shield Vermont Medicaid, when she relocated to Vermont from New Hampshire as the first Vermont MMIS was implemented in 1976. In 1981, when EDS was selected as the new fiscal agent, Barbara was hired by EDS to oversee the successful implementation of the claims processing components of the new legacy Vermont MMIS that was implemented on time and within budget. In 1992, when OVHA's vision was a state-of-the-art client/server system, Barbara led this successful effort, and again the system was implemented on time and within budget. Her skills and experience provide OVHA with a solid foundation to enhance current infrastructure and support program growth.

Throughout the years, Barbara's efforts have led to significant cost savings for the state. In 2002 alone, Barbara led a team of drug rebate recovery specialists in recovering more than $23 million dollars in drug rebate dollars. During the past six years, the specialists recovered a total of more than $81 million, increasing recoveries each year. When the state asked EDS to help identify cost savings, Barbara added a staff pharmacist to work with our drug rebate team to identify additional recovery methodologies. This pharmacist has led our team in implementing J-code processing and a more targeted approach to dispute recoveries, leading to more than $700,000 in additional recoveries during the current state fiscal year. As a result of Barbara's 2002 cost containment initiative on behalf of OVHA, to define money-saving system and processing changes, the account team has identified more than $5.6 million in cost savings ideas, many of which have been implemented.

In addition to continually evaluating and improving the way in which Vermont's Medicaid dollars are spent, Barbara designed and implemented the Quality

Improvement Process (QIP) that has led to significantly improved account productivity through the identification of “bottlenecks” in work flows and the streamlining of key processes and functions. This improved performance has led to higher client satisfaction as evidenced by the most recent client satisfaction survey, which awarded the account the highest rating available. The QIP process has since been rolled out in other state Medicaid programs across the nation with similar success. She also coordinated a multistate effort to address the HIPAA assessment of the Vermont MMIS to ensure OVHA meets the numerous requirements and time line for HIPAA compliance.

Career Feature

Barbara has been a leader in encouraging her employees to give back to the community in which they live and work. Her staff consistently volunteers in the community; participates in local school mentorship programs; and is actively involved in the United Way, March of Dimes, and Red Cross blood drives. Barbara fully supports her team’s community efforts and has served as the Barre Distribution Coordinator for the SERVE, a food for the needy program, since 1996. In 1999 and 2001, Barbara was awarded the prestigious EDS Leaders Inner Circle award for her contributions to OVHA and to the Vermont Medicaid account. The account’s outstanding performance was attributed to the high client satisfaction achieved in customer surveys, improved processing metrics when compared to peer accounts, and for high employee satisfaction ratings in EDS’ annual employee satisfaction surveys.

Barbara demonstrates the optimism and willingness to embrace change that is required in this fast-paced environment and serves as a positive role model to her team. She and her team ensure EDS will do what it takes to get the job done.

EDS Experience

Client Delivery Executive, Vermont Medicaid Account .....January 1987 to Present
EDS has provided Medicaid fiscal agent services for Vermont's Agency of Human Services since October 1981.

- Leads the EDS workforce of 74 people (65 on-site and 9 off-site) acting as the Medicaid fiscal agent for Vermont under a 12-year agreement
- Oversees all fiscal agent services, including claims processing, call center, MMIS system life cycle support, data warehousing, drug rebate processing, third-party liability, provider enrollment, and extensive management reporting
- Ensures EDS team meets all contractual requirements and focuses the team on achieving OVHA goals
- Supports new program initiatives and legislative changes through allocation of staff and resources to new program enhancements and modifications
- Coordinates with other Medicaid accounts to leverage each team's best practices in support of OVHA
- Initiates cost savings and cost containment activities in support of OVHA's budget reduction actions
- Assists other EDS Medicaid fiscal agent accounts with system testing, financial and operational performance reviews, and MMIS implementations

Claims Administration Manager, Vermont Medicaid Account .....May 1982 to January 1987
EDS has provided claims processing services for Vermont since October 1981.

- Managed team of 23 EDS employees responsible for processing Medicaid claims, including areas such as mail room, data entry, resolutions, medical policy, adjustments, and quality improvement, in meeting all contractual requirements and quality goals
- Reduced the manual effort required to resolve claims by 45 percent through the implementation of online worksheets
- Initiated the first EDS "National Data Entry" competition and worked with 17 accounts across the United States to lead this effort, improving Vermont's data entry performance and productivity

Claims Processing Supervisor, Vermont Medicaid Account ..... August 1981 to May 1982
EDS has provided claims processing services for Vermont since October 1981.

- Supervised team of 18 claims processors responsible for all Medicaid claim types
- Implemented the first integrated "whole person" claims processing concept, where one employee would oversee a claim from keying to resolution further improving claims processing accuracy and turn around time
- Reduced error percentage to less than one percent and improved productivity by 18 percent using the new whole person concept

Claims Processing Supervisor, Vermont Blue Cross and Blue Shield .....June 1976 to August 1981
Vermont Blue Cross and Blue Shield provided Medicaid claims processing services from July 1976 to September 1981.

- Supervised staff for 16 claims operations departments, establishing unit goals and objectives, and ensuring timely Medicaid claims adjudication
- Programmed the Univac CADE system
- Recognized in *Computerworld* magazine for implementation of data entry motivational productivity improvements

Data Entry Supervisor, New Hampshire Blue Cross and Blue Shield.....September 1971 to June 1976
New Hampshire Blue Cross and Blue Shield provided Vermont claims processing services from September 1971 to June 1976.

- Supervised and trained a staff of seven Vermont data entry operators who worked at the New Hampshire account supporting Vermont's human services program
- Designed, programmed, and tested all Vermont MMIS data entry application programs
- Directed the implementation of the tape-to-tape billing education and training

Education and Training

EDS University Leadership Curriculum—more than 650 hours in leadership training, including customer service and interaction, project management and planning, business development and process modeling, requirements definition, and continuous performance improvement

Lakes Region Chamber of Commerce Leadership Champlain Curriculum, 1999 to 2000

Attended Norwich University—Management Essentials, 1978

Cobol Programming, 1979

References

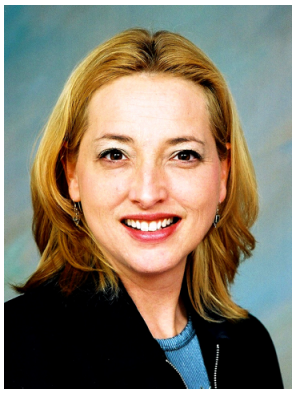
Mr. Paul Wallace-Brodeur
Medicaid Director
Office of Vermont Health Access
802 241 2156

Mr. Robert Butts
Contracts Director
Office of Vermont Health Access
802 241 3897

Ms. Barbera Bridgewater
Chief Executive Officer
FOUR**THOUGHT**GROUP
602 340 8450

Cherie Bergeron

Systems Manager



The VermontAIM is the heart of many of the functions we perform for the program. As I have watched the Vermont program evolve, it has given me great pleasure to be able to assist the state, providers, and other stakeholders during the many transitions. I look forward to continuing to support these efforts by:

- *Offering guidance and direction during system and program changes*
- *Being consistently available*
- *Accessing necessary data*
- *Using the VermontAIM flexibility to supply the most appropriate solution to the changing needs of the MMIS*

Cherie Bergeron is the systems manager for EDS' contract to provide Medicaid fiscal agent services for Vermont. Cherie has supported the Vermont account for the past 17 years in a variety of roles, including claims operations management, provider services management, supervisory, and administrative roles. She currently oversees an EDS systems team of 13 on-site staff and nine off-site staff members supporting the state. This team includes systems engineers, systems administrators, database administrators, system operators, local area network (LAN)/desktop administrators, and support personnel to provide maintenance and modification support of the MMIS applications. Her extensive system and Vermont program experience provides the institutional knowledge that is required when making modifications and enhancements to a program as complex as the Vermont Medicaid Program.

Key Medicaid Experience

Cherie's Vermont-specific systems knowledge was responsible for EDS' successful Y2K transition, resulting in an award from CMS for our diligent performance. She most recently led the team in the full MMIS HIPAA Assessment and is currently overseeing the on-time HIPAA remediation of the VermontAIM.

The following list provides an overview of Cherie's successful project implementation experience:

- 1998 BusinessObjects Implementation
- 1999 Platform Upgrade Project
- 1999 Y2K Readiness
- 1999 PC*Plus* Implementation
- 2001 HIPAA Assessment
- 2001 General Assistance Program Implementation
- 2002 HIPAA Remediation

Cherie provides oversight and approval of all proposed MMIS development and modifications and ensures that all requests are entered into the tracking system for documentation and audit purposes. Under her guidance, the systems team has completed 1,971 modifications and enhancements to the system since 1995. Cherie is a member of the Vermont Health Access Transition Team (VHAT), which reviews all proposed budget/legislative changes for impact to the MMIS and provides suggestions for implementation. Most recently, Cherie has been working with the Global Clinical Record (GCR) project requirements team to assist in the definition of that project for the Department of PATH.

Career Feature

Cherie is a prime example of the career opportunities provided by EDS. She joined the Vermont account staff in 1985 as a data entry operator. Her excellent work ethic and team spirit brought continuous opportunities for professional growth. Cherie has served as the systems manager for EDS' Medicaid account for the past eight years and has supported the Vermont account during the past 17 years in a variety of roles.

Each year during the annual legislative session, Cherie is the primary contact for the state. Her in-depth knowledge of the system provides guidance and direction for proposed annual legislative changes. Six program changes were approved for implementation during the legislative session of 2002. Upon final notification of these changes, Cherie fully assessed the system flexibility and supplied the state with recommendations to meet the two-week implementation deadline assigned to these changes while maintaining uninterrupted service to all stakeholders.

In April 2000, Cherie accompanied Paul Wallace-Brodeur and Medical Director Joe Jacobs to evaluate the Physician Pharmacy Education Project in Maine to determine the feasibility of replicating this program in Vermont. As a result of this evaluation, Cherie worked with the medical director to design a similar profile report. Cherie then developed and implemented a quarterly process to provide primary care providers with a drug profile for each of their patients. Each profile contains clinical information for the primary care provider to assist them in managing their patients.

In June 2000, Cherie was awarded the commissioner's Quality of Service Award for the implementation of the PC*Plus* program. This award was presented to the Transition and Enrollment Team for PC*Plus,* of which Cherie was the key member for EDS. Cherie's contributions to this effort included participation in all status, design, and implementation planning meetings; MMIS requirements definition; generation of computer service requests; work plan staffing; and project development oversight. Cherie attended regular ongoing meetings with the state and other stakeholders to ensure a smooth transition. Under her direction as the previous claims administration manager, her claims operations department consistently exceeded all claim processing timeliness standards, which contributed to the 1991 recognition of Vermont as being number two in the nation in claims processing timeliness by *Modern Healthcare* magazine.

EDS Experience

Systems Manager, Vermont Medicaid Account .....January 1995 to Present
EDS has provided fiscal agent services for Vermont's Agency of Human Services since October 1981.

As the systems manager, Cherie oversaw the following implementations:

- Upgrade of the Provider Electronic Solutions software, which is available to all providers for use in billing Vermont Medicaid
- Implementation of Vermont Medicaid Managed Care and Primary Care Case Management (PCCM) programs
- Implementation of state-only pharmacy program (Vscript), which includes claim processing and drug rebate processing
- MMIS platform upgrade, including both hardware and software upgrades, to improve overall system performance by more than 36 percent
- Implementation of Vermont's SCHIP waiver program, which processed more than $27 million worth of claims during the first year of operations
- Automation of General Assistance (GA) claims processing. Integrating the GA claims into the VermontAIM infrastructure automated the manual processes required to administer this program, reduced the state's administrative expense to manage this program, and increased reporting and editing capabilities.
- Coordination of annual Statistical Analysis System-70 (SAS-70) audits
- Implementation of prospective Drug Utilization Review (proDUR) modifications, which resulted in an annual savings of $1.6 million in drug expenditures for the state
- Vermont HIPAA project, a multistate effort that includes both assessment and remediation of the Vermont MMIS to ensure the OVHA will be prepared to meet the federal time frame for HIPAA implementation

Claims Administration Manager, Vermont Medicaid Account .....December 1988 to January 1995
EDS has provided claims processing services for Vermont since October 1981.

- Managed a team of 18 claims operations department staff members responsible for processing Medicaid claims, including mail room, data entry, resolutions, medical policy, and research units
- Worked closely with Medicaid program officials to ensure that the claims operations department complied with applicable state and federal regulations and program policies
- Obtained the necessary documentation to support the Federal System Performance Review (SPR) and worked directly with the federal SPR auditors as the primary contact
- Implemented productivity performance measures that included purchasing a new microfilm device with automated functions for the mail room
- Assisted with the implementation of front-end claims force and denial capability for the data entry staff

Administrative Assistant, Vermont Medicaid Account.....September 1987 to December 1988
EDS has provided claims processing services for Vermont since October 1981.

- Maintained all personnel files and appropriate documentation
- Responsible for all accounting functions, including entering accounts receivable into the automated Accounts Receivables Invoice Control System (ARICS), accounts payable, monthly bank reconciliations, and weekly Medicaid draw processing
- Organized Meeting Get-Together with the Department of Social Welfare (DSW), EDS, and the Office of Government Affairs; prepared minutes to document key customer meetings

Data Entry Supervisor, Vermont Medicaid Account .....September 1986 to September 1987
EDS has provided claims processing services for Vermont since October 1981.

- Monitored a staff of data entry clerks to ensure timely and accurate data processing
- Trained staff on the IBM System 34 data entry system
- Assisted the Systems department by performing nightly transmission and backup procedures

Data Entry Operator, Vermont Medicaid Account..... October 1985 to September 1986
EDS has provided claims processing services for Vermont since October 1981.

- Responsible for data entry for all 11 claim types
- Assisted in the data entry and resolution of nursing home claims
- Assisted in the adjudication of nursing home retroactive rate adjustments

Education and Training

Associate Degree in Computer Science; 1984; Hesser College; Manchester, New Hampshire

References

Mr. Robert Butts
Contracts Director
Office of Vermont Health Access
802 241 3897

Mrs. Gloria Jacobs
School-Based Health Services Supervisor
Office of Vermont Health Access
802 241 2763

Mr. Frank M. Puleo
Special Agent Office of Investigation
U.S. Department of Health and Human Services/Office of Inspector General
802 651 9622

Valerie Lewis

Program Services Manager

I will leverage my extensive business, consulting, and management experience to provide service excellence to the Department of PATH, the providers, and other stakeholders in the Vermont Medicaid Program. The Program Services team will develop and sustain professional partnerships with all providers through:

- *Proactive education, training, and program information*
- *Ongoing communications*
- *Timely resolution of all provider issues*

We will work with the Department of PATH and the rest of the EDS team to continually leverage best practices and innovative solutions on behalf of all Vermont Medicaid stakeholders.

Valerie Lewis is the program services manager for EDS' contract to provide Vermont Medicaid fiscal agent services. She has more than 20 years of experience in leadership, human resources (HR), consulting, and organizational development. In addition, she has extensive experience in developing and providing services to state and local governments. She is highly skilled in identifying key customer needs and designing value-added solutions and services. Valerie continually demonstrates her strong business perspective and applies systemic thinking and creative solutions to business problems and opportunities. This experience and skill set, combined with her ability to successfully manage a wide array of personnel, best positions Valerie to manage the Program Services unit.

Key Experience

Valerie brings a unique blend of state of Vermont and EDS experience to her role as program services manager. She began her career with the Vermont Agency of Human Services, providing strategic planning support to Agency departments and programs and to the Office of the Governor. She then moved to the Department of Social Welfare, first as a training specialist, and then as the director of staff development and training. In that role, she was responsible for the training of all Department and related Agency staff in health and welfare program requirements and practices, technology applications, and business management and leadership skills.

Valerie followed her experience in Vermont with health and welfare service programs service at the national level as a research analyst for the American Public Welfare Association. She analyzed government legislation and assessed its impact on state and local program operations.

At EDS, Valerie continued her support for health and welfare programs through the development and provision of systems for Medicaid; Women, Infants, and Children (WIC); child support enforcement; mental health; and related programs.

In addition to this extensive experience in state and local government and in health and welfare systems and services, Valerie has comprehensive experience in supporting people development and training to audiences from the boardroom to the call center. She has developed, designed, and delivered training across industry groups, cultures, and organizational levels and to multiple constituencies globally.

Throughout her EDS career, Valerie has been dedicated to assisting EDS customers and internal business units with their human resource performance issues. She develops strategic and operational plans to help her customers manage change and obtain their goals and objectives. She has years of experience managing people, processes, and procedures. She is skilled at evaluating these procedures and processes and making recommendations on improvements.

As an experienced practitioner in managing change and enabling organizational transformation, Valerie has helped customers engage all stakeholders in enacting and supporting business and service improvements for their customers. This experience with effectively managing relationships among multiple partners in a business or government program will enable Valerie to work effectively with the many providers participating in the Vermont Medicaid Program.

Career Feature

In her work with organizational change, Valerie has created change strategies and practices that have assisted her customers in implementing large-scale business and system changes. With the support of a detailed change readiness assessment and project plan developed by Valerie's team, individual companies within a large U.S. utility holding company were able to successfully install and execute multiple new software applications on or before schedule with minimal transition problems.

Valerie worked with one of the largest agencies of the U.K. government on a plan for improving process and technical efficiencies and enhancing leadership capabilities. Key objectives of the plan were to avoid a potential 25 percent lay-off of staff and demonstrate more effective leadership to avoid privatization of the agency. Both objectives were achieved.

Working with a transportation services organization, Valerie provided strategic planning, leadership, and team building services to the executive and key leaders. As a result of this work, a leadership team was developed that was able to improve business processes and quality of service, raise employee morale, and reduce operational expenses.

EDS Experience for Valerie Lewis

Senior Consultant and Service Delivery Leader,
Business Process Innovation Services ..... August 1997 to Present
Consultant and service delivery leader for multiple customers such as Texas Utilities, Systems Technology Management, and Western Kentucky Energy.

- Oversees the delivery of human performance, organizational change management, and business process transformation services to commercial and government customers
- Conducts organizational change readiness assessments and works with information technology and business leadership on human and cultural aspects of change. Develops strategic and operational plans to successfully manage change and achieve business goals.
- Provides business consulting and solutions to streamline business processes, reduce costs, improve customer and provider satisfaction, and enhance service delivery
- Applies best practices and innovative procedures to customer business, management, and technical operations
- Develops and implements communication and education strategies for customer constituencies

Workforce Development Consultant, Technical Development .....September 1993 to August 1997
Consultant for multiple EDS customers and internal organizations across the globe.

- Directed EDS business units and internal clients in the development of HR and change plans aligned to strategic business direction. Consulted on HR, leadership, business improvement, and change management best practices.
- Developed strategies and business plans for creation of the EDS Asia Pacific Education and Training Centre. Established the centre in Adelaide, South Australia, as part of the start-up of an EDS organization serving the Government of South Australia. Transitioned government employees to EDS.
- Assessed the leadership and workforce capabilities of a key agency of the government of the United Kingdom and developed recommendations for leadership and staff initiatives in support of the strategic business plan
- Analyzed HR processes and procedures for a South Korean company. Designed and negotiated a two-year HR restructuring and change management project to develop and implement HR practices consistent with the needs of a global business.
- Adapted U.S.-developed leadership courses to the business and cultural requirements of six countries, including redesigning the delivery mechanism

Human Resource Business Analyst, Leadership Design Lab ..... October 1991 to September 1993
Developed, piloted, and applied competency-based HR training and tools for EDS globally.

- Researched, developed, and tested integrated competency-based HR and leadership development programs. Served on the Competency Integration Steering Committee to ensure integration of all corporate HR processes, practices, and tools.
- Created training program for leaders on applications of all competency-based HR processes and tools
- Served as the project manager for development and integration of processes and tools resulting in the on-time completion of all project components

Leadership and Business Skills Instructor, Leadership Development.....July 1989 to October 1991
Developed and taught EDS leadership and professional skills courses for EDS business managers and supervisors.

- Developed, customized, and taught leadership and professional skills courses. Taught progression of leadership from supervisory to account and business unit levels.
- Managed the Account Leaders Program for the Eastern Region in Herndon, Virginia

Account Services Manager, Corporate Communications ..... May 1988 to July 1989
Provided business communications support for all of EDS' government business.

- Managed staff of account service representatives responsible for providing business communications expertise and services to business units

Business Development Consultant, Government Technology.....January 1988 to May 1988
Provided consultative support for the government sales staff.

- Developed business opportunities and strategies in support of sales staff

Sales Support Manager, State and Local Government.....February 1986 to December 1987
Provided sales support for EDS State and Local Government division.

- Managed the development of all technical business proposals for EDS State and Local Government division

Product Manager, Human Services..... January 1985 to February 1986
Provided market presence in health and welfare programs of the human services industry.

- Developed EDS' market presence and business development strategy in selected segments of the human services industry
- Applied industry knowledge to help develop EDS' system and services

Director of Program Development, Health and Welfare Systems.....October 1983 to December 1984
Sold health and welfare systems and services to state and local governments throughout the U.S. from 1983 to 1984.

- Sold EDS health and welfare systems and services
- Managed marketing of specific health care systems

Other Relevant Experience

Program Manager, U.S. Department of Agriculture, Graduate School Executive,
Management and Supervisory Training.....May 1982 to October 1983

Provided leadership and management skills training to executives, managers, and supervisors.

- Managed the development, delivery, and marketing of training programs for executives, managers, and supervisors

Senior Research Analyst and Project Manager,
American Public Welfare Association..... June 1981 to May 1982
Researched and analyzed government legislation impacting state welfare programs.

- Researched and analyzed impact of government and regulatory changes on state and local human service programs
- Developed regional education and conference strategy for Association programs

State of Vermont, Agency of Human Resources.....April 1974 to June 1981
Provided training and human resources services to the state of Vermont.

- As the director of staff development and training, managed all training and staff development programs for state department and provided development support to related human service agencies
- As a staff development and training specialist, designed and delivered training programs for all staff levels within Department of Social Welfare and related human service programs
- As the assistant state planner, developed, implemented, and evaluated plans for integrating human service delivery at local and regional levels. Served as special assistant to Secretary of Human Services and provided policy and communications support to the Office of the Governor.
- As a planning and evaluation associate, managed the project to establish the management information system for state alcohol and drug abuse programs

Adjunct Instructor, University of Vermont and Community College of Vermont.....1981 to 1982

- Taught counseling and communications skills to undergraduate and graduate level students

Education and Training

Bachelor of Arts Degree in History and Political Science, Summa Cum Laude; 1973; University of Vermont; Burlington, Vermont

Graduate work in organizational development and human resources; University of Vermont; Burlington, Vermont

Continuing professional education in consulting, leadership, organizational development, training, and human resources

References

State of Vermont
Agency of Human Services
Jane Kitchel, former Secretary
P.O. Box 82
Danville, Vermont 05828
802 684 3482

State of Vermont
House of Representatives,
Government Operations
Cola Hudson, Chairman
Box 511
Lyndonville, Vermont 05851
802 626 9428

State of Vermont
Agency of Human Resources
Department of Social Welfare
Jennifer Trombley, former Training
Director, Systems Manager
N7375 910 Street
River Falls, Wisconsin 54022
715 425 0774

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Representative Resume

Claims Manager

EDS commits to hiring a fully qualified claims manager to lead the Claims Operations Department. This department comprises the mail room, data entry, resolutions, third-party liability (TPL), adjustments, and medical policy units and employs 26 individuals. The claims manager we hire will have health care claims administration experience, previous claims management experience, and the leadership skills necessary to manage a department of this size. The experience below shows a representative sample of the leadership qualities and claims management skills that we will provide for this position.

Experience

Claims Processing Manager, TennCare Account ..... 1999 to Present
EDS has operated and maintained TennCare's Management Information System (TCMIS) since October 1995.

- Manages the claims operations staff with oversight for mail room, data entry, adjustments, file maintenance resolution, and TPL
- Plans, directs, and coordinates the activities related to the TennCare managed health care system
- Responsible for compensation, primary care physician (PCP), and budgetary cost containment ideas

Operations Support Supervisor, TennCare Account.....1995 to 1999
EDS has operated and maintained TennCare's TCMIS since October 1995.

- Responsible for oversight of the data entry, premium, resolution, file maintenance, and enrollment teams
- Coordinated operational activities with multiple EDS groups, state entities, and vendors
- Monitored projects from inception to final mailing
- Provided technical and health care-related direction to the staff
- Ensured that state and federal guidelines and procedures were followed

Medicaid Specialist I, TennCare .....1986 to 1995
The Tennessee Department of Health/TennCare has operated the Tennessee Medicaid Program since 1969.

- Served as the resolutions liaison for the Information Services area with the fiscal agent's resolutions staff
- Worked directly with the fiscal agent, monitoring claims processing for timeliness and system anomalies
- Responsible for resolution of complex claims that required special handling

Mailroom Supervisor, TennCare Account.....1982 to 1984
EDS provided facilities management services in support of the Tennessee Medicaid Program beginning in 1982.

- Managed document preparation, screening, sorting, batching, and filming for numerous types of forms, including the management of a comprehensive micrographics process
- Managed the remittance advice (RA) and check mailing process, monitored courier and van activities, and prepared the monthly postage report
- Maintained and monitored inventory control of envelopes and forms for internal and outside vendor use

Education and Training

Bachelor of Science Degree; 1980; Tennessee State University; Nashville, Tennessee

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Staff Responsibilities

RFP Reference: 3.2.2.8.4, p. 3-14

The following table identifies proposed staff positions for the Operations Phase and describes their anticipated responsibilities and qualifications.

Staff Responsibilities

Position/Title	Job Description	Qualifications
	Administration	
Client Delivery Executive Barbara Davis	• Oversees the entire fiscal agent services contract during all phases • Ensures that all contract requirements are met • Brings innovation and "best practices" from the collective EDS accounts to the customer organization • Serves as the primary contact for the director of the Department of PATH/OVHA and EDS corporate leadership • Facilitates weekly Medicaid fiscal agent meetings • Attends other Department of PATH meetings as requested • Acquires the personnel resources required to fulfill contractual obligations • Reviews weekly quality/operational reports to assess current operations performance • Reviews corrective action plans as needed • Conducts weekly status meetings with leadership staff • Establishes and communicates the account vision and goals to all project staff • Emphasizes the importance of all levels of the organization operating as a quality-driven unit • Emphasizes the importance of responding to customer requests in a courteous, timely, and informative manner • Develops and maintains a contingency plan for adequate backup and recovery for vital operations • Directly mentors and coaches the managers of each functional area	• Demonstrated leadership skills • Proven people and career path development skills • Strong analytical skills • Record of accomplishment • Excellent written and verbal communication skills • Strong presentation and community affairs skills • Superior customer relations skills • Extensive knowledge and experience in Medicaid or other large-scale health care organizations

Position/Title	Job Description	Qualifications
Administrative Assistant	• Handles account benefits • Coordinates account travel • Completes corporate and hiring paperwork • Maintains employee files and conducts new employee orientation • Responsible for account invoice processing, balancing of the management and administrative reporting subsystem (MARS) to financial, bank reconciliation of disbursement account, client invoicing and tracking, Health Insurance Premium (HIPP) check processing, tax assessment check processing, and weekly verification of bank deposits • Attends customer meetings • Sends the Weekly Status Report to OVHA	• Detail oriented • Excellent organization skills • Strong administrative business office procedures • Excellent written and verbal communication skills • Executive-level interface capabilities • Good customer relations skills • Strong working knowledge of various software products, including Microsoft Word, PowerPoint, Excel, and Outlook
Receptionist	• Answers all telephone calls within three rings • Greets visitors • Enters account invoices for approval • Completes the Weekly Status Report, daily bank deposit slips, and tax assessment documents • Maintains accurate files for status and invoices	• Strong multitasking skills • Professional appearance and attitude • Excellent written and verbal communication skills

Position/Title	Job Description	Qualifications
Physical Therapist/ Occupational Therapist (PT/OT) Clinician (OVHA Office)	• Responsible for knowledge of all operative, office, and procedural records to determine correct coding and to verify medical necessity of equipment dispensed • Serves as a liaison with the provider community for medical review, including the OVHA physician consultant • Serves as a medical resource for OVHA and internal employees; helps establish policy • Reviews documentation and provides prior authorization for specific items • Interprets OVHA guidelines, policy, and regulations • Educates providers on proper billing and reimbursement procedures • Educates OVHA staff on use of prior authorization screens • Responsible for manual pricing	• Extensive clinical experience • Graduate degree from an accredited physical therapy program • Must have current Vermont license and meet any additional qualifications as stated in the Vermont requirements
Financial Coordinator/ Accountant	• Possesses thorough knowledge of accounting policies and procedures • Ensures proper recording of financial transactions • Reviews, prepares, and analyzes financial, statistical, and analytical reports • Uses automated financial modeling tools • Reviews financial statements, trends, and variances • Interacts with customer, management, operational, and financial staff on financial issues • Coordinates financial reporting, budgeting, and outlooking • Coordinates and reviews customer invoicing to ensure proper billing • Completes routine accounting functions, such as monthly close, journal entries, balance sheet reconciliations, audit, and tax package reporting • Ensures compliance with generally accepted accounting principles (GAAP) and contractually required federal and state reporting requirements	• Educated and experienced in accounting practices • Proficient in automated financial modeling tools • Detail oriented • Excellent written and verbal communication skills • Excellent organizational skills • Ability to coordinate activities with multiple entities • Excellent analytical and problem-solving skills • Strong multitasking skills

Position/Title	Job Description	Qualifications
Cash Coordinator (OVHA Office)	• Researches and enters all TPL cash and writes off remaining balances • Sends checks to be deposited to EDS TPL coordinators • Responsible for retroactively billing health insurance companies for newly accounted for policies using cost avoidance criteria • Reviews trauma data report supplied by EDS and sets up cases to be pursued • Sets up criteria for casualty process thresholds • Initiates changes to criteria to cost avoidance screens and processes and reviews impact of changes • Works the Suspect Report and enters information into the system • Reports TPL information monthly, including recoveries, write-offs, billed amounts, and balancing MAR to TPL • Works with systems engineers and customer to complete customer service requests (CSRs), production logs (Plogs), and special requests	• Thorough understanding of TPL operations • Excellent written and verbal communication skills • Excellent analytical and problem-solving skills • Minimum of associate's degree and experience in similar corporate environment • Strong personal computer skills

Position/Title	Job Description	Qualifications
HIPAA Compliance Officer	• Gains approval of and publishes all HIPAA privacy and security policies and procedures • Trains account staff on HIPAA privacy and security regulations, policies, and procedures • Performs internal audits of security and privacy procedures • Ensures that security and privacy incident reporting is addressed by management and that OVHA is informed • Establishes written plan and process for addressing security and privacy policy issues • Develops a configuration management plan, and grants and rescinds promotion/migration security levels • Oversees and reviews all system security changes, modifications, and deletions	• Knowledge of HIPAA codes and transactions requirements • Experience in the implementation of HIPAA within a state Medicaid program environment • Excellent project management skills • Experience with state Medicaid programs • Knowledge of HIPAA solutions regarding translators • Ability to plan, organize, and schedule tasks • Demonstrated leadership experience
HIPAA Business Analyst	• Sends out and records receipt of trading partner agreements and business agreements • Maintains documentation supporting agreement files • Answers questions from trading partners and OVHA staff regarding status of agreements • Follows up on security and privacy issues and ensures that all staff members are aware of regulations and policies	• Knowledge of HIPAA codes and transactions requirements • Experience with state Medicaid programs • Ability to plan, organize, and schedule tasks

Position/Title	Job Description	Qualifications
	Program Services Unit	
Program Services Manager Valerie Lewis	• Responsible for educating the health care community on Medicaid policy, programs, and billing issues • Responsible for management of provider help desk, provider enrollment, and provider representatives • Coordinates all written and verbal communication to providers, including letters, provider manuals, and newsletters • Ensures the maximization of Web technologies for improved communication, training, provider feedback, and access to information • Coordinates training of state staff, account staff, and providers to include scheduling of multiple training sessions • Develops training material, curriculum, and training reports • Responsible for provider services budget • Responsible for ensuring excellent customer service to Medicaid providers in a timely and efficient manner	• Demonstrated leadership skills • Strong analytical and problem-solving skills • Strong presentation and community affairs skills • Superior customer relations skills • Extensive knowledge and experience in Medicaid or other large-scale health care organizations
Provider Enrollment Specialist	• Coordinates new enrollment and recertification of providers into all Medicaid programs • Responsible for sending and processing enrollment applications and reviewing all applications for content and accuracy • Responsible for file maintenance and filing • Communicates with providers on enrollment issues	• Thorough understanding of provider enrollment procedures • Excellent written and verbal communication skills • Excellent organizational skills

Position/Title	Job Description	Qualifications
Provider Representative	• Trains providers on billing issues by conducting field visits and provider workshops • Attends provider association meetings as an EDS/Medicaid representative • Researches provider issues • Produces bimonthly advisory, fee schedules, and billing manuals	• Experienced liaison • Excellent written and verbal communication skills • Excellent organizational skills
Provider Services Telephone Analyst	• Answers all incoming telephone calls from providers • Provides quality customer service to providers and resolves billing issues • Researches and pulls claims, answers written inquires, and reviews dead claims • Supports eligibility verification point of service (POS) and offers provider training over the telephone	• Excellent written and verbal communication skills • Professional attitude
SCHIP Representatives	• Trains schools and supervisory unions on billing and related changes • Conducts provider workshops • Attends Department of Education staff meetings • Conducts provider visits to schools in representative territory • Attends bimonthly SCHIP meetings • Conducts various school work group meetings • Assists billers with electronic claims submission • Produces SCHIP provider manuals • Researches school billing issues • Trains providers on proper claims submission guidelines • Produces ad hoc reports as needed	• Thorough understanding of electronic claims submission process • Excellent written and verbal communication skills • Strong leadership skills

Position/Title	Job Description	Qualifications
Publications Coordinator	• Researches provider issues and responds to their requests • Works closely with OVHA staff to ensure legislative changes are implemented timely • Works with OVHA policy chief to post provider information on the Web • Designs and develops provider mailings and obtains OVHA approval of content • Works with OVHA staff to maintain, update, publish, and post provider manuals to the Web • Assists with research for provider representative staff members who visit providers	• Experience in building and maintaining Web pages • Excellent organizational skills • Excellent written and verbal communication skills • Technical writing experience
Systems Unit		
Systems Manager Cherie Bergeron	• Provides overall leadership and direction to the systems team to ensure that the MMIS is operational and meeting contractual performance standards • Coordinates priorities and scheduling with systems staff regarding requests for maintenance/user support and modifications and enhancements • Maintains appropriate staffing levels • Provides ongoing technical training in database administration and client/server methodologies • Oversees computer operations, network administration, systems administration, and database administration • Participates in all system design and requirements definition meetings • Serves as the primary contact for all federal or state audits, including annual staff SAS-70 audits, Office of the Inspector General (OIG) federal audits, and internal EDS audits	• Demonstrated leadership skills • Exceptional customer facilitation and project delivery skills • Strong technical capabilities • Strong analytical and problem-solving skills • Strong presentation and community affairs skills • Extensive knowledge and experience in Medicaid or other large-scale health care organizations

Position/Title	Job Description	Qualifications
Systems Engineer (SE)	• Participates in the development of test plans and test cases • Implements CSRs according to the priorities set by OVHA • Designs, codes, tests, implements, and documents changes to the MMIS • Consults with OVHA and internal users on new changes to the MMIS that support business processes • Maintains a technical relationship with other state agencies, insurance carriers, and federal agencies to facilitate the transfer of information electronically • Incorporates the latest advances in technology into the MMIS as appropriate • Participates in periodic unit reviews of quality and performance	• Ability to lead design team to develop system and subsystem specifications for MMIS system • Bachelor's degree and proven experience in systems engineering • Excellent verbal and written communications skills • Strong analytical and problem-solving skills • Capable of producing specifications (functional and design) and test requirements and performing acceptance testing
Business Analyst	• Monitors the progress of system documentation and account processes • Helps resolve issues that could impact successful operation of the Vermont Medicaid account • Ensures all system changes follow documented processes • Supports the creation of quality procedures for all departments	• Experience providing and monitoring quality control standards in a document processing environment • Understanding of manual and automated features associated with information processing • Detail oriented • Ability to communicate standards to other team members

Position/Title	Job Description	Qualifications
Quality Assurance Analyst	• Writes, reviews, and tests CSRs and Plogs • Works with SEs to help solve claims issues • Researches and responds to client inquiries • Responds to ad hoc requests from internal and external inquiries • Works with Medicaid and Medicare provider fraud control units • Updates user manuals, resolutions manual, and tables manuals	• Ability to design, develop, and deliver training and support materials • Ability to interact with customer and account personnel to diagnose and resolve problems • Excellent written and verbal communication skills • Excellent organizational and time management skills • Excellent analytical skills • Detail oriented
Systems Administrator	• Creates platform deliverable • Designs system interfaces (not application interfaces) between the user and the MMIS development platform • Develops utilities and configures products to support the development staff • Installs and tests the operating system software programs • Interacts with customer, support group, and database administration groups • Loads and maintains system software • Manages vendor relationships, which include product and service pricing, problem resolution, resource acquisition, and other areas that affect the overall success of the project • Acts as primary authority on technology issues, including all computer platforms, middleware, networking and communication peripherals, and system administration tools • Provides recommendations for system upgrades to support system enhancements or performance	• Experience working with customer technical staff at multiple levels • Strong leadership abilities in managing technical functions for multiple teams • Experience tuning a large production database in a complex networked environment • Ability to interact with executive-level customer, corporate, and account staff • Experience supporting UNIX, Solaris, CITRIX, Windows and Windows NT, Ingres, and Data Base/2 (DB2)

Position/Title	Job Description	Qualifications
LAN Administrator	• Resolves complex problems, performs trend analysis, and creates tools to prevent customer problems related to hardware, software, or network functions • Sets up all new computer hardware and software for account staff; installs software on customer computers • Travels to customer location to troubleshoot computer problems with EDS software • Troubleshoots network problems • Assembles appropriate hardware and connects peripheral devices • Establishes processes and procedures for inventory and accounting management • Submits purchase order processing for all hardware and software orders • Monitors software and hardware inventory for the account • Assists with all on-site inventory audits • Designs and implements automated processes to ensure hardware, system/applications software, and network components are operational • Defines and implements metrics that measure system performance to ensure design specifications are met • Periodically reviews and approves Site Administration Manual documentation • Leads the development and testing of business continuity plans	• Excellent analytical and problem-solving skills • Excellent written and verbal communication skills • Knowledge and experience in technical hardware, software, and network functions • Associate's or bachelor's degree in an information technology discipline • Knowledge of customer environment

Position/Title	Job Description	Qualifications
Database Administrator	• Performs database installation and configuration • Handles database change management, including table, index, trigger, and procedure changes • Performs data tape loads and system backups • Performs database space management • Manages database products and utilities • Monitors and tunes database	• Experience with Data Base/2 (DB2/UDB) version 7.0 • Experience writing load and unload scripts • Experience tuning a large production database in a complex networked environment • Ability to interact with executive-level customer, corporate, and account staff
Electronic Data Interchange (EDI) Coordinator	• Responds to telephone inquiries and assists providers with electronic claims submission (ECS) questions, including research and resolution of data transmission problems • Assists providers with various software problems and issues • Travels to provider locations to install Provider Electronic Solutions billing software when necessary	• Thorough EDI knowledge • Thorough HIPAA transaction knowledge • Provider Electronic Solutions software knowledge • Maintains good provider relationship • Excellent written and verbal communication skills
Reporting Specialist	• Assists account and OVHA staff with data analysis, report definition, and ad hoc report generation • Analyzes problems and develops solutions • Documents complex procedures and processes • Provides ongoing training on the BusinessObjects reporting tool • Codes and tests canned ad hoc reports	• Strong analytical and problem-solving skills • Experience in technical writing field • Excellent written and verbal communication skills

Position/Title	Job Description	Qualifications
Computer Operator	• Responsible for the setup and maintenance of production job schedules • Runs all production cycles • Works with SEs in resolving abnormally ended jobs • Performs on-call duties, including communication to account leadership in the event of cycle escalation • Prints, tracks, and distributes paper reports • Performs data loads and system backups	• Ability to develop, document, and follow procedures for job-specific computer operations • Excellent written and verbal communication skills • Ability to multitask • Computer operations experience
Technical Writer	• Communicates detailed assignment status weekly to project manager • Enhances technical expertise in project toolset • Maintains the Web-based Project Workbook • Follows established communication guidelines • Performs administrative tasks related to Project Workbook • Ensures that all project documentation is accurately developed and stored	• Excellent analytical and organizational skills • Detail oriented • Excellent written and verbal communication skills • Experience supporting Web-based applications
Claims Unit		
Claims Manager	• Leads claims operations team meetings • Provides overall leadership and direction to the claims team to ensure that claims are processed accurately and meets contractual performance standards • Works with SEs to help resolve claims issues • Orders publications necessary for daily processing, such as CPT and ICD-9 • Oversees coordination with the TPL subcontractor, Health Management Systems (HMS), to increase TPL recoveries	• Proven leadership experience • Solid interpersonal skills • Solid customer relations skills • Effective written and verbal communication skills • Solid analytical skills • Claims processing experience

Position/Title	Job Description	Qualifications
Claims Operations Supervisor	• Oversees the TPL, mailroom, and medical policy team • Holds team meetings and advises management of issues • Evaluates staff performance and provides recommendations for assignment of additional duties • Ensures team members are aware of roles and responsibilities within the unit • Promotes teamwork within the unit • Represents the resolutions team at edit/audit workgroup meetings	• Excellent written and verbal communication skills • Proven leadership • Strong interpersonal skills • Knowledge of TPL, mailroom, and medical policies and procedures
Document Control Clerk/ Courier	• Responsible for picking up and delivering mail • Opens mail and sorts claims by type • Captures claims and attachments • Delivers claims to data entry department • Prepares mailings • Picks up and delivers mail to OVHA and other state agencies	• Possesses valid drivers license • Familiar with the Williston area • Ability to lift and transport 40-pound mail trays • Detail oriented • Good knowledge of postage rules and equipment used to process mail
Data Entry Clerk	• Responsible for data entry of all claims types using the Viking System • Files claim batches • Reviews claim reports and ensures all batches are entered • Reviews error reports and quality assurance tracking reports	• Good problem-solving skills • Proven record of quality work and good attendance • Excellent written and verbal communication skills • Works independently and with general supervision • Flexibility in acceptance of assignments • Ten-key data entry skills

Position/Title	Job Description	Qualifications
Third-Party Liability (TPL) Clerk	• Handles explanations of benefits (EOBs) received from other insurance, including processing payments and writing off receivables on denied claims • Contacts insurance carriers to obtain updated information on recipients • Reviews trauma report and sends questionnaires to beneficiaries to determine if there is a possible casualty case for OVHA to pursue • Assists in coordinating with TPL subcontractor, HMS, to increase TPL recoveries	• Excellent written and verbal communication skills • Understands TPL policies and procedures • Detail oriented • Strong analytical skills
Utilization Review Analyst	• Reviews medical documentation to determine correct claims processing • Serves as a liaison with OVHA for medical review • Maintains reference files and resolutions pages • Assists with banner pages, provider manuals, and advisory articles	• Strong organizational skills • Thorough understanding of claims processing • Thorough knowledge of utilization review guidelines, including Milliman & Robertson Healthcare Management Guidelines and InterQual Utilization Review Guidelines • Bachelor's degree in nursing • Knowledge of medical necessity and appropriateness of health care treatment across the continuum of care, including inpatient medical and surgical, rehabilitation, home health care, home infusion, hospice, and outpatient rehabilitative therapies

Position/Title	Job Description	Qualifications
Resolutions Supervisor	• Oversees the resolutions team, holds team meetings, and advises management of issues • Evaluates staff performance and provides recommendations for assignment of additional duties • Ensures team members are aware of roles and responsibilities within the unit • Leads resolutions team meetings • Provides resolutions training and education on new processes or edits • Promotes teamwork within the unit • Represents the resolutions team at edit/audit workgroup meetings	• Proven leadership skills • Excellent written and verbal communication skills • Strong analytical and problem-solving skills • Resolutions experience
Resolutions/Adjustment Clerk	• Processes claim suspensions per guidelines issued by OVHA • Responsible for data entry of various claim types using the Viking System • Attends edit/audit committee meetings • Assists in testing processing changes • Updates resolutions manual as needed	• Good personal computer skills • Strong organizational skills • Commitment to quality • Detail oriented • Excellent analytical and problem-solving skills

Position/Title	Job Description	Qualifications
	Drug Rebate Unit	
Drug Rebate Coordinator	• Responsible for all billing and collections of drug rebate dollars • Works and communicates with CMS • Produces weekly reports for the state and answers client questions and concerns • Communicates with manufacturers on billing concerns and disputes • Tracks disputes until resolved • Contacts pharmacies when necessary • Travels to attend resolution meetings and conferences • Initiates any necessary system changes • Reads and complies with all CMS guidelines	• Knowledge of drug claims billing • Excellent written and verbal communication skills • Excellent analytical and problem-solving skills
Pharmacist Consultant	• Provides assistance to account staff and the customer on matters related to pharmacy • Fields questions from the customer on drug rebate • Works with drug labelers, the state, and CMS in all matters related to drug rebate • Reviews past due drug rebate accounts and follows up with drug labelers • Reviews drug rebate invoices prior to mailing for discrepancies and outliers • Reviews, works, and resolves drug rebate disputes • Works with EDS corporate pharmacist and drug rebate analyst networks representing the Vermont account • Identifies innovative ideas to streamline drug rebate processes and procedures	• Experienced liaison • Excellent written and verbal communication skills • Detail oriented • Strong analytical and problem-solving skills • Prior experience with drug rebate program

Additional Staff

RFP Reference: 3.2.2.8.5, p. 3-14

Staff consistency throughout the contract is important for the smooth and uninterrupted administration of the Vermont Medicaid program. Employee continuity paves the way for advanced training opportunities that create a team of highly qualified staff to support the needs of program stakeholders—the state, providers, and beneficiaries.

EDS will continue to staff the contract with our current infrastructure of experienced employees and will expand our recruiting efforts to retain the staff necessary to support the Department of PATH under the new contract. We have a vested interest in retaining our experienced staff. They have received the training and ongoing development to secure the expertise necessary to support Vermont. Our tenured employees are vested in EDS' retirement plan, possess strong loyalty, maintain a desire to live in Vermont, support the citizens of Vermont, and continue their professional growth to support the Department of PATH.

To recruit additional staff, we will continue to use proven and successful approaches, as well as maximize the expertise offered by other EDS technical and clerical resources. We will support the local economy by offering employment opportunities within the local community. The following examples demonstrate our ability to supplement our local employee base with resources from across the country:

- **Sharing data entry resources with Pennsylvania Medicaid**

  When we had difficulty attracting applicants and filling open data entry positions in Vermont, we turned to our sister Medicaid account in Pennsylvania. Within two weeks, the Pennsylvania-based team hired three data entry operators who were able to dial directly into our system and key the backlog of claims that had accumulated.

  For more than three years, this flexible arrangement for additional resources has benefited both accounts, enabling us to share resources to handle the peaks and valleys inherent in paper claims submission. We will continue to leverage this staff for timely and cost-effective data entry.

- **Quick action from expert DSS resources in Plano, Texas**

  When the state was faced with unsatisfactory performance of a new decision support system (DSS), they turned to EDS to solve the problem. We called on our DSS experts in Plano, who met with state staff, identified the state's requirements for management reporting, and developed a robust table structure that now handles all the state's multiple programs and funding streams. The ability to access this corporate resource allowed us to rapidly assemble a team of the most knowledgeable DSS personnel in the industry to address Vermont's issue. The state has been very pleased with this new and improved ad hoc reporting system, Enhanced Vermont Ad Hoc (EVAH), for its speed, accessibility, and user-friendly query tools. The number of state users continues to grow as the value associated with our solution cascades throughout the Department.

The Plano, Texas-based team created a cost-effective solution that surpassed expectations and cost less than projected. These experts are focused on the latest technological advancements and are a central source of expertise gained from implementations in other states. By leveraging these resources, the state reduced the level of effort—both time and staff—required to secure innovative technology.

- **Provost Technical Support Centre provided additional staff for Y2K audits**

  For the Y2K project, EDS assisted the state in performing CMS-required full system audits to verify whether the rollover to the year 2000 would cause any concerns. Y2K Team Lead Chrissie Racicot managed the full MMIS audit project with the support of our account staff and off-site resources from our Provost Technical Support Centre. When the CMS team visited the account to perform their level IV and V audits, they categorized the Vermont MMIS as "low risk," and the audit findings documented this assessment with a rating given only to systems that offered the ***lowest risk available.*** The project was deemed a complete success, and Chrissie received a commendation from John Koskinen, Chair of the President's Council on Year 2000 Conversion, on her fine work:

  > "Thank you for your important contribution to our efforts to minimize the effects of potential problems associated with the Year 2000 date change. Your hard work in helping to prepare your agency for Y2K was critical to the Government's overall commitment to ensure that federal benefits and services provided to Americans continued without interruption during the Year 2000 transition."

  Our ability to leverage resources from the Provost Technical Support Centre was critical to the success of this project. They provided additional staff positions that we needed for a short time period, eliminating the need to hire and then terminate technical employees.

We will continue using these types of methods to supplement our Vermont-based team for future initiatives, and we will continue our retention and staff development plans to ensure consistency for the Vermont Medicaid Program.

Leveraging Experienced Technical Personnel From Central Support Centres

The Vermont-based team does an excellent job of retaining on-site technical staff. For special projects, we supplement this staff with the expertise offered by our corporate resources. Central support centres are staffed with experienced Medicaid SEs and are both cost-effective and reliable. We will continue to offer this option for additional resources to the state for major projects. These centres combined have more than 300 technical personnel experienced with the design, implementation, operation, and enhancement of MMISs.

Vermont will benefit from leveraged central support centre personnel in the following ways:

- **Access to technical staff experienced in the Medicaid industry**

  Our central support centres employ hundreds of SEs with Medicaid experience who have provided thousands of hours of expertise to design, develop, implement, and support ongoing operations or special projects identified by our Medicaid customers. They are on the forefront of technology advances and actively participate in numerous organizations that impact Medicaid programs across the country. They provide a wealth of knowledge that benefits Vermont, including knowledge gained from participation in HIPAA workgroups, Systems Technical Advisory Group (S-TAG), and Medicaid Information Technology Architecture (MITA). Because our corporate technical staff is familiar with industry standards for Medicaid applications and actively participate in these organizations, they often are able to present state concerns to top levels of the organization. It is an excellent way for our state to be heard.

  Vermont enhancements will be staffed primarily from the EDS central support centres specializing in Medicaid. These centres are located in Vancouver, Washington; Richmond, Virginia; Plano, Texas; and Little Rock, Arkansas. The SEs working in these centres have significant experience in Medicaid and have participated in projects ranging from the original implementation of the VermontAIM to the ongoing New England AIM HIPAA remediation and MMIS implementations for Pennsylvania and Tennessee. These SEs are experienced in both Medicaid and AIM, so they will be productive from the beginning, without spending time compensating for a learning curve. They are experienced in making modifications like those requested in Vermont, such as the platform conversion, claims system change for ClaimCheck and ClaimReview, provider enhancements, and the Internet enhancements. With this experience, they will make these modifications more rapidly and more accurately than any other possible resource.

- **Access to the latest technological advances and improved processes**

  Our central support centres have the expertise and focus to develop tools that can be used in multiple states. For example, support centre staff developed electronic claims submission (ECS) software, which is used in Vermont and other states. This software is easy to use and effective in raising electronic submission rates. Raising the electronic submission rate not only improves claims throughput, improving provider cash flow, but it is extremely well received by the Vermont provider community as evidenced from these quotes from our most recent 2002 Provider Survey:

  — "Electronic claims turnaround and processing is great!" – Oral Surgeon

  — "Online billing works great—customer support for this service is also top-notch." – Mental Health Ph.D.

  MMIS implementations across the nation have contributed to this unprecedented foundation of technical expertise and many chapters of lessons learned, as well as success stories. The lessons learned have precipitated the evolution of both our MMIS infrastructure and approach to project management. For example, a team of dedicated staff within our Plano support centre focused their energies on the lessons learned to

create EDS' revolutionary new product offering—Project Workbook. Incorporated within the design of Project Workbook is decades of implementation experience as well as creativity, innovation, insight, and the most advanced technologies. Oklahoma was EDS' first customer to reap the rewards associated with this offering, often referred to as the "nucleus" that enabled their successful implementation.

Project Workbook is a Web-based application that not only offers two-way communication protocols, but also serves as a repository for all project documentation, including contractual requirements, performance standards, status reports, work plans, change orders, deliverable specifications, business and system process flows, stand-alone test environments, and sign-off documents. Through the linking features included in the Project Workbook, the state and EDS staff members can gain a mutual understanding of the current status of virtually every aspect of the project necessary to support an on-time implementation within budget.

Our customers have been extremely pleased with the ease of use and organization of this tool. Project Workbook is at the heart of the Kansas, Pennsylvania, Tennessee, and Idaho MMIS implementations. We are excited about the opportunity to bring not only the Project Workbook application, but also the expertise from our central support facilities to support the enhancements required for the new contract.

- **Cost-effective solutions**

  Another avenue of exploration of the EDS central support centres is cost-effective solutions. Our ability to leverage expert resources across multiple projects for different customers offers increased opportunities for our customers to receive excellent service at a reduced fee. Perhaps this approach is no more evident than among the New England states. EDS resources have been leveraged across four states—Vermont, Connecticut, Rhode Island, and New Hampshire—to perform remediation services for HIPAA. Because the resources for this project are from a support centre, in addition to personnel from each individual account, the states are sharing the costs of support centre personnel.

- **Repository of Expertise**

  The use of central support centre SEs permits a great degree of leverage across multiple systems, which saves expense. For example, the same SEs who developed the PowerBuilder windows for the Delaware MMIS implementation formed the core of the team that is developing the PowerBuilder windows for Vermont, Rhode Island, New Hampshire, and Idaho—all states involved will benefit from the experience gained in Delaware.

Central support centres have supported multiple remote MMIS operations and are familiar with the Vermont team, infrastructure, and processing environment. Supplementing our local staff with this level of support creates a distinct delineation of responsibility and focus. Our Vermont-based team will continue to focus on the daily operations, while our central support staff focuses on the seamless integration of the many enhancements required in the new contract.

Hiring Local Talent

In addition to leveraging support from other EDS resources, we will secure locally qualified candidates. We have achieved great success with local newspaper advertisements and local temporary agencies. Our local team comprises individuals who work and live in Vermont, so we strive to strengthen the local economy by retaining local employees and supplier services. We are fortunate to have a staff that is dedicated to volunteer activities, such as the Chittenden County United Way Program, AIDS Ride for the Cure, and March of Dimes. We believe that our corporate presence is strengthened when we expand our reach throughout the community.

Our hiring and retention methods include a comprehensive process that helps ensure our employees are forthright citizens. To support the ongoing security of our customers' information, we will continue to mandate drug testing and conduct background investigations of all prospective employees.

New employee orientation serves as the starting point to acclimate new staff members. Orientation materials encompass EDS corporate information, including our corporate vision, employee benefits, and other administrative topics. The orientation also delves into our specific role in support of Vermont and highlights our account goals, organizational structure (both the account and the state), operational areas of responsibility, our commitment to quality initiatives such as our formal Quality Improvement Plan (QIP), security procedures, and other account-related details.

We require new members of our team to become familiar with our organization, client expectations, job responsibilities, and performance criteria. More importantly, we want new employees to understand how to perform the functions necessary to meet your expectations. To supplement the orientation training, **all Vermont-based team members** must complete a series of job-specific training programs in a structured training environment. This portion of our employee training encompasses a Claims 101 course followed by customized training specific to their responsibilities.

Claims 101 is a two-hour class that helps new employees understand basic claims processing. Topics include:

- EDS and Department of PATH responsibilities
- Beneficiary information and aid categories/state programs supported
- Provider information and enrollment status codes
- Life of a claim—eligibility verification, claim submission, document control processes, claim form information, edits/audits, and payment
- Other elements such as internal control number, transaction type and status, funding source, and pricing
- Adjustments
- Reporting

After completing Claims 101, employees are able to articulate the basic function of each department and describe the various stages of claims processing. When employees understand the overall process, they are better able to understand the criticality of their specific job and how it affects timely and accurate claims processing for Vermont providers and beneficiaries.

High Retention Record/Staff Longevity in Vermont

People are EDS' most valuable asset, so we take a proactive approach to staff retention. We offer excellent health benefits, an employee assistance program, financial benefits, company stock options, training programs through EDS University, and significant discounts for personal insurance, retail services and merchandise, and new car purchases.

Our high retention record demonstrates that EDS is a great place to work. The following list of initiatives provides some insight into our successful approach to secure and retain the best employees:

- **Development program**—Employee training remains at the forefront our ongoing commitment to employee development. Employees are offered more than 330 different classroom courses with nearly 600 Web-based training courses available at the desktop.
- **Performance appraisal**—EDS' performance management approach integrates performance management processes and tools to effectively differentiate and communicate performance assessment. The new process provides higher rewards for those employees whose contributions have contributed to our customers' success. By managing individual performance more closely and consistently, we link and document contributions to EDS' overall results, provide remedial actions in the areas requiring improvements for growth, and strengthen the "pay for performance" program.
- **Pay for performance**—EDS believes that employees should be rewarded based on individual and team contributions that add value to our customers' business. This philosophy reflects our commitment to contribution-based pay. It also represents a significant growth opportunity for each person who works here. Essentially, our employees earn rewards based on performance, creativity, and contribution.
- **Stock option plan**—Our PerformanceShare benefit provides employees with the opportunity to become owners of EDS with no out-of-pocket investment. This benefit enables employees to buy tomorrow's value at today's stock price, with no required additional investment. It also gives them an additional financial stake in EDS' success because the potential reward is tied directly to the performance of our stock.
- **Strong employee recognition program**—EDS understands the importance of communicating to employees our appreciation for a job well done. We formally recognize employees who have reached service anniversary milestones, and often may initiate a non-monetary form of recognition that is meaningful or specialized for a specific employee.
- **Employee survey**—EDS administers an anonymous, Web-based, cumulative employee survey annually. The employee survey captures the attitudes and perceptions of

employees concerning key issues such as opportunities, leadership, recognition, and compensation; their organization and work teams; and EDS overall. The results of past employee surveys have been a catalyst for many companywide changes.

In addition to corporate retention initiatives, the Vermont-based team has incorporated many of its own successful retention initiatives. Several of our team members have many years of experience in Vermont in varying roles. In fact, more than 25 percent of our current staff have worked at the Vermont Medicaid account for more than 10 years, with several team members having more than 20 years of Vermont experience. Overall, our account staff averages more than 6.5 years of Vermont experience.

We are exceptionally proud of having no turnover of our Vermont technical staff in more than five years at a time when the average turnover rate of technical personnel has been nearly 24 percent. Client Delivery Executive Barbara Davis has implemented creative ways of encouraging staff retention, including flex time to allow working parents to better balance their job and family responsibilities.

To illustrate our support of staff retention and training, we briefly describe the careers of Vermont team members who have worked their way into positions of increasing responsibility.

Chrissie Racicot: "The One We Count On"

Chrissie Racicot brings more than 17 years of experience with Vermont's Medicaid program. This long-term dedication started when she joined EDS' Vermont team in 1986. From the beginning, her story is one of steady career growth, as she has learned new disciplines and taken on new challenges to better serve the Vermont Medicaid program. For example, working with Vermont's provider community, her people skills and persuasive presentation were key factors in the growth of electronically submitted claims from 18 percent to 73 percent.

More recently, Chrissie worked closely with the state to implement a cash control project. This project created a new check tracking system, which tracks checks from the time they are received until they are fully dispositioned in the system. This system has helped EDS to deposit all received checks into the correct account, and to monitor the time it takes to receive the checks in the system and realize savings to the state's Medicaid budget. She has also worked with each of the funding departments on a funding source redesign project, which (when implemented) will give the state even more flexibility in tracking funding sources.

Her leadership of the Y2K remediation ensured that Y2K was a nonevent in Vermont. The new century dawned, and VermontAIM continued to process without missing a cycle or a checkwrite.

Today, Chrissie is the Tri-State AIM HIPAA project manager, overseeing the batch coding changes that are being implemented in EDS' HIPAA Phase 1 Remediation. She is also supporting the remediation for New Hampshire and Rhode Island. By sharing this effort with other states, Chrissie and EDS are helping to reduce the HIPAA costs incurred by Vermont and the other states.

During these intensive design and implementation efforts, Chrissie has been a key contributor to the QIP, the account's process for identifying areas for improved performance and developing plans to make the improvement. One of the best examples of her use of the QIP was developing the Best Practices Document. The Best Practices Document is a collection of repeatable templates and guidelines for organizing and managing changes within the context of more extensive projects.

In recognition of her many contributions to Vermont's Medicaid program and her long-term dedication, the commissioner of the Department of PATH honored Chrissie with the 2002 OVHA Distinguished Performer Award for:

> "Her outstanding contributions to the Office of Vermont Health Access. It seems like you took a breath after Y2K and then jumped into HIPAA and all of the changes made to the VHAP Benefit package. In spite of this, you managed to find time for your day job! **You are the one we count on to be there, behind the scenes, applying the detail that makes a change—**or a commissioner's crazy vision – come to life. Your ability to work with just about anybody and the clarity of your thinking is much appreciated. This recognition is long overdue. Congratulations!"

With EDS, you can continue to depend on Chrissie for a long time.

Cindy Littlefield: Long-Term Commitment to Medicaid and Vermont

Cindy has supported EDS' Vermont Medicaid project from the beginning. When we opened for business in 1981 (at our first project site on Green Mountain Drive in South Burlington), Cindy was there, keying claims for medical, dental, pharmacy, crossover, inpatient, outpatient, home health, durable medical equipment (DME), vision, and nursing home claims. Soon after that, she took on added responsibilities in resolutions. This set a pattern she has followed ever since: new challenges, new growth, steadily increasing the value she brings to Vermont Medicaid.

Cindy has taken advantage of career growth opportunities offered by EDS to learn new skills while working in her home state of Vermont. Before making the career switch to the technical world, she helped providers with the enrollment process, responded to provider inquiries, and supervised the data entry area. In 1992, when EDS and Vermont started the implementation of the VermontAIM client/server MMIS, Cindy made the decision to move from provider services into the technical arena. The implementation of VermontAIM presented an excellent opportunity for this evolution. The experience she gained in this implementation helped her implement client/server MMIS solutions for other EDS clients (Rhode Island, Indiana, and Connecticut), but she always came back to her home account in Vermont. The knowledge she gained during each assignment made her a more valuable, experienced asset for Vermont.

As one of the account's leading systems engineers, she was heavily involved in the 1998 MMIS platform upgrade that reduced daily cycle time by 50 percent and brought hardware up to the

most current standards. Most of the past three years have been devoted to the Tri-State HIPAA remediation project. She works with Chrissie Racicot and other members of EDS' HIPAA team to implement this regional solution for Vermont Medicaid. Cindy was the team leader for the assessment team in 2000, and worked with the state on all Medicaid HIPAA assessment related items. Today, she is the technical architect for the Tri-State remediation project. Her leadership of this project will ensure that HIPAA will be implemented accurately and timely for Vermont.

From data entry clerk to technical architect, Cindy exemplifies the valuable investment in people and training that Vermont and EDS have made together.

Judy Isham: Career Commitment to Vermont Medicaid Program

Judy has spent the greater part of her professional career serving the Vermont Medicaid program in a succession of challenging positions with EDS. She is another example of long-term career growth offered by EDS to our best people.

Judy brings more than 21 years of Vermont Medicaid experience and history, since she joined the staff early in our first contract. Like so many of our long-term people, she started in the data entry unit, keying a variety of claim types. She then expanded her skill set to include claims resolutions and gained a thorough understanding of edits and audits and the program policy that they enforce. To this day, she stays involved with the edit/audit meetings to review suspense reports and make recommendations for improved edits and audits.

She was soon the claims supervisor and filled in for the manager when needed.

From the beginning, Judy championed the quality process and its most important lesson: "Do it right the first time." Today, she helps the entire project team do it right the first time through her position as the quality assurance/testing coordinator. She draws on her experience with the program and her understanding of policy as she works with the state and with our technical staff to analyze application performance against specifications before system modifications are released to production. She personally writes EDS' response to CSRs for legislative mandates and tests the results in a model office environment to ensure accuracy prior to implementation. Client Delivery Executive Barbara Davis said it best: "A change does not go in until it has the Judy stamp of approval."

In support of her quality assurance responsibilities, Judy gets involved with all improvements that result from the QIP process. She ensures that the requested changes are accurate and well-documented before they are released to production. She also worked on the AIM Health Care Credit Balance project, which brings in additional money for claims that our AIM auditors have identified as overpayments (through audits at hospitals) that would not have been identified otherwise. This activity brings in $175,000 annually.

The next contract period promises to bring even more change and further evolution, as the Department of PATH and EDS implement mandatory and optional enhancements and the

selected cost containment mechanisms, and prepare for the next generation of MMIS. Judy, always ready to step up to exciting challenges, is looking forward to her involvement in all these activities and continuing her lifetime commitment to Vermont.

Cross-Training Initiatives

Our entire leadership team makes every effort to retain excellent employees and prepare them for career advancement opportunities; however, the team also must prepare for turnover situations. Our preparation includes the identification and mentoring of primary backup personnel for key positions and cross-training plan to expand our cross-operational knowledge. Cross-training is an ongoing initiative and has expanded under our QIP. As the lead for this QIP item, Perry Melvin tracks the cross-training efforts of the entire account. He documents each team member's primary backup and monitors the training efforts to achieve the responsibilities of the other team member. For example, a suspense resolutions analyst typically focuses on a single claim type, but once proficient, the analyst will be cross-trained to process multiple claim types. Another example is the cross-training and backup procedures in place for our technical staff. Each systems engineer is assigned to support a primary subsystem but is also trained to serve as a backup technical resource for another subsystem.

With access to a central source of cross-training information for the entire account, managers can quickly determine the most appropriate individual to fill in for a set of responsibilities. Although the managers of each department determine specific methods of cross-training their individual teams, our goal is to cross-train as many employees as possible to better serve you—our customer.

PROJECT MANAGEMENT AND CONTROL (OPERATIONS)

RFP Reference: 3.2.2.9, p. 3-14

In working together to support Medicaid operations and other Department of Prevention, Assistance, Transition, and Health Access (PATH) programs over the past 21 years, **the state and EDS have established a real comfort level with the proven, reliable procedures that have been put in place to support project management and control.** Together, we achieve daily and weekly work assignments during the Operations Phase. Providers remain happy. The state does not have to worry about project management and control with EDS.

By leveraging successful procedures and approaches to project management and control during the Operations Phase, we provide stability and uninterrupted service. This stability will be a key foundation for smooth operations and, later, for enhancing operations during the Enhancements/Modifications Phase. The stable, proven, and reliable project management and control approach described in this section significantly reduces overall project risk and assures the state that it can continue meeting its overarching objectives for program operations:

- Support smooth, continued operations of a Medicaid Management Information System (MMIS) that meets the current and future needs of the Department of PATH, Agency of Human Services (AHS), and state and federal requirements
- Provide uninterrupted claims processing, financial management, and provider services for the medical service programs within AHS
- Incorporate new industry best practices for project management and control procedures as appropriate for the Operations Phase once they have proven successful for Vermont in the Enhancements/Modifications Phase
- Support the efficient and timely implementation of cost-containment ideas throughout the contract by applying proven best practices for project management and control

To support smooth, ongoing operations, the state needs a partner who offers the least risk and has experience with meeting the tight deadlines demanded in major implementation projects. As a partner with the state since 1981, EDS understands the processes and demands facing the state. We have the experience, processes, and capabilities to ensure the state's success in achieving its goals and objectives.

Our Approach

EDS is committed to a disciplined approach to project management. In 2000, we documented our best practices for project management in Vermont by customizing our extensive corporate experience in managing and delivering large-scale projects. This customized project management methodology is based on Carnegie-Mellon University's Software Engineering Institute (SEI) practices and Project Management Institute (PMI) fundamentals. The Vermont-focused best practices for project management incorporate key elements of our Global Solutions Management Systems (GSMS) methodology. **In the second year of operations, EDS will enhance established practices by adopting additional GSMS best practices applied to the Enhancements/Modifications Phase in support of the Operations Phase.**

We describe our project approach in the following sections:

- **3.2.2.9(a) Project Management and Control—**We will continue to provide thorough and effective project management through the use of disciplined, controlled processes. All project planning is iterative, and assumptions, risks, and estimates in this proposal are re-evaluated at regular intervals to ensure initial planning is still valid. If not, necessary change is incorporated to keep the project on schedule. Work products will be delivered on time with high quality and will be maintained throughout the project. Quality control processes will be used throughout the project.
- **3.2.2.9(b) Staff Resources and Time Estimating Methods—**We will use the Tracking Log (TLOG) System to carefully track the time of our systems engineers and business analysts against project estimates. This TLOG process is fully integrated into our system team's daily tasks and provides an accurate accounting of the actual time spent working on individual system tasks.
- **3.2.2.9(c) Procedures for Sign-off of Completed Milestones and Deliverables—** Working with the state, the project manager establishes appropriate milestones and deliverables for each project and applies standard processes for walkthroughs and sign-off by the appropriate state staff.
- **3.2.2.9(d) Management of Contractor Responsibilities, Milestones, and/or Deliverables—**Client Delivery Executive Barbara Davis and her team of key managers are well versed in the detailed contractor responsibilities and will continue to monitor performance statistics carefully for anomalies. When they identify issues, they intervene quickly to prevent interruptions to operations.
- **3.2.2.9(e) Assessment of Project Risks and Approach to Monitoring and Managing Risks—**EDS will use its risk management methodology to identify, document, and plan mitigation for potential risks during the Operations Phase. We use the same proven approach that we did during the Y2K IV and V audits performed by the Centers for Medicare and Medicaid Services (CMS) in which we received "low risk" ratings—the most sought-after rating granted by CMS—in each category.

- **3.2.2.9(f) Approach to Problem Identification and Resolution—**By using Vermont's established procedures for problem identification and resolution, we quickly identify, communicate, and resolve problems.
- **3.2.2.9(g) Internal Quality Control Monitoring of Relations With the State, Providers, and Other Stakeholders—**Leveraging the proven and effective Quality Improvement Plan (QIP) initiative will support continual improvement in Vermont Medicaid operations. This QIP process has proven successful not only on the Vermont account, where it was initiated, but across several other EDS accounts as well. Using the QIP, we quickly deploy staff to perform a detailed analysis of the problem and develop an action plan to improve productivity, remove barriers, or obtain resources to quickly address the situation.
- **3.2.2.9(h) Project Status Reporting—**The state can rely on consistent, standardized project status reporting from EDS—reporting that demonstrates the status of the project deliverables, the expected outcome of the project, the time frame for completion, and the process for transition to the operations team for full integration into operations. Starting in the second year of the Operations Phase, we will enhance our project status reporting by making project status reports available to state and EDS personnel online through our Web-based Project Workbook.

We will continue to work with the state to apply our project management and control methodologies to achieve the state's vision of delivering quality health care to Vermonters.

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a. Project Management and Control Methodology

RFP Reference: 3.2.2.9(a), p. 3-14

The Department of PATH can rely on EDS' project management and control methodology for the successful support of project work without interruption to the daily operations of its programs:

- Medicaid
- Vermont Health Access Program (VHAP)/PC*Plus*
- VHAP Pharmacy payment processing
- VScript payment processing
- Healthy Vermonters Program
- State Children's Health Insurance Program (SCHIP)
- School-Based Health Services Program
- General Assistance
- Home- and Community-Based Waivers
- 1915 Home- and Community-Based Waiver
- Breast and Cervical Cancer Treatment Program

Key advantages of our approach include:

- **Proven effective in Vermont—**EDS has used its corporate methodology in Vermont for more than 21 years. Two years ago, however, EDS tailored standard corporate methodologies into a documented set of best practices for project management that have proven effective in streamlining operational projects.
- **Customized to the Vermont Medicaid environment—**In 2000, we customized our project management approach for Vermont, selecting standard tools and templates appropriate for typical Vermont projects.
- **Familiar to state personnel—**Our consistent approach to Vermont projects means state personnel are familiar with standard templates and approaches.
- **Flexible and adaptable to meet project requirements—**A key component of our methodology is flexibility. Not every project requires the same level of reporting or sign-off. We work with state personnel at the beginning of each project to agree on appropriate levels of communication for the project.

- **Enhanced project status communication through the Web-based Project Workbook—**In the second year of the Operations Phase, we will enhance status reporting by providing all key status reporting documents to state and EDS personnel online in the Web-based Project Workbook. This innovative Web-based tool provides a comprehensive journal of all project documentation and includes status reports, work plans, change orders, deliverable specifications, test data, test results, and even sign-off documents.

- **Strong corporate support for project management methodologies—**Supporting our Vermont-specific processes are strong corporate methodologies for project management and control that are based on Carnegie-Mellon University's Software Engineering Institute (SEI) practices and Project Management Institute (PMI) fundamentals.

Most recently, our project management methodology has proven effective in supporting the Health Insurance Portability and Accountability Act (HIPAA) assessment and remediation efforts in Vermont. During the tri-state assessment, we used a single team of personnel to execute a common assessment process in all three states. The result was more thorough review for all states

In the HIPAA remediation project, we have leveraged templates and processes based on our corporate methodologies and customized for the Idaho HIPAA remediation effort. These proven templates enabled the team to create design and definition documents for all three states in a very short four-month time frame. The same templates have continued to support the team in supporting construction, system test, and implementation phases.

We describe our project management and control methodology as we will use it in the Operations Phase in the following subsections:

- a.1 Identifying a Project
- a.2 Prioritizing Projects
- a.3 Putting Customized Project Management Methodologies to Work
- a.4 Ensuring Quality
- a.5 Leveraging Corporate Project Management Methodologies and Tools
- a.6 Proven, Customized Project Management and Control

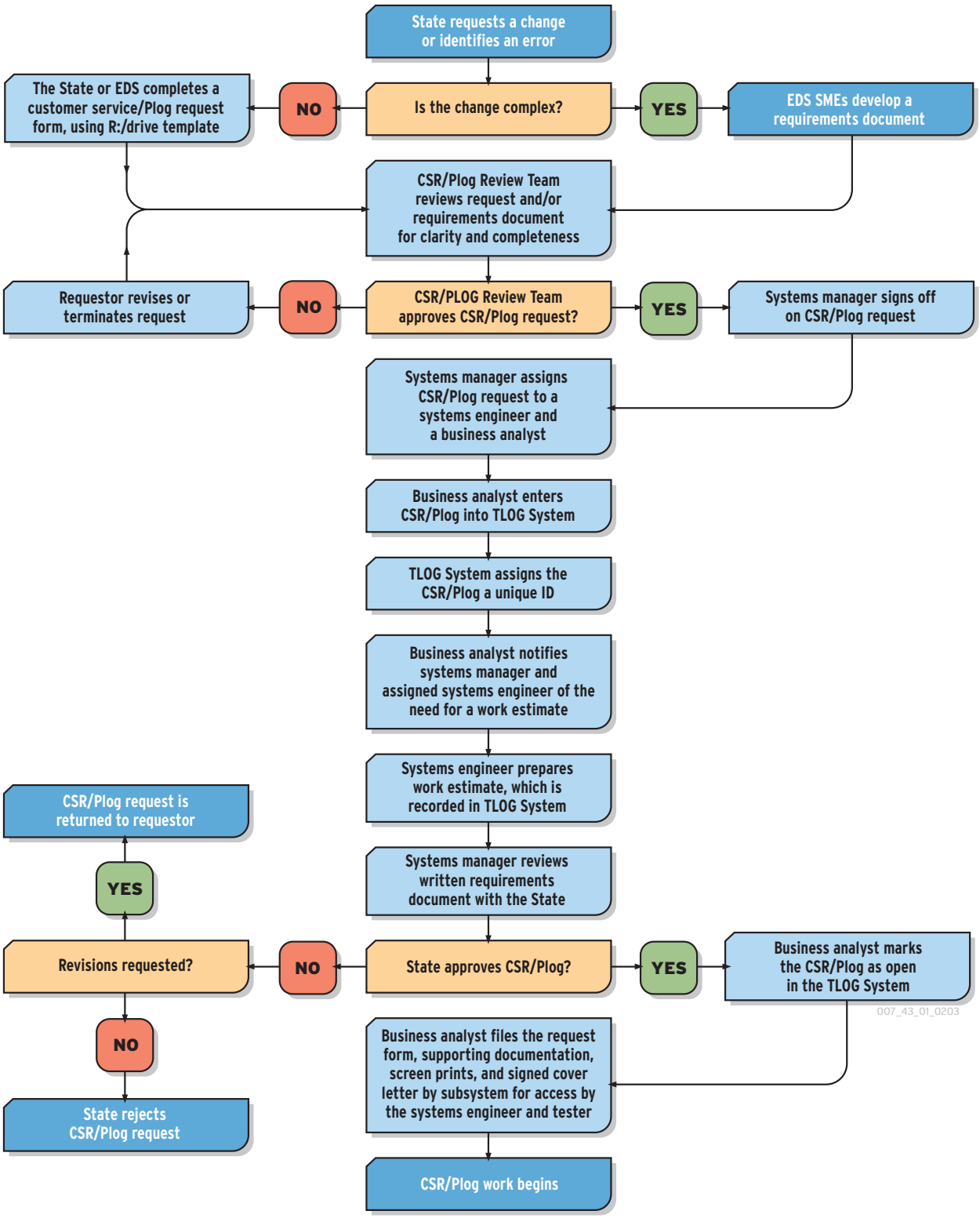
a.1 Identifying a Project

Projects identified during the Operations Phase typically come as a result of one of these initiatives:

- Requests from state personnel
- State or federal regulation changes
- Identification of design errors
- Quality Improvement Process (QIP) suggestions

The Department of PATH and EDS have a streamlined process for prioritizing and identifying enhancements and changes that occur during operations. The graphic on the following page describes our process.

Customer Service Request/Plog Process



The state benefits from the continuity of using our proven, familiar CSR/Plog process.

a.2 Prioritizing Projects

Open CSRs/Plogs are prioritized each week by the state during the fiscal agent meeting, using a report of open projects from the Tracking Log (TLOG) system.

a.3 Putting Customized Project Management Methodologies to Work

With the state's approval, the assigned project manager for the CSR or Plog refers to Vermont's best practices for project management and control and begins the project.

Following is a brief overview of the process as customized for Vermont:

- Determine the Scope of the Change
- Select Tools to Support the Project

Determine the Scope of the Change

The first step of any project is to determine its scope. The scope of the project dictates which formal tools are required. Project managers use various methods to develop a list of the items that will be added, changed, or deleted. Some methods to support the scope definition include:

- Kickoff meeting
- Process flow meetings
- Planning meetings
- Project definition meeting

Once the list of items that will be added, changed, or deleted is complete, the project manager uses documented parameters to classify the project as a small project, medium project, large project, or major enhancement. The following table provides a guide to help a project manager classify the scope of the project.

Classifying Projects by Scope

Scope	Characteristics
Small Project	• Minor changes to three or fewer reports, windows, processes, or manuals
Medium Project	• Minor changes to four to seven reports, windows, or processes • Medium changes to three or fewer reports, windows, processes, or manuals

Scope	Characteristics
Large Project	• Minor changes to eight to 15 reports, windows, processes, or manuals • Medium changes to four to seven reports, windows, processes, or manuals • Large changes to three or fewer reports, windows, processes, or manuals
Major Enhancement	• More than 15 minor changes • More than eight medium changes • More than four large changes

Select Tools to Support the Project

Our approach to project management and control is flexible. Based on the size and classification of the project, the recommended tools and approaches vary. In this section, we describe standard project management and control tools that we regularly implement to support Vermont projects:

- Automated Software Tools
- Project Communication Documents
- Meetings
- Reports
- Documentation Updates
- Code Updates

Automated Software Tools

In the following table, we introduce key automated software tools that the Vermont team uses to support project management.

Automated Software Tools

Tool	Description	Purpose
TLOG System	Automated tracking system for CSRs and Plogs	• Tracks authorized CSRs/Plogs • Tracks systems engineer and business analyst hours against projects • Produces project status reports
Microsoft Outlook	Software that supports the development of task lists, calendars, and automated support for scheduling meetings	• Lets users track items needing completion • Supports project managers in determining people's availability and scheduling meetings • Supports the creation of calendars
Process Sourcerer	Process management tool developed by EDS that provides powerful means for capturing and leveraging process knowledge	• Helps organize large projects • Provides process flow capabilities • Lets users link documents within the process flows
Change Management and Promotion (CHAMP)	EDS-designed application that provides automated support for change control management	• Ensures version control and that no two people are working on the same piece of code • Maintains past iterations of code in case a user needs to go back to a previous version • Supports quality by promoting a common approach for promoting source code • Promotes efficiency
Microsoft Word	Word processing package	• Contains templates for most recommended project management tools
Microsoft Excel	Spreadsheet application	• Contains templates for other recommended project management tools
Microsoft Project	Project planning application	• Supports the creation of project plans • Lets users organize a series of tasks for a project

Project Communication Documents

To promote continuity of approach, our best practices include the use of several templates to promote project communication. We describe these documents in the following table.

Tool	Description
Roles and Responsibilities Document	• Lists people involved in the project along with titles and project responsibilities
Communication Plan	• Lists the types of meetings and status reports that will support the project • Includes the responsible party, the item's frequency, template locations, and distribution methods
Contact List	• Lists the name, phone number, and e-mail address of each project team member

Meetings

Our best practices for meetings include creating agendas and taking minutes. A scribe documents any requirement determinations, actions items, outstanding items, and general minutes.

Following are some of our standard meeting formats, which are used as appropriate to the scope of the project.

Standard Meeting Formats

Meeting	Purpose	Attendees
Kickoff meeting	• Review change to determine scope of work • Gather input on approach	• Person requesting change • EDS managers of affected departments • Any other person knowledgeable on the subject, known as the subject-matter expert (SME)
Planning meetings	• Plan changes • Examine process flows, if appropriate	• Person requesting change • EDS managers of affected departments • EDS SME for the affected subsystem • EDS systems engineer for the affected subsystem
Process flow meetings	• Develop or review a pictorial view of the process changes • Gain consensus on the new process	• Facilitators Perry Melvin or Valerie Lewis • Person requesting change • EDS managers of affected departments • EDS SME for the affected subsystem • EDS systems engineer for the affected subsystem

Meeting	Purpose	Attendees
Status meetings	• Share status information regarding the project • Consider issues as a team	• Person requesting change • EDS managers of affected departments • EDS SME for the affected subsystem • EDS systems engineer for the affected subsystem

Reports

The state and EDS have worked together to develop several standard report formats that we rely on for documenting key information. We describe these reports in the following table.

Report	Purpose/Description
E-mail Notification	• Notifies the OVHA or the EDS team of critical or urgent information, such as POS downtime, a new edit, a power outage, or process changes going in over the weekend • Ensures team members not directly involved in a project recognize its impact
Requirements Document	• Documents the scope of work of the project and the details of what will be changing with the implementation
CSR/Plog Requests	• Documents a request for additional functionality: CSR • Documents changes to fix system errors: Plog
Project Definition	• Documents the project's mission statement and goals
Project Plan	• Organizes a series of tasks in sequence and assigns time frames to each task • Supports the project manager in evaluating whether the project is on schedule • Highlights problem areas early so that the project manager can adjust the approach to address challenges

Documentation Updates

Each project creates changes. The EDS team does not consider a project complete until documentation is updated to reflect those changes. As we implement each project, we consider whether changes will affect the documents maintained at the account, including the following:

- Resolutions Manual
- Provider Billing Manual
- Operating Procedure Manual
- User Manual
- Tables Manual

Following are the standard steps for updating procedures and documentation.

Updating Documentation

Step	Action
1	Check out the affected document from the document coordinator.
2	Update the document.
3	Return the document to the coordinator for review and approval.
4	Distribute updated document. **Note:** All updated documents are forwarded to users who have hard copies and are saved on the R:/drive.
5	Refer to the distribution lists in the Best Practices Document for information on whom to notify regarding each type of change. The Best Practices Document contains the Vermont team's customized processes for project management. These best practices are based on EDS' corporate methodologies.

Code Updates

As mentioned before, the Vermont team uses an EDS application called CHAMP to provide automated support for promoting new source code. This software and the standard procedures designed for source code promotion result in a high rate of successful changes that work right the first time.

Following is the standard process we use for updating source code.

Updating Code

Step	Action
1	Systems engineer codes changes in the Model Office environment.
2	CSR is moved to TEST status in the TLOG system.
3	Tester creates a Test Plan to document the tests and expected outcomes.
4	Tester implements the Test Plan.
5	**If the CSR requires additional changes,** it is moved into a REOPN status, a detail is entered in the TLOG System, and steps 1 through 4 are repeated. **If the test results are favorable,** the CSR is moved to the APPRV status and notes and findings are documented in the TLOG System. Proceed to step 6.
6	Systems engineer moves the changes from CHAMP in Model Office to the production environment within two weeks. **Result:** The code promotion is listed on a daily report of changes moved out of CHAMP.
7	Business analyst receives and files the daily report.
8	State and EDS personnel concerned with the production receive a weekly report of CSRs ready to be operative.
9	The five daily reports of CSRs moved to production are compared with the weekly summary report.
10	Business analyst verifies that CSRs moved from CHAMP have also been moved from Model Office to production in the TLOG system.
11	If any CSRs moved from CHAMP to production have not been updated in the TLOG system, the business analyst notifies the appropriate systems engineer.
12	Two weeks after the CSR is moved to production, the business analyst changes the TLOG system status for the CSR to COMP (complete).

By employing these consistent project management and control techniques, the state and EDS save time and achieve greater success in implementing both process and system changes correctly the first time.

a.4 Ensuring Quality

Ensuring quality is a critical commitment of the EDS Vermont team. In 1998, we established the QIP initiative in an effort to increase the quality of our services. The work groups that support QIP efforts take input from the state and EDS team members for quality improvement efforts. Since its inception, the QIP team has completed 48 projects. Of these, 32 require ongoing tracking. QIP status is shared in weekly fiscal agent meetings and in an annual report card.

In addition, the EDS Vermont team supports several other initiatives to ensure quality. These include:

- Gathering client feedback on EDS performance, which is posted for all corporate managers to review in our Web-based Service Excellence Dashboard tool
- Supporting an annual provider survey
- Gathering feedback from providers on a random sampling of call center conversations
- Soliciting provider feedback on field representative visits
- Identifying claims keying errors and providing follow-up training, verifying batches, and correcting the resolutions instructions
- Reviewing performance reports and statistics in an ongoing effort to detect issues and intervene early
- Collecting feedback on provider workshop evaluation forms

For more information about our commitment to quality in Vermont, see our response to RFP requirement 3.2.2.9(g), "Internal Quality Control Monitoring of Relations With the State, Providers, and Other Stakeholders."

a.5 Leveraging Corporate Project Management Methodologies and Tools

Supporting and undergirding the best practices for project management and control established by the Vermont team is EDS' deep corporate commitment to maintaining and continually improving a methodology architecture that supports all EDS projects. Many of the templates, tools, and practices adopted as best practices for Vermont were selected from the larger body of EDS' project management and system development methodology architecture, which is incorporated in EDS' Global Solutions Management System (GSMS). **In the second year of operations, EDS will enhance established practices by adopting additional GSMS best practices applied to the Enhancements/Modifications Phase in support of the Operations Phase.**

GSMS takes the best of EDS' corporate methodologies and combines them into a single proven, documented, and repeatable project management approach. GSMS is a common global solution process set for application/information engineering and operations work. GSMS is a system of global processes, based on existing corporate methods and tools and incorporating the in-use best practices EDS uses around the world. The scope of GSMS is operational and software application development, implementation, and support. GSMS comprises corporate methods that are integrated into one process set:

- Project Management Version 2.3
- Systems Life Cycle Version 3
- Production Support Method
- Enterprise Testing Method
- Requirements Determination Process
- Estimating

Our GSMS approach is structured to help our solution centers meet Capability Maturity Model (CMM) criteria. The CMM is a tool developed by the SEI of Carnegie Mellon University to help organizations improve their software processes. It provides a framework for improving the management and development of software products in a disciplined and consistent way. The CMM consists of five maturity levels that are indicators of process maturity and capability:

- Level 1—Initial
- Level 2—Repeatable
- Level 3—Defined
- Level 4—Managed
- Level 5—Optimizing

GSMS Release 1 satisfies Level 2 and Level 3 key process areas of the SEI CMM and will help position EDS organizations to move toward SEI CMM Levels 4 and 5, as appropriate. The investment in CMM-based software process improvement will help our clients in many ways, including:

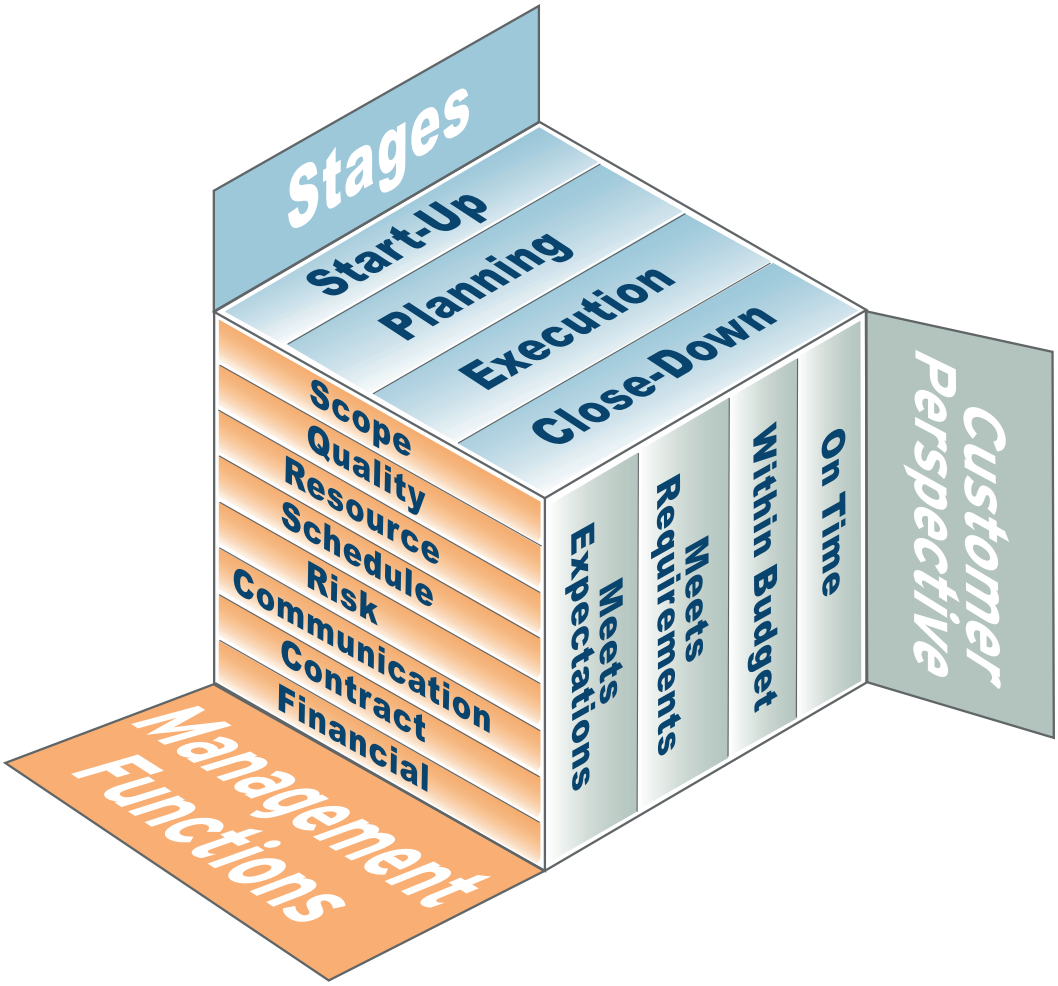
- Improved project predictability, with on-time, on-schedule, and on-budget delivery
- Reduced and more predictable development times
- Improved quality and lower defect rates
- Increased client satisfaction
- Increased employee satisfaction and lower employee attrition
- Ability to work seamlessly from multiple sites
- Effective use of the engineering workforce
- Increased effectiveness through reduced learning curves
- Enhanced competitive advantage and company reputation
- Increased organizational capacity for change

GSMS enables EDS to increase its technical delivery capability, resulting in global competitive advantage and elevating EDS to a leading-edge market position. We will use GSMS to globally and consistently increase our process and organizational maturity to ensure that we have sustained superior execution in our delivery to our clients. **We look forward to applying the best of project management and control methodologies to support the reliable, timely operations that meet the state's expectations.**

Project Management Version 2.3

Project Management Version 2.3 (PM 2) is based on Carnegie-Mellon University's SEI practices and PMI fundamentals. This methodology complements our Systems Life Cycle Version 3 (SLC 3) methodology discussed later in this section and establishes a standard approach for implementing projects. As illustrated in the following graphic, PM 2 provides a solid foundation that enables project managers to create project plans and manage change effectively.

Project Management Version 2.3



The industry-recognized principles in PM2 provide for consistent, successful project outcomes.

PM 2 defines management of systems development projects, systems maintenance releases, systems integration, consulting engagements, proposal development, or other project-based activities. The methodology defines a project as any effort that has a plan and deliverables; that is constrained by schedule commitments, resource requirements, and budget limitations; and that can be delineated from other concurrent activities.

The project management methodology encompasses the following eight functions:

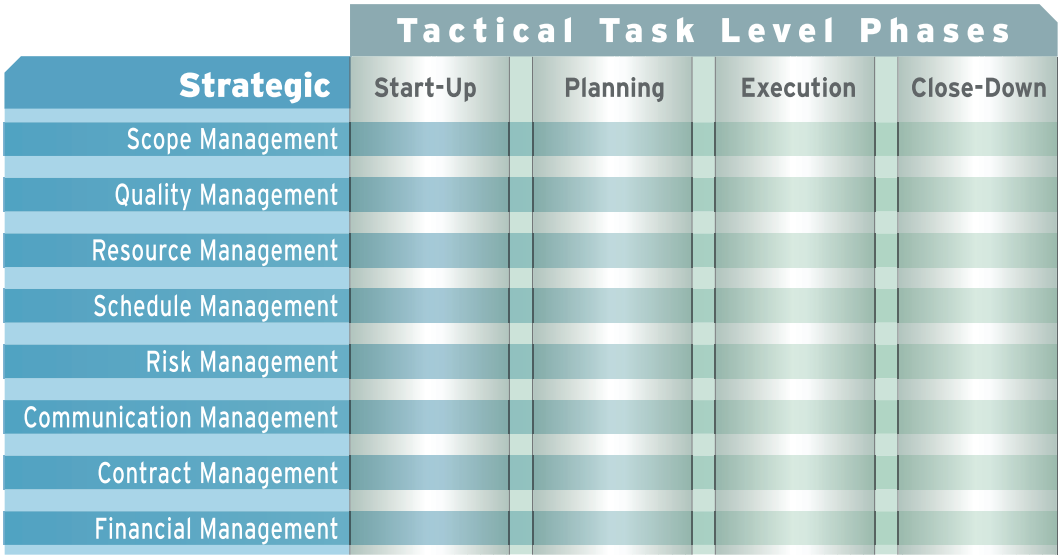
- Scope management
- Quality management
- Resource management
- Schedule management
- Risk management
- Communication management
- Contract management
- Financial management

These functions are interwoven as activities into the following stages:

- Start-up
- Planning
- Execution
- Close-down

The following graphic, EDS' PM 2 Methodology, depicts the integral relationship between the tactical and strategic components.

EDS' PM 2 Methodology



Using PM2 enables us to provide comprehensive management to meet key milestones and dates.

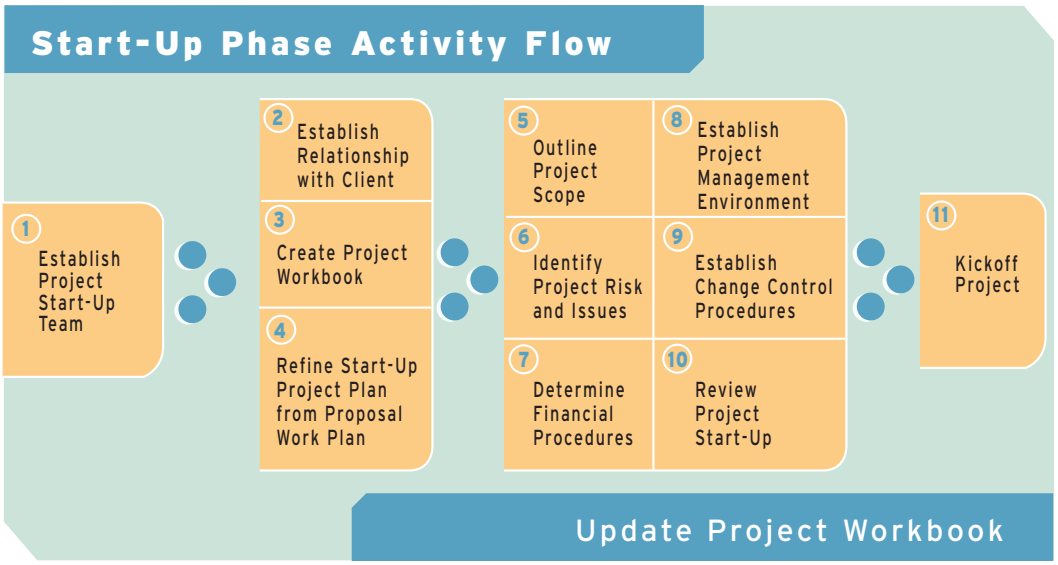
Managing Tactical Project Phases

Each project task and subtask fits within a project phase. These phases are not strictly sequential, particularly the planning and execution phases. During execution, if changes to the original plan are identified, those changes will require replanning. Thus, PM 2 is an iterative process that we establish between planning and execution that lasts throughout the project.

Start-Up Phase

The start-up phase sets the project in motion and establishes the operational framework. The following graphic depicts this start-up phase activity flow.

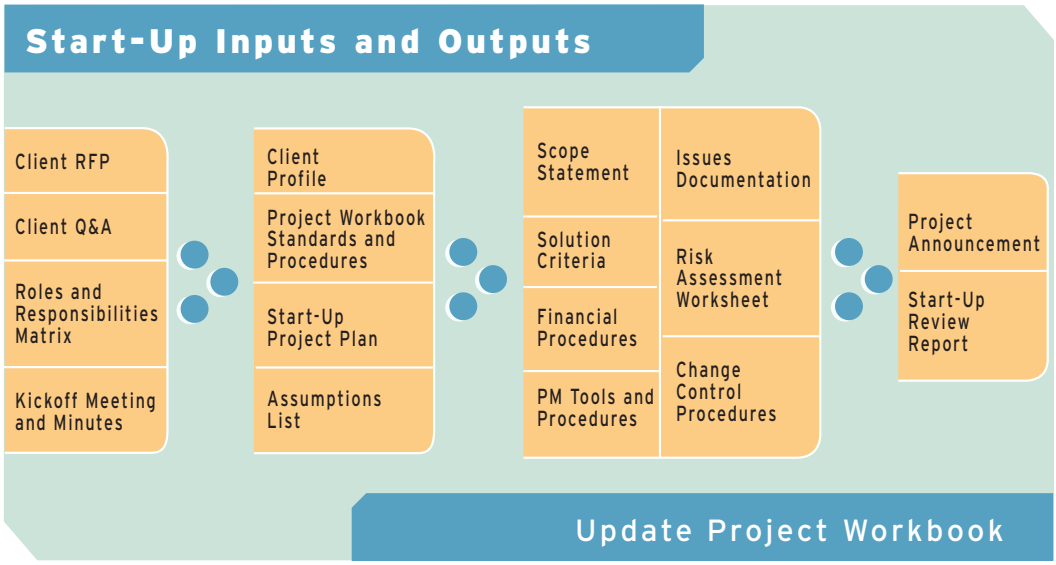
Start-Up Phase Activity Flow



Structured planning for start-up phase activities ensures success.

In addition to activity flow, we associate specific inputs and outputs with the start-up phase as depicted in the following graphic.

Start-Up Phase Inputs and Outputs



By identifying required start-up phase inputs and outputs, we support an organized management approach.

PM 2 provides process steps, tips, and checklists to help manage the start-up activities.

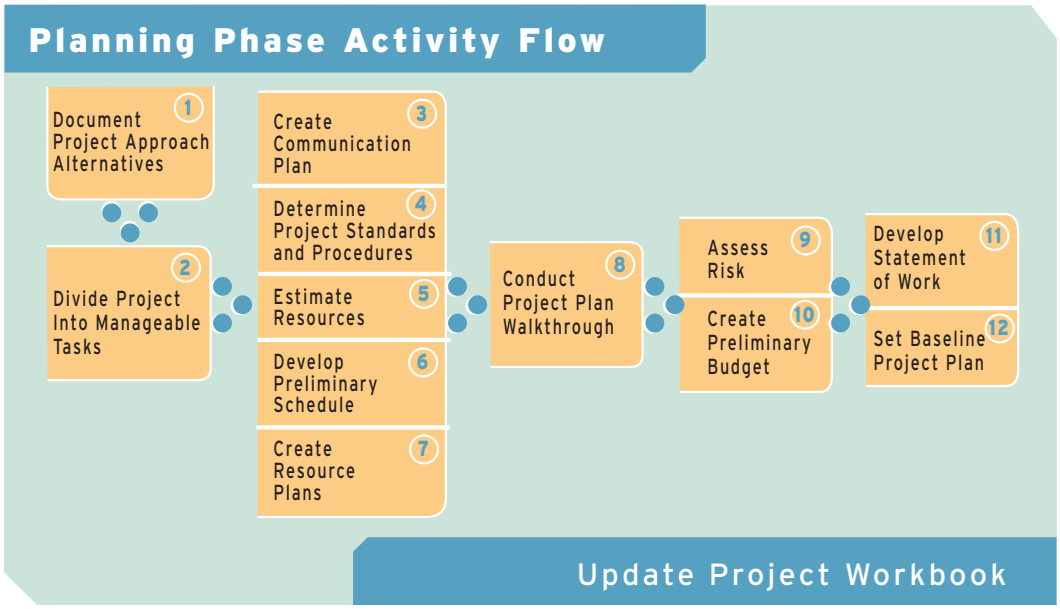
Planning Phase

When planning for changes, the EDS team clarifies work to be done, gains participation of those best qualified to do the work, and develops an appropriate schedule to meet objectives. Sound planning minimizes lost momentum and clearly defines participants' roles in the project. The planning phase also includes adequate consideration of project resources and adherence to completion dates. We completed preliminary planning when we completed the project work plan for this proposal. We will validate our assumptions and plans during the start-up and planning phases, making modifications gained from a shared understanding of stated objectives.

Planning is an iterative process, and although some sequence exists to performing the activities defined in this stage, we will perform many activities simultaneously. Planning takes into account the requirements, organization, communication channels, personnel skills, business and governmental regulatory environments, and project execution strategy.

The following graphic illustrates the relationships among the planning activities that comprise this phase.

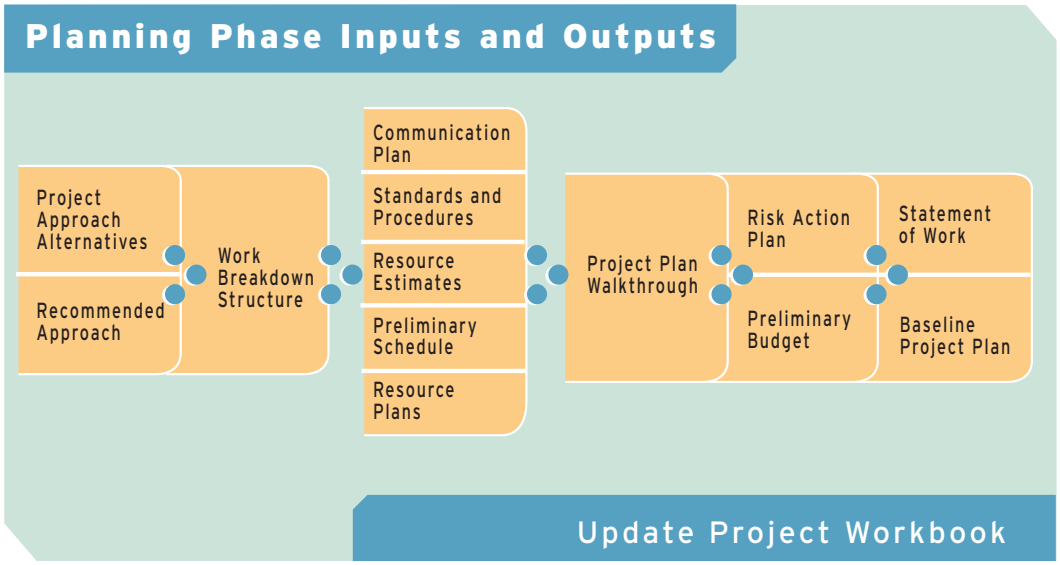
Planning Phase Activity Flow



These tasks are scheduled to occur during the planning phase.

In addition to the activity flow, we associate specific inputs and outputs with the planning phase as depicted in the following graphic.

Planning Phase Inputs and Outputs



By identifying required planning phase inputs and outputs, we support an organized management approach.

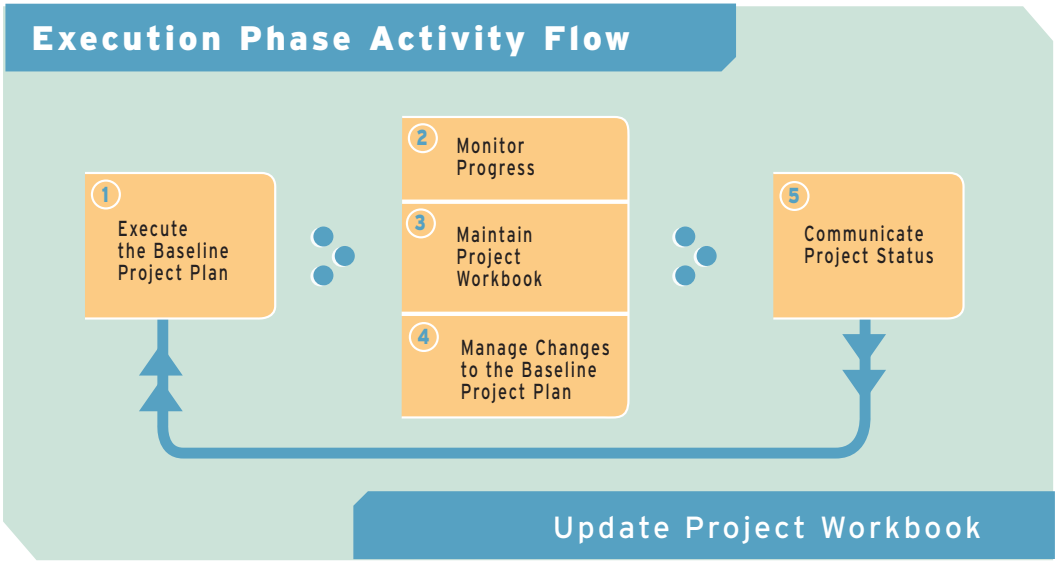
Execution Phase

If execution could be characterized with one phrase, it would be "managing client requirements and expectations." Successfully managing the execution phase requires teamwork and communication skills, particularly listening skills. Our project managers eagerly accept the challenges of managing change and effectively communicating with you and with other EDS team members, setting the stage for project success.

During the execution phase, we put the finalized project plan into action. We are responsible for controlling the actions taken to achieve the project's objectives. The project manager directs the EDS team by implementing and carrying out the approved plans to achieve your stated objectives. He or she also oversees staffing, training, supervising, delegating, motivating, counseling, and coordinating project activities.

The project manager controls the project by measuring progress toward project objectives, evaluating remaining tasks, and taking necessary corrective actions to achieve the project's objectives. These activities are iterative—they are performed many times throughout this project phase. The following diagram depicts the relationships among the execution activities that comprise the project management processes defined in this phase.

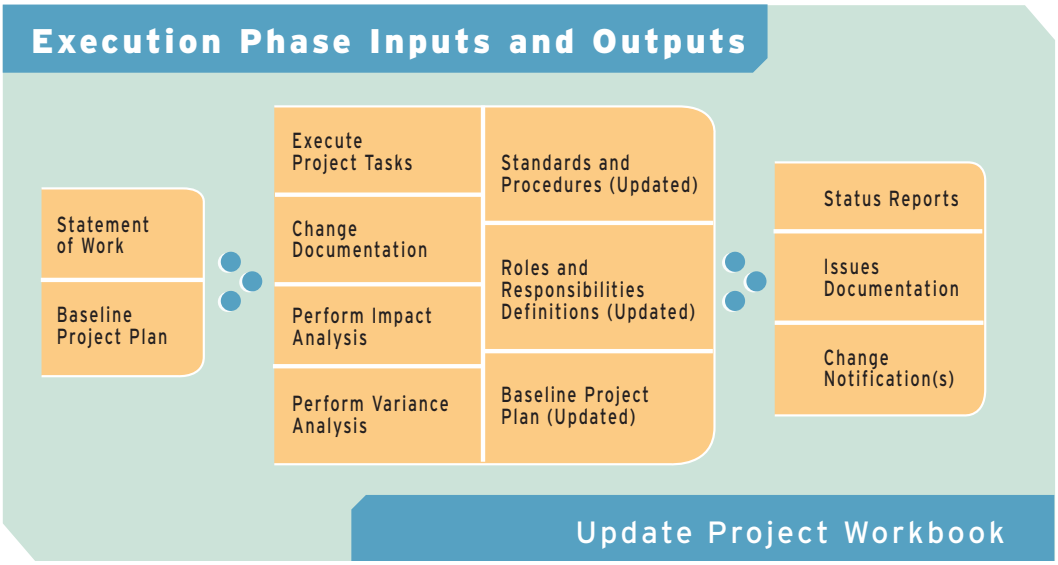
Execution Phase Activity Flow



Structured planning for execution phase activities ensures success.

In addition to activity flow, we associate specific inputs and outputs with the execution phase as depicted in the following graphic.

Execution Phase Inputs and Outputs



By identifying required execution phase inputs and outputs, EDS supports an organized management approach.

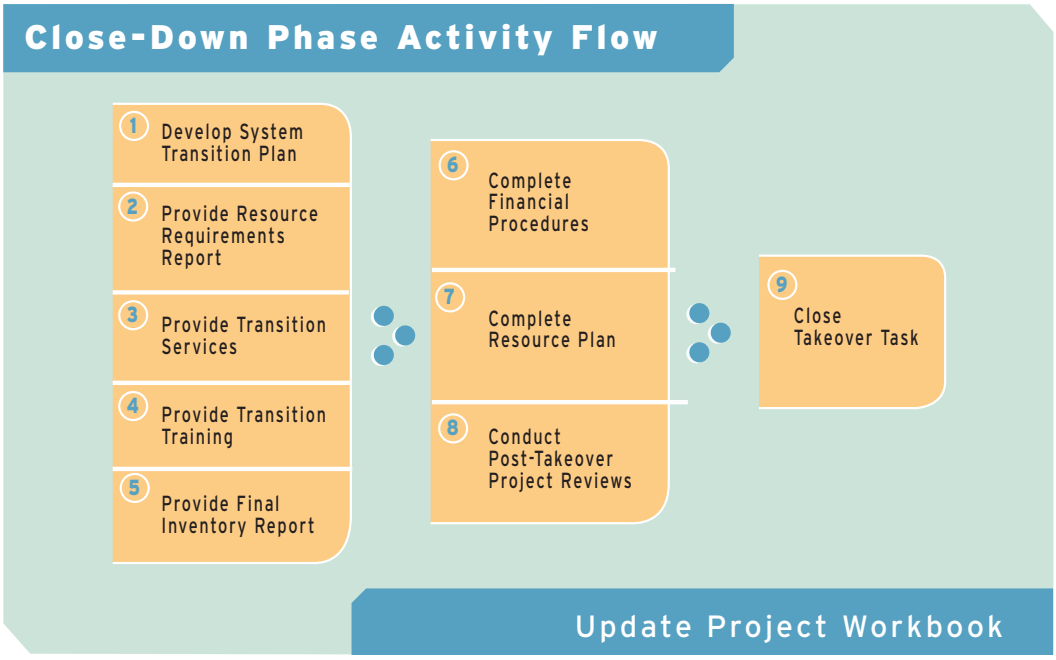
Close-Down Phase

The final phase in PM 2 is close-down. The project manager ends the project in an orderly, controlled manner by reviewing the project's progress and outcomes and archiving for future use the project planning documents.

We conduct postimplementation reviews with you and our team members to measure participant satisfaction, identify areas for improvement, and share lessons learned. This information becomes part of the Operations Quality Improvement Plan and is incorporated into future projects for you. We also add the information to our corporate best practices repository to benefit other Medicaid clients, just as the knowledge gained from other clients is used to benefit you.

The following graphic illustrates the relationships among the close-down activities that occur in this phase.

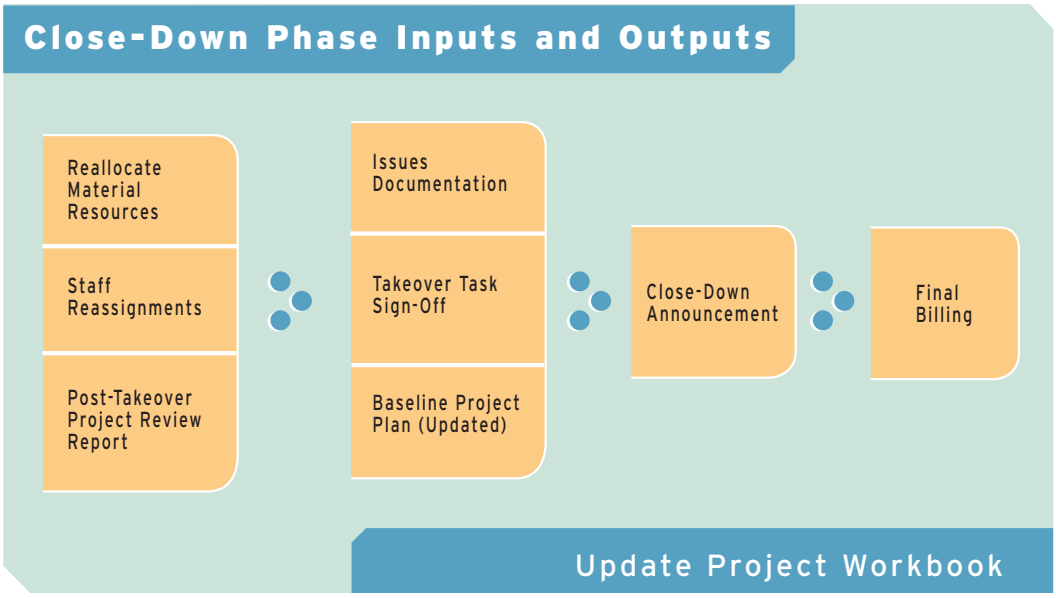
Close-Down Phase Activity Flow



Structured planning for close-down phase activities ensures success.

In addition to the activity flow, we associate specific inputs and outputs with the close-down phase as depicted in the following graphic.

Close-Down Phase Inputs and Outputs



By identifying required close-down phase inputs and outputs, we support an organized management approach.

Managing Strategic Project Components

Our project management approach also includes strategic components. In the following subsections, we discuss each of these components.

Scope Management

Scope management helps project managers and their teams identify requirements and deliverables and establish a shared understanding and agreement about project requirements. Managing project scope helps avoid scope creep that can result in delays. Once we have agreed upon project requirements, we divide work into manageable tasks so that completion dates can be forecasted.

Quality Management

Effective quality management practices help the EDS team define performance requirements and create a plan to achieve these requirements. We involve all key project participants to help ensure that the plans and procedures are followed. The team analyzes performance against the project's requirements, goals, and standards, and the team evaluates progress at appropriate points to check compliance with all parties' expectations.

Resource Management

The team uses resource management to determine the procedures for timely, cost-effective acquisition, use, and reallocation of resources to provide quality products and services to you. Effective resource management ensures that people and technology resources are available and used effectively and efficiently throughout the project.

Schedule Management

We use schedule management to create a project schedule to deliver the required work products with the allocated resources. Effective schedule management helps ensure that the project is delivered on time, within budget, and according to specifications.

Risk Management

Risk management helps the project management team systematically assess the risk factors of a project and identify specific risk items. We manage risk by taking action to accept, transfer, or mitigate risk. To reduce uncertainties and unintended consequences, we also create contingency plans and submit them for your approval.

For more detailed information about our risk management process and a list of risks we have identified for this project, see our response to RFP requirement 3.2.2.9(e), "Assessment of Project Risks and Approach to Monitoring and Managing Risks."

Communication Management

Effective communication management helps ensure that all stakeholders receive the needed information for decision-making when they need it and in a format that allows them to take action. We use communication management to determine the kind of messages to send, who should receive them, when to send them for effectiveness, and how to compose them.

Contract Management and Financial Management

Contract and financial management helps us establish the contract and financial infrastructure and project requirements to estimate, forecast, budget, and track project economics and contract stipulations. We also determine contract requirements that involve our subcontractors. We then monitor adherence to all of these requirements.

Systems Life Cycle Version 3

SLC 3 is a systems engineering methodology that evolved from EDS' collective systems engineering experience, industry insight, and SEI-recommended development approaches. It applies technology to evolve solutions that meet rapidly changing client business needs. SLC 3 lets us deliver value by providing a strong combination of engineering discipline and flexibility. SLC 3 decreases systems engineering risks by encouraging active involvement throughout the process and by using planned iterations to validate intermediate results.

We can tailor the SLC 3 methodology to meet unique needs and deliverables and to support maintenance, minor enhancement, development, systems integration, and other work. It offers the flexibility to support systems engineering on various platforms and tools, from mainframe to desktop.

Benefits

SLC 3 offers many benefits that help EDS provide superior products and services:

- Aligns information technology with business requirements
- Strengthens communication
- Delivers the best practices from all of EDS
- Reduces risk by applying iteration to verify and validate intermediate results
- Facilitates process customization to meet unique needs
- Reinforces consistent, repeatable processes and therefore, allows continual improvement
- Facilitates continual improvement as EDS develops, field tests, and deploys new practices and technologies throughout company
- Establishes a common basis for communication
- Assists the project team in blending its requirements with engineering discipline and proven best practices from across EDS
- Provides a foundation for increasing systems engineering process maturity
- Reduces time and effort expended on retraining personnel on processes when personnel transfer from one team to another

SLC 3 describes the system development activities to be performed and is tailored to the process level of detail according to the methodology architecture. SLC 3 consists of the following six-phase spiral approach that blends planned iteration with management control:

- **Define**—Identify the business need and determine high-level requirements
- **Analyze**—Refine high-level requirements into detailed business requirements
- **Design**—Build design specifications
- **Produce**—Translate designs into executable components to satisfy the business need
- **Optimize**—Verify that the produced system is ready to implement
- **Implement**—Install the produced system

The first four phases will be repeated as a group to produce intermediate results for verification, approval, and validation. This phased repetition, or iteration, helps focus on different areas and requirement levels as the system evolves.

Iterative solution development offers the following benefits:

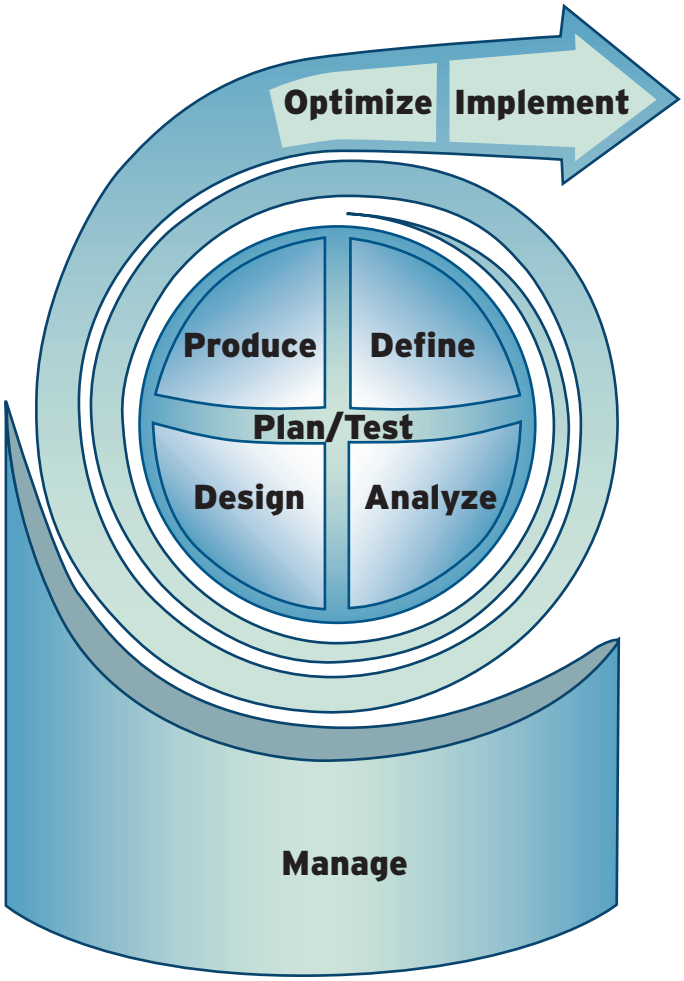
- **Provides a cycle of plan, do, learn, and improve—**Outputs of each iteration result in learning that can be applied in successive iterations to evolve the best overall solution.
- **Aids mutual understanding of requirements or solution ideas—**The completion of an iteration results in models, prototypes, or partially completed products that can be reviewed by you. These outputs provide a what-you-see-is-what-you-get medium for better communicating the intended solution, which results in better validation and feedback.
- **Tests the validity of critical or fundamental solution ideas before spending time and resources on development of contingent details—**Solutions usually consist of many interdependent decisions, some of which are critical and fundamental to the remaining decisions. Some of the most critical and fundamental decisions are based on major assumptions and understandings. By using preliminary iterations to deliver a proof of concept to validate these decisions, necessary adjustments can be made before spending a lot of time and resources on the remaining dependent decisions.
- **Provides actual results earlier in the process—**This, in turn, provides a higher level of confidence that EDS is meeting its commitments and schedules.
- **Allows users to feel involved in developing the solution—**User involvement is essential to ensuring client satisfaction and the effectiveness of the delivered solution. Continuous involvement of all affected persons, however, is not usually practical. Iterative development can involve user representatives throughout each iteration, and at the end of each iteration, we provide iteration results to a larger audience for a complete validation of the decisions made.
- **Focuses resources and management attention on a limited portion of the solution at one time**—Scattered across large projects, resources and management attention can become diluted and less effective. Using an iterative development approach can focus the resources and attention on one selected portion or cross-section of the problem at a time. This concentration of effort can improve both quality and productivity.

The last two phases are performed when the iterative portion is complete. Each phase includes individual plan and test components. Additionally, all phases have an underlying component, called manage, which enables continuous monitoring and control of process resources and results.

SLC 3 complements other EDS methodologies, such as those that establish business direction, identify business process change opportunities, and set technology direction at the enterprise level.

As illustrated in the following figure, SLC 3 balances iteration with management control to develop the business solution. Appropriate iteration evolves the business solution, providing early opportunities to clarify expectations and anticipate changing business needs.

Systems Life Cycle Version 3



SLC 3 balances iteration with management control to develop the business solution.

The management component defines work that cannot be scheduled because it recurs throughout the project. This includes management control functions critical to a successful project, such as scope management, issue management, software configuration management, and risk management.

Many of these components are integrated with EDS' PM 2. Like other systems development life cycles (SDLCs), EDS' project management methodology is integrated throughout the SLC 3.

The organization of each phase can be described as "plan-do-test." This cycle is repeated for each phase within each iteration and for each iteration.

- **Plan**—Preparation required to perform the phase effectively. Planning keeps the phase's work directed toward the objectives of that particular iteration.
- **Do**—Actual performance of the defined work within each phase.
- **Test**—Verifies that the work was performed as specified and validates that the work properly addresses the business need. Test also assesses results according to the phase's objectives to determine and report the project's progress and status.

SLC 3's structure is logical rather than sequential. It provides the flexibility necessary for customization and continuous process improvement. The six SLC3 phases are documented in logical groupings; however, a sequential occurrence of events is not implied. The sequence of SLC 3 work is determined during each project's customization process.

Production Support Method

The Production Support Method provides an integrated approach to help EDS provide better software maintenance and other production support services to clients. It offers greater productivity and quality for production support teams and greater recognition of the importance of production support to EDS business.

This method offers practical guidelines and procedures, proven techniques, and suggested templates and examples to help the systems engineering team successfully support a production system.

The Production Support Method provides the following value and benefits:

- Improved service excellence through an integrated approach for software maintenance and other production support activities
- Method support for GSMS production support work types
- Greater recognition of the importance of production support

Enterprise Testing Method

The Enterprise Testing Method is the EDS-preferred methodology for enabling comprehensive testing. This methodology promotes productivity, quality, and comprehensiveness in our testing practices, providing a better deliverable for our clients with reduced risk of solution failure.

The methodology defines test-related activities from the initial stages of a project to the implementation of the final solution. The methodology also encompasses test activities across all deliverable components. From software to infrastructure to hardware, this method describes appropriate test activities.

Enterprise Testing Method has associations with other EDS methods, processes, and strategies. Enterprise Testing Method links, by direct reference, to other methods for cross-discipline functions, such as project management and requirements determination.

Enterprise Testing Method enables greater consistency in the delivery of testing services, helping EDS and its clients achieve service excellence.

Requirements Determination Process

The Requirements Determination Process (RDP) provides a framework for communicating with clients and those who will receive and use requirements documentation to build a product or service.

The role of the RDP is to establish a set of requirements that describe the correct product or service to be delivered to the client. The key benefits of RDP are:

- Reduced costs as a result of properly directed efforts and increased productivity
- Improved time to market
- Reduced risk due to clear understanding of client requirements

The RDP is divided into five major activities:

- Plan/Manage
- Obtain
- Understand
- Validate
- Evaluation

The core of the RDP—obtain, understand, validate—is executed multiple times, one for each set of requirements that the project team wants to obtain, understand, and validate.

Requirements must be reviewed by appropriate groups, including the project team, before they are incorporated into an overall project. Requirements become the basis for all project plans, work products, and activities.

Requirements determination identifies what is really wanted, needed, and expected—a familiar and necessary part of business and personal life.

Requirements determination in EDS is based on the following principles:

- Delivering the client's full requirements and expectations into any EDS process used to produce a product or service
- Providing clients with EDS' leadership and expertise in using the RDP and the associated tools and techniques
- Adapting requirements determination to the unique needs of accounts and their particular clients or situations

Estimating

The EDS estimating process is a rigorous method that helps us develop valid estimates for programming projects. The estimating method is practical, adaptable, and scalable to cover a wide range of project/task sizes. Our estimating process is founded on the following three principles:

EDS' Estimating Process

Principle	Justification
Apply the correct resources to create and refine the estimate	The magnitude of a project, the risk of an inaccurate estimate, and the number of project uncertainties influence the level of detail and scope of the estimate created. The project team should invest in the estimate relative to these factors.
Do not arbitrarily change the resource estimate required for a given scenario	Unless a change occurs in the constraints, assumptions, or risks associated with a given scenario, an estimate should not be changed. The project team will develop alternate scenarios to provide the most effective mix of resources based on the existing constraints, assumptions, and risks.
Re-estimate often, even if the deadline cannot be changed	Even if commitments are made to a client based on the original estimate, it is vital that the project manager create accurate estimates of remaining work. The project team should base decisions on the most current information available. Re-estimates are created when a constraint, assumption, or risk changes; when a scope change occurs; or when a major milestone occurs, such as the end of the design.

Estimating Process

The goal of the estimating process is to predict as accurately as possible the project's resource needs so that anyone having a vested interest in the initiation, execution, or outcome of a project can make informed decisions.

Realistic estimates, based on sound assumptions and historical information, assist in planning projects for the best use of resources, thereby avoiding:

- Depletion or waste of resources
- Excess effort within severe time constraints
- Last-minute project surprises
- Too many resources and not enough work

Realistic estimates are a key tool in completing the Vermont enhancements/modifications project on time and within budget. The estimating process described below has six basic steps, which are an integral part of the EDS project management process:

1. **Estimate Planning—**Identify required participants and their roles. Define the timing of the estimates and the details for each of the steps.

2. **Determine Project Size—**Identify high-level requirements, constraints, and assumptions. Use this information with historical data from similar projects/tasks to determine current project/task size. We accomplish this step through a variety of techniques, including function-point analysis, source-statement estimating, and component (window, report, and process) estimating.

3. **Develop Project/Task Estimates—**Estimate the project/task using two approaches: bottom-up and top-down. A bottom-up estimate involves separating the project into smaller parts, estimating them separately, and then aggregating the results. A top-down estimate involves looking at the project as a whole, using environmental characteristics, size, and historical information. We use automated tools to assist with each type of estimating. These tools are based on historical data from the information technology industry and previous EDS Medicaid implementations.

4. **Reconcile Differences—**Reconcile estimates from step 3, "Develop Project/Task Estimates," and historical data from similar projects/tasks into one solution set for each scenario. Portions of the process may be repeated to resolve differences as needed. The final estimate is not a single solution, but forms a set of possible solutions bounded by the associated risks.

5. **Assemble Estimating Documentation Package—**Create an estimating documentation package and a schedule and resource plan for the solution set. Consider the required resources available in the schedule and resource plan.

6. **Review Estimate With Stakeholders—**The review and approval process involves stakeholders such as the management team, the project team, and any other affected staff. We will use the estimating process output for the next steps, such as prioritizing decisions by the management team regarding which scenario best fits their needs, and the creation of a proposal package.

In conjunction with the estimating principles, we use metrics to measure progress toward the completion of a task or project. Each work plan task is represented by the amount of work hours required for completion. We use a standard systems engineering assessment that allows for the measurement of progress and provides accurate estimates for development and enhancement work efforts. Metrics examples include lines of code and the total number of reports, windows, and processes completed to date, as compared to the entire proposed system. Metrics from previous projects give us an accurate baseline from which to estimate realistic time frames and effort required for an activity, allowing us to adhere to the project schedule.

a.6 Proven, Customized Project Management and Control

The Department of PATH has been working with EDS for more than 21 years in implementing system and process changes to operations of Medicaid and other PATH programs. Our documented best practices for project management and control are customized to Vermont and proven effective. In addition, our practices are flexible in adapting to projects of widely varying scopes.

Since 2000, this standardization has increased the quality of project management on the Medicaid project and reduced delivery risks. Additionally, the familiarity of state personnel with standard approaches, meetings, and templates makes the cooperative effort comfortable and easy. Our project management approaches consistently meet state expectations, reducing the state's time commitment to supporting change.

At the same time, our customized methodology benefits from the continuous improvement efforts of our corporate methodologies for managing projects and systems development.

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b. Staff Resources and Time Estimating Methods

RFP Reference: 3.2.2.9(b), p. 3-14

To track staff resources and document staff hours, EDS uses two key tools:

- The Tracking Log (TLOG) System, a software application that tracks technical staff time against projects
- SAP, a standard corporate tool that tracks all time use for all project team members

These two tools are the primary methods for tracking staff resources and documenting staff hours. We describe these tools and their applications in the following sections.

Tracking Time for Technical Personnel

Tracking time for technical personnel on key projects is essential for evaluating and improving our time estimation efforts and for overseeing staff productivity. To support this activity, we use the TLOG System. The TLOG System tracks systems engineer and business analyst hours against approved problem logs (Plogs) and customer service requests. The system also supports status reporting that helps project managers make informed decisions regarding project prioritization, resource management, and change management.

The TLOG System will support the communication of project information to all levels of the organization. Through the TLOG System, we can:

- Provide a view of all projects related to the Vermont MMIS
- View project status and summaries of project activities
- View resource utilization across projects
- Track corrective actions from discovery to resolution

Tracking Time for Non-Technical Project Personnel

To access information regarding nontechnical project personnel, managers can run reports from EDS' standard corporate time-tracking system, the SAP. In fact, the TLOG System also interfaces to our corporate time tracking system so that reports from SAP can reflect all EDS staff.

Managers use this system to review and evaluate how both operational and technical employees are using their time in support of client needs.

The information in these tools and our first-hand experience with the current environment and operational cycles guide us in staffing appropriately and efficiently.

Estimating

Realistic estimates are a key tool in completing the Vermont enhancements and modifications project on time and within budget. We describe our thorough process for estimating in the "Estimating" subsection of the "a. Project Management and Control Methodology (Operations Phase)" section.

c. Procedures for Sign-off of Completed Milestones and Deliverables

RFP Reference: 3.2.2.9(c), p. 3-14

Formal sign-off of completed milestones and deliverables provides the state a checkpoint to ensure project progress is proceeding and verifies that our work is meeting state expectations.

The assigned EDS project manager is responsible for managing the sign-off process for completed milestones and deliverables. During communication planning, the project manager and state personnel jointly determine which milestones and deliverables will require formal sign-off. These formal milestones are marked in the project plan for tracking purposes.

When it is time to receive state sign-off, we provide the deliverable in hard copy and/or electronic form with a cover memo attached for signature. As stated in the RFP, the state has 10 days for its review. Our project plan reflects this 10-day review period.

Should the state have an issue with the deliverable, we revise it and return it to the state for another 10-day review period. We avoid issues during the sign-off process by walking state personnel through an outline of the deliverable to gather feedback prior to the deliverable due date. This technique helps us to verify that our approach will meet state expectations.

Once the deliverable is satisfactorily revised and signed off, the project manager records this successful milestone in the project plan.

This standard approach assures an organized process for deliverable and milestone sign-off.

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d. Management of Contractor Responsibilities, Milestones, and/or Deliverables

RFP Reference: 3.2.2.9(d), p. 3-14

Effective management of contractor responsibilities, milestones, and/or deliverables is central to our established approach to project management and control.

Contractor Responsibilities

Client Delivery Executive Barbara Davis and her key managers undertake several key activities on a daily basis to see that EDS fulfills its contractor responsibilities. These activities include:

- **Education and training—**Education and training is designed to make sure each person on the team understands his or her responsibilities and why the task is important. Managers, in particular, must know by heart the performance standards for their areas of responsibility.
- **Use of established procedures—**These established procedures document the most efficient way to perform each task.
- **Use of VermontAIM automated features—**These features further streamline all system-related procedures.
- **Follow-up and monitoring—**These activities verify that all procedures are being followed and that all performance standards are being met.
- **Review of statistics and reports—**These reports include regular performance statistics reports, reports from EDS staff regarding workload spikes or other issues, reports from providers through the call center, and reports from state personnel.
- **Fast identification of trouble spots—**Managers use statistics and reports to identify potential problems and promptly develop corrective action plans to remediate the issues.

Barb and her managers address any issues aggressively and communicate both issue and resolution as appropriate to the state. Some issues might warrant immediate conversations with state personnel. Most issues are reported and monitored through weekly fiscal agent meetings. For more information on our approach to resolving problems, see our response to RFP requirement 3.2.2.9(f), "Approach to Problem Identification and Resolution."

Milestones and Deliverables

Also during the Operations Phase, we must meet multiple milestones and deliverables. These include not only regular, anticipated milestones or deliverables that are reflected on the

operations project plan, such as periodic updating of the Business Continuity Plan, but also deliverables and milestones related to special projects. For special projects, project managers create project plans that reflect key milestones and deliverables.

The responsible manager uses the methodologies described in our "Project Management and Control Methodology" response to requirement 3.2.2.9(a) in this Operations Narrative section to monitor and manage the meeting of contractor responsibilities, milestones, and deliverables.

We provide a hard copy or electronic copy of the deliverable and a cover sheet for sign-off to appropriate state staff. State staff members have 10 days, according to RFP requirements, to review the deliverable and either request revisions or sign off on it. When appropriate, EDS will prepare an outline of the deliverable in advance of the due date to validate our approach.

For a more detailed description of the sign-off process, see our response to RFP requirement 3.2.2.9(c), "Procedures for Sign-off of Completed Milestones and Deliverables" in this Operations Narrative section.

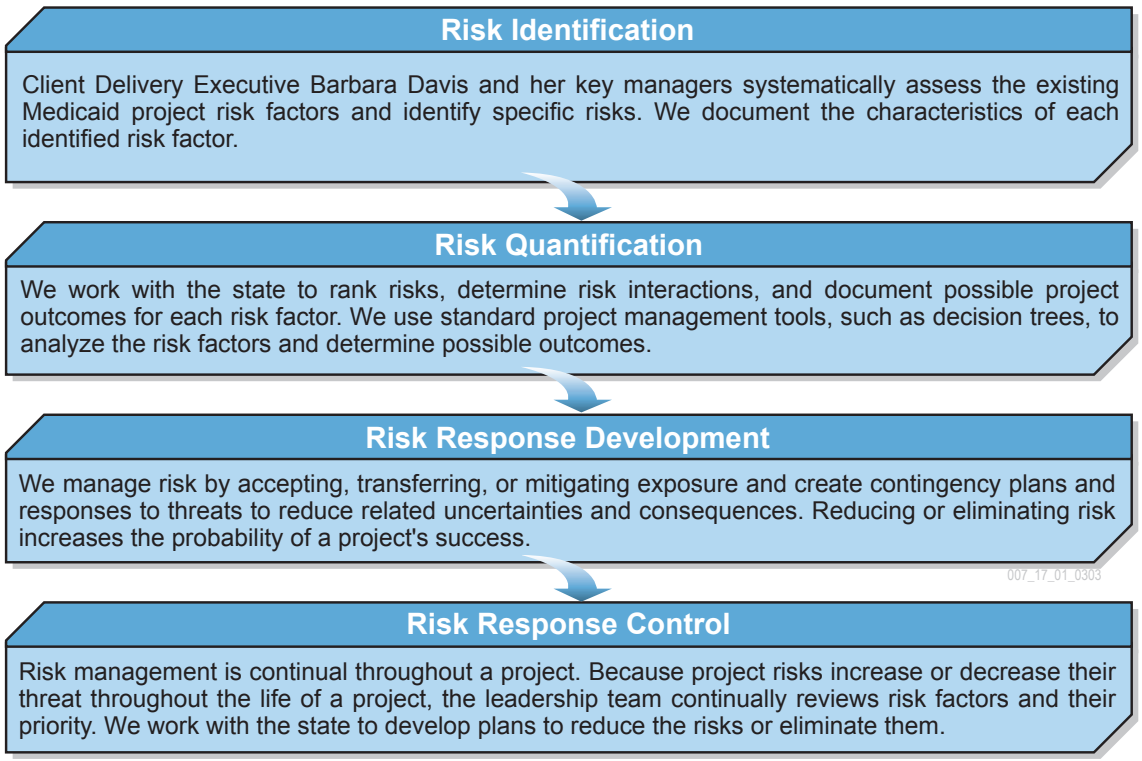
e. Assessment of Project Risks and Approach to Monitoring and Managing Risks

RFP Reference: 3.2.2.9(e), p. 3-14

The risk management component of the project management methodology helps teams systematically assess, monitor, and manage the risk factors of a project. Effective risk management provides the capability to predict and prevent many problems before they occur and to rapidly correct any problems that do occur. As a result, properly assessing risks can substantially decrease project problems. In the following subsections, we identify our overall process for managing risk during the Operations Phase and discuss the potential project risks we have identified and begun mitigating.

We recognize and use a risk management process consistent with the Project Management Institute (PMI) body of knowledge. The following graphic depicts the major risk management components.

Risk Management Components



Our team has years of experience proactively identifying, quantifying, quickly responding to, and successfully controlling risk.

EDS' project management methodology provides tools, templates, and processes that help identify risk. The process provides an early identification of major obstacles to project success. It helps determine and communicate the degree of risk the project faces and details plans to handle that risk. The risk identification process and the resulting table also provide the state with the opportunity to discuss the consequences of doing or not doing specific project activities. Major obstacles to success are identified in a timely, objective manner. This identification provides the state and EDS with the opportunity to identify an action plan to resolve risk issues and increase the success of the project. The leadership team plans a detailed review of all identified risks with the state so that we can effectively resolve risk issues.

The risk identification table includes the following information:

- **Risk Item No.—**The identification number assigned to the risk
- **Responsible Team/Person—**The person ultimately responsible for resolving the risk
- **Risk Description—**Type of risk
- **Risk Status—**The current status of the risk; if the risk is open, an "O" will appear in this column; if closed, a "C"
- **Risk Level—**The magnitude of the impact of the risk; "L" is used to indicate a low level, "M" is used to indicate medium level, and "H" for high level
- **Probability—**The probability that the risk will occur; "L" indicates a low probability, "M" is a medium probability, and "H" is for a high probability that the event will occur
- **Potential Impact—**The impact to the project if the risk should occur
- **Approach—**The suggested approach to be taken; the state will review and approve all approaches before action is taken
  - "E" indicates eliminate: The risk is immediately acted upon, based on the cost of eliminating the risk compared to the cost of potential impact and the likelihood that it will occur
  - "A" indicates accept: Accept the consequences of the risk occurring; an appropriate strategy for risks with low possibilities of occurring or little impact if they do occur
  - "T" indicates transfer: The authority and accountability to actually deal with the risk lies elsewhere and has been transferred to the accountable entity
  - "M" indicates mitigate: Reduce the impact of the risk and the likelihood that the risk will occur to an acceptable level should the risk occur
  - "S" indicates study: Resources are needed to further investigate the risk to acquire more information and better determine its characteristics to enable more knowledgeable decision-making
- **Anticipated Mitigation—**Describes how EDS will affect the probability or the impact of the risk. The mitigation process allows us to reduce the impact of the risk, thus reducing the risk event value

The following table lists potential technical obstacles and business issues associated with the Operations Phase of the project. The table includes an initial list of potential risks that we have identified and our plan to handle those risks.

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Potential Risks for Vermont Medicaid and Other PATH Programs

Risk Item No.	Responsible Team/Person	Risk Description	Risk Status (O, C)	Risk Level (L, M, H)	Probability (L, M, H)	Potential Impact	Approach (E, A, T, M, S)	Anticipated Mitigation
R1	Client Delivery Executive	Experienced EDS staff cannot be assigned according to project schedule	O	H	L	Work tasks are not assigned or scoped according to schedule and tasks begin to slip.	A	EDS has an experienced and successful team in place today. Additionally, EDS is the largest provider of services to Medicaid agencies across the country. We will draw upon corporate resources to identify and recruit the best possible staff to backfill for required positions as necessary.
R2	Client Delivery Executive	Inaccurate or unclear RFP requirements	O	M	L	Project scope is increased, which expands the demands on the state and EDS and jeopardizes our ability to deliver on schedule.	M	Our understanding of the existing system validates our assumption that the RFP is thorough and represents a good faith effort to fully document the requirements of the replacement system/operations. The requirement validation meetings will enable the state and EDS to finalize requirements and document results of our meetings. We will mitigate this risk by thoroughly mapping the RFP requirements to system objects to ensure that we are performing the right tasks and cooperating with the state to efficiently plan activities and resources to meet RFP requirements.
R3	Client Delivery Executive, Systems Manager	The availability of full-time dedicated state staff with the necessary decision-making authority to provide thorough and timely review of all project deliverables	O	H	M	Lack of state staff participation in the review of the schedule, work plans, project status reports, associated project records, and deliverables within the established time frames may negatively impact the overall project. Potential impacts include project task end-date slippage, cost overruns, and rescue availability.	M	EDS will work with the state to meet requirements timely. We will use status meetings to review and identify potential threats to the work plan before they affect the dates, cost, and resources. To ensure timely completion of all deliverables and project goals within required time frames, EDS recommends that the state provide to EDS written approval of deliverables within 10 calendar days of the submission of a deliverable. If written notification is not provided within the 10 calendar day period, EDS will assume the state has approved the deliverable.

Risk Item No.	Responsible Team/Person	Risk Description	Risk Status (O, C)	Risk Level (L, M, H)	Probability (L, M, H)	Potential Impact	Approach (E, A, T, M, S)	Anticipated Mitigation
R4	Client Delivery Executive	Insufficient program experience and system proficiency to address problems or questions	O	M	L	EDS is unable to retain personnel with the necessary qualifications to operate the Vermont MMIS.	A	EDS has access to sufficient staff and will be able to use them if this risk event occurs. EDS currently provides similar services to 15 Medicaid clients and more than 150 health care clients. Moreover, we operate versions of the system in place for several clients and have more than 20 other health care system solutions.
R5	Systems Manager	Equipment delivery delayed, causing delays in installation and operations	O	M	L	Because of unanticipated manufacturing, inventory, or transportation delays, required equipment may not arrive as scheduled.	M	The draft work plan allows for appropriate lead time to minimize the possibility of manufacturing, inventory, and transportation delays having a negative impact on the project schedule. We will work with the state to finalize schedules presented in the final work plan. Our work plan mitigates this risk.
R6	Systems Manager	Implementation schedule affected	O	M	L	Through the addition of features, Medicaid change requests, Vermont legislation, or CMS directive, project scope could expand to exceed the available implementation schedule.	A	EDS' project plan incorporates methods to identify issues, risks, assumptions, and project constraints early in the project, allowing EDS to be proactive and work with the state to resolve and avoid problems that affect the schedule, therefore minimizing impact to scope.
R7	Client Delivery Executive	The state and EDS have different definitions of "acceptable performance" of contract requirements	O	M	L	There is variation in performance and deliverables because the state and EDS use different operational definitions for performance, deliverables, or sign-off.	A	As part of the quality management process, the state and EDS will jointly define performance requirements and methods for measuring and reporting results.
R8	Client Delivery Executive	Hardware downtime	O	H	L	EDS is unable to process claims through the MMIS because of unanticipated hardware downtime or lack of hardware reliability.	M	EDS will work with the state to develop a finalized disaster recovery plan that includes the ability to continue processing at an alternate state site, or EDS facility, in the event of an unexpected system outage.

Our proactive approach to project risk management helps us keep projects on track for implementation. Based on our unmatched knowledge of the Vermont Medicaid environment, we have allocated adequate time to respond to unanticipated risk situations that may arise, or have developed a mitigation plan to address possible risk areas. In addition, our broad health care experience across numerous clients allows us to effectively handle risk issues specific to health care because we have worked with similar systems.

EDS carefully monitors the vital tasks on the critical path continuously throughout the implementation. Should a vital task appear at risk of slippage, management is prepared to act quickly to shift resources as needed to ensure all critical tasks are completed on schedule.

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f. Approach to Problem Identification and Resolution

RFP Reference: 3.2.2.9(f), p. 3-15

The state and EDS have established a regular process to identify issues, communicate them, and quickly resolve them. Our approach to corrective action is direct and logical. We use proven methodologies to identify, track, and report issues. The issue resolution process includes problem definition, root cause analysis, and error severity classification solutions. This process also includes ongoing communication with you in fiscal agent meetings and other regular work group meetings until the issue or problem is resolved.

In addition, Client Delivery Executive Barbara Davis has a succession plan in place for replacing key personnel when necessary.

We provide additional information on our approach to operations problem identification and resolution in the following sections:

- Resolving Operational and System Issues
- Replacing Key or Technical Personnel

Resolving Operational and System Issues

Client Delivery Executive Barbara Davis and her leadership team are all responsible for monitoring and identifying problems and resolutions. They do this by knowing their teams' contract responsibilities, keeping their fingers on the pulse of account operations, reviewing performance reports regularly, and intervening when trends indicate a potential issue.

When we identify a system or operational deficiency, we notify the state no later than the close of the business day during which we identified the problem. We provide verbal notice of our discovery of any delays in report distribution or MMIS access. We then follow up with written notification.

This notification includes:

- Date
- Problem
- Impact to the state
- Impact to providers
- Corrective action plan

After identifying and reporting the problem or issue, the EDS team develops and presents a corrective action plan. The following table highlights the steps included in the process.

Corrective Action

Area/Function	Quality Checks	Frequency
Corrective Action	When issues or problems occur during any task, we have an established process for correcting them. The approach includes the following steps: • Document the issue or problem • Use temporary interventions to stop incorrect outcomes if possible • Communicate by written and verbal means to other staff and the state, then solicit input on cause and solution • Research and analyze the issue or problem to identify its root cause • Develop alternative solutions • Choose best solution • Develop a corrective action plan • Evaluate the time necessary to correct • Prioritize tasks in relationship to the work plan • Evaluate the impact on any existing project schedules and adjust as needed • Implement the corrective action • Update or correct corresponding documentation and/or perform training • Communicate action to other areas	As needed

Once the team has identified the issue or problem, we track the progress. Operational issues are tracked in appropriate action item lists for either the fiscal agent meeting or other work group meetings.

System issues are tracked through the Tracking Log (TLOG) System according to the customer service request (CSR)/problem log (Plog) process until we make the correction, change, or modification. Briefly, this process involves:

- Tracking corrections and changes
- Prioritizing modifications
- Implementing corrections, changes, and modifications
- Supporting continual improvement

For a more detailed description of the CSR/Plog process, see our response to RFP requirement 3.2.2.9(a), "Project Management and Control Methodology."

As a result of our established processes for identifying and resolving operational and system issues, we promote good communication regarding issues and fast resolution.

Replacing Key or Technical Personnel

People are EDS' most valuable asset, so we take proactive steps to retain them. We offer excellent health benefits; an employee assistance program; financial benefits, company stock options, and performance bonuses; training and tuition programs through EDS University; and significant discounts for personal insurance, retail services and merchandise, and new car purchases. Client Delivery Executive Barbara Davis and her team of managers make every effort to retain employees and prepare them for career advancement opportunities; however, the team prepares for turnover situations by identifying and designating primary backup personnel for key positions and cross-training staff to handle multiple account responsibilities.

The Vermont team has been very successful in retaining technical personnel. In a time when the turnover of technical personnel averages 24 percent, we have had no turnover of technical staff for the last five years. This high retention record speaks to the team's sincere commitment to making EDS a great place to work.

Succession Planning

Client Delivery Executive Barbara Davis and her management team have established cross-training plans for each unit to facilitate staff readiness in taking on new responsibilities. They have identified people who have demonstrated both the desire and ability to perform multiple duties and given them the opportunity to learn new functions. For example, when we needed an additional systems engineer to work on the VermontAIM system, Cindy Littlefield, our claims team lead, who had been the dedicated testing coordinator throughout the implementation period, spoke to her manager and asked if it would be possible for her to take the EDS University Systems Engineering courses so that she could become a systems engineer on the Vermont account. Cindy traveled to Plano, Texas, and was enrolled in the 10-week course of studies and graduated at the top of her class. In fact, she was asked to stay on for an additional time period to act as the assistant instructor. The management team focuses on facilitating the career development of our staff, which not only keeps our staff progressing in their careers, but also allows us to provide dedicated resources who know the Vermont Medicaid program and want to continue to live and work right here in Vermont.

To assist employees in increasing their skills for new opportunities, EDS created EDS University to provide employees with complete technical, professional, sales, and management training that is aligned to our evolving business needs. In keeping with our tradition of technology leadership, EDS University is a "virtual" campus available to every employee. Furthermore, EDS offers a tuition assistance benefit for employees to attend colleges and universities of their choice. We encourage our employees to obtain depth in their skills with formal technical and business professional degrees and certifications.

Leveraging Experienced Technical Personnel From Central Support Centres

To augment staff during the Enhancements/Modifications Phase, we will use people from our central support centres who have experience implementing similar enhancements. Our central support centres employ hundreds of systems engineers with Medicaid experience who regularly support our Medicaid clients on implementations and special projects. They are in Richmond, Virginia; Vancouver, Washington; Plano, Texas; and Little Rock, Arkansas. Central support centres offer cost-effective and reliable expert support.

The state has witnessed the advantage of using central support centre staff quite recently during the HIPAA remediation project. Experienced staff members from central support centres have seamlessly backfilled for on-site staff in their regular positions so that staff members who are thoroughly familiar with the system can support the HIPAA remediation. Central support center staff members have also brought specific expertise to augment the account team's skill set in supporting the HIPAA remediation project.

Using central support centre personnel will provide excellent continuity and support to the state during the Operations Phase.

Hiring Local Talent

In addition, we will look for qualified candidates throughout Vermont. To support the ongoing security of our customers' information, we mandate drug testing and background investigations of all prospective employees.

To orient new staff, we conduct new employee training. We want new members of our team to fully understand their company, customer expectations, job responsibilities, and performance criteria.

EDS will comply with Affirmative Action and Equal Employment Opportunity (EEO) regulations. EDS is an EEO employer and does not discriminate in employment practices with regard to race, color, religion, age (except as provided by law), gender, marital status, developmental disability, political affiliation, national origin, or handicap. We comply with all applicable provisions of the Americans with Disabilities Act.

Through our long-term involvement with Medicaid programs across the country and our more than 21-year relationship with Vermont, we can anticipate how changing circumstances in the dynamic Medicaid environment influence day-to-day operations. EDS is uniquely positioned to offer a low-risk Operations Phase with a staff that possesses the skills to meet stringent deadlines.

Proven Processes for Resolving Issues

Any operation of the size and complexity of Vermont's Medicaid program will have issues from time to time. **What differentiates EDS is a record of addressing those issues quickly and competently—before they disrupt operations.** As a result of our experience and excellent people care, we avoid potential issues every day. In the Operations Phase, we will continue to use proven processes, first, for preventing issues and, second, for communicating, tracking, and resolving issues to the satisfaction of the state.

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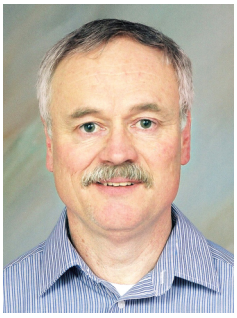
g. Internal Quality Control Monitoring of Relations With State, Providers, and Other Stakeholders

RFP Reference: 3.2.2.9(g), p. 3-15

The commitment to quality control monitoring of relations with the state, providers, and other stakeholders is paramount to the Vermont team. We take pride in our history of strong performance and effective relationships in Vermont that have helped contribute to the success of the Vermont Medicaid Program. Through the quality training, monitoring, and improvement initiatives we incorporate into our operational processes, we will continue to provide high performance levels and excellent service to respond to Vermont's changing business needs.

Account-Specific Quality Improvement Plans (QIPs)

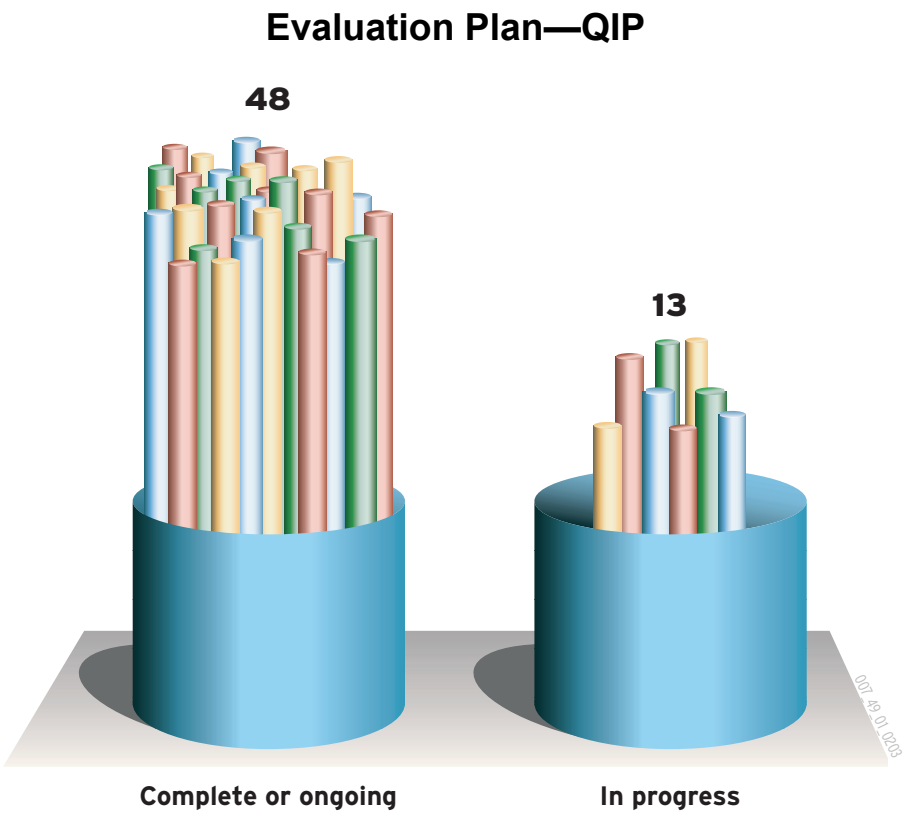
We will continue to use the Quality Improvement Plan (QIP), established in 1998, as a method of identifying areas where we can better serve the Vermont Medicaid Program. Business Analyst Perry Melvin manages the QIP process based on regular input from a team lead assigned to each QIP item. We encourage team members to participate in QIPs unrelated to their current job responsibilities. By doing so, they broaden their understanding of other processes and bring a fresh outlook that often results in innovative improvements.



Business Analyst Perry Melvin manages the successful QIP initiative for the Vermont-based team.

Either EDS or state staff initiate QIP items. When an item is placed in the QIP, an e-mail is sent accountwide to solicit volunteers to join the team in addressing the item. Once the team is in place, a team lead is selected and the current process flow of the item is reviewed. As this process evolves, new ideas are interjected as a way to improve the process flow. For example, in the Customer AIM Training item, it was identified that several new members of the PATH/OVHA team were unable to find information they needed in the VermontAIM system. We developed a training matrix and, with the help of the state, identified new VermontAIM users and offered training times. Several of these training sessions were completed on a one-on-one basis to best accommodate the new employee. This item is considered a completed/ongoing QIP item. Chris Haskins is available to train any staff member on the VermontAIM system. This training has also been offered to other stakeholders as necessary.

The following graphic shows the status of the QIP process as of February 2003. Most QIP items are in a "COMP/On-going" status, which means they are completed. However, ongoing review is necessary. We communicate QIP results to the state regularly through fiscal agent meetings as well as an annual report card.



After identifying QIP initiatives, we manage them proactively with the state to benefit from suggested changes as quickly as possible.

Successful Ernst & Young SAS 70 Audit

The independent auditing firm of Ernst & Young, chosen by the state, performed a Statement on Auditing Standards 70 (SAS 70) audit at both level 1 and level 2 from May 2001 to the fall of 2002. Ernst & Young was requested by the state to assess the quality and effectiveness of our processes and procedures. During level 1, Ernst & Young verified that the master file data (such as client, provider, reference, and claims data) used in Medicaid system processing is authorized, complete, and valid, and the correct versions are used in production processing. They also verified that system security, physical access, adjudication of claims, and Medicaid payments were accurate and timely. Ernst & Young filed a "no findings" report with the state, further assuring them of EDS' effective quality control methods. During the level 2 review, auditors conducted actual tests of various procedures. Again, Ernst & Young filed a "no findings" report with the state. We included a detailed account of these audits in our response to RFP requirement 2.6.11.

EDS Service Excellence Dashboard

EDS' Service Excellence Dashboard enables EDS employees and clients to monitor client satisfaction based on client input and review. The Service Excellence Dashboard is a highly visible, global communications vehicle for the consistent reporting of client relationship status. It enables EDS leaders to focus on problems and attend to them quickly.

As a key component of the service excellence initiative, the Service Excellence Dashboard provides graphical, up-to-the-minute status of how EDS is performing on delivery to each of our clients. Every account has its own client detail page, which displays client satisfaction levels among the service offerings in the company. The Service Excellence Dashboard accommodates management comments and client feedback. It enables EDS leaders to focus on problem areas and ensure that we are addressing them appropriately. At a glance, senior leadership, client executives, and their support teams are able to see which client support teams need assistance. The Service Excellence Dashboard allows calls for help to be answered very quickly.

As clients provide feedback on the Client Survey, their results are posted on the Service Excellence Dashboard next to the EDS client executive's ratings. This allows a comparison of the EDS client executive's assessment of our performance to that of the client's view.

The Office of Vermont Health Access has consistently ranked its satisfaction with the Vermont account's performance as good or excellent.

Provider Relations Surveys and Other Feedback

To monitor our relations with providers, we send a survey each year to a random sample of 1,000 actively enrolled providers. This survey includes questions related to claims processing, adjustment processing, provider services telephone responses, on-site visits by provider representatives, and staff professionalism. **Vermont providers have consistently rated EDS above average on these surveys.**

To ensure consistent quality, our provider services training plan includes proper phone etiquette with follow-up reminders during weekly team meetings. For reference material after initial training, each telephone employee has a complete manual with regularly updated policies. To monitor quality of provider telephone service, supervisors monitor a random sample of phone calls for accuracy and etiquette by contacting those providers for feedback on the information they received during the call and the professionalism of the person handling the call. Supervisors also contact providers who have had recent site visits for feedback and follow-up on the visit. The feedback we received is provided to the state through the fiscal agent meeting.

Our provider representatives are actively involved with several provider associations throughout the state, including Vermont Patient Accounts Managers (VPAM), the Healthcare Finance Managers Association (HFMA), and the Community Mental Health Care (CMHC) centers. Our provider representatives attend scheduled provider association meetings to assist with billing concerns or explain upcoming changes. They also periodically present topics that concern providers, such as the adjustment process. We ask providers to evaluate each workshop so we can continually improve our service.

Consistent Points of Contact for Other Stakeholders

We have a full understanding of the relationships required between EDS and other vendors supporting the many Medicaid programs. To ensure that no disruption of service occurs, we have established several points of contact with whom other stakeholders can communicate. These individuals have become subject-matter experts to these stakeholders and the solid relationships with them have evolved based on the commitment, trust, and efficiency with which the concerns are addressed.

EDS Points of Contact

Area Description	Point of Contact
Contract compliance – overall	Barbara Davis
HIPAA compliance – overall	Chrissie Racicot
PBM contractor	Cindy Littlefield
Recipient benefit counselor	Chris Haskins
Global clinical record contractor, technical	Bob Randall
Centers for Medicare and Medicaid Services (CMS)	Louise Brooks
Business Objects support for OVHA and DDMHS	Louise Brooks
Business Objects support for other state entities and the EDS staff	Ann Markle
Drug manufacturers	Chris Dapkiewicz
Banks	Cherie Benoit
Office of Investigations, Office of Inspector General	Cherie Bergeron
Medicaid Fraud Unit	Judy Isham
Vermont Program for Quality in Health Care	Cindy Littlefield
Anthem Health Care (state audit reports)	Ann Markle
Legislature regarding changes and impacts upon MMIS	Cherie Bergeron
Ombudsman's office	Niki Holton
Vermont Patient Accounts Managers	Barbara Jackson

Area Description	Point of Contact
Healthcare Finance Managers Association	Chris Haskins
Bi-State Primary Care Health Partners	Barbara Jackson
Community Mental Health Centers	Chris Haskins
New Hampshire/Vermont Strategic HIPAA Implementation Plan (NHVSHIP)	Sarah Johnson
New England Medical Equipment Dealers (NEMED)	Chris Haskins

Through the years, the Vermont-based team has established many solid relationships with other stakeholders by recognizing the importance of consistent communication with our point of contact employees. These continued relationships will ensure uninterrupted service for all programs.

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h. Project Status Reporting

RFP Reference: 3.2.2.9(h), p. 3-15

Client Delivery Executive Barbara Davis maintains ongoing accountability for accurate project status reporting. She provides the state this reporting information through the following:

- Weekly Status Report
- Fiscal Agent Meeting
- Special project status reports
- Drug rebate reports
- Weekly Draw Request Calculation Worksheet
- Annual Provider Survey Report
- Annual Quality Improvement Process Report Card

In the second year of the Operations Phase, **we will enhance status reporting by providing all key status reporting documents to state and EDS personnel online in the Web-based Project Workbook.**

In the following sections, we provide an overview of our established reporting mechanisms and introduce the Web-based Project Workbook:

- Weekly Status Report
- Fiscal Agent Meeting
- Special Project Status Reports
- Drug Rebate Reports
- Draw Request Calculation Worksheet
- Annual Provider Survey Report
- Annual Quality Improvement Process Report Card
- Web-Based Project Workbook
- Sample Reports

Weekly Status Report

Every week, the state's Medical Operations Administrator, Robert Butts, receives a status report from Client Delivery Executive Barbara Davis. This report is copied to Gloria Jacobs, Pat House, Bill Kelly, Mark Davis, Roger Campbell, and Roger Trembley. **This established report effectively communicates key operational statistics and achievements.**

We provide a sample of the report's contents in the following table.

Weekly Status Report Content Overview

Report Category	Sample Contents
Claims processing	Claims inventory, suspense rates, total checkwrite, total copayments, postage costs, errors, new providers
Program services	Provider relations statistics, including phone calls, written inquiries, visits, and seminars/workshops
Cash	Beginning inventory, receipts, transactions, ending inventory
Education field representative weekly activity	Phone contacts, professional meetings, visits, correspondence, meeting locations
Drug rebate	Receipts by week and by quarter
Adjustments	Pending research, new receipts, adjustments, inventories
Systems	CSRs/Plogs moved to production, system availability statistics

A sample Weekly Status Report appears at the end of this section.

Fiscal Agent Meeting

At 9:30 a.m. every Friday at the EDS offices, key state managers meet with EDS managers to review the week's activities and look ahead to upcoming events. Each EDS manager presents a report of the week's key accomplishments and issues.

Discussion items in this meeting include:

- Past events
- Upcoming events
- Program changes
- CSR/Plog status
- Problem resolution status

Each week, the EDS administrative assistant takes meeting minutes and distributes them to all attendees. **This established meeting provides an efficient means of communication and idea exchange for key state and EDS managers.**

At the end of this section, we include sample Fiscal Agent Meeting Minutes.

Special Project Status Reports

In addition to the standard weekly status report, the state receives periodic written status reports for each special project. We work with the state to develop the format, frequency, and distribution of this report for each project during the communication-planning phase of the project.

Special progress reports indicate:

- Project progress against the schedule
- Project scope changes, if any
- Project issue resolution

This report also effectively communicates key project milestones, issues, and achievements. At the end of this section, we include a sample HIPAA Project Status Report.

Drug Rebate Reports

Weekly drug rebate reports reconcile drug rebate financial transactions. These reports also show weekly and past quarterly figures for the following:

- Financial cycle run dates
- Beginning balance
- Write-offs
- Overpayments
- Rebates invoiced/adjustment
- Rebates dispositioned
- Ending balance
- Variance adjustment
- Adjusted ending balance

Additional drug rebate reports track all manufacturers' participation in the program.

A sample VScript reconciliation report appears at the end of this section.

Weekly Draw Request Calculation Worksheet

The Weekly Draw Request Calculation Worksheet identifies the funding source for the week's payments. For every program supported by the VermontAIM, the worksheet identifies dollars in the following categories:

- Suppressed checks
- Medicaid dollars
- State dollars

- Manual payouts
- Total funds disbursed
- Adjustments
- Refunds and voids
- Draw amounts
- Number of paid claims

A sample Draw Request Calculation Worksheet appears at the end of this section.

Annual Provider Survey Report

Each year, the provider services department sends satisfaction surveys to 1,000 randomly selected providers. Providers rate the services of EDS as the fiscal agent for the Vermont Medicaid program in four areas:

- Provider services
- Provider relations
- Claims processing
- Eligibility verification

Each year, we tally these survey results and use them to evaluate the success of the last year's initiatives and to identify new initiatives that we can address with our Quality Improvement Process.

Portions of a sample Provider Survey Results packet appear at the end of this section.

Annual Quality Improvement Process Report Card

Annually, we provide a Quality Improvement Process (QIP) Report Card that lists all initiatives that the QIP committee has undertaken with a current status. In 2002, the report presents the status of 60 initiatives.

A sample Annual Quality Improvement Process Report Card appears at the end of the section.

Web-Based Project Workbook

EDS will implement a Web-based version of our Project Workbook during the contract's Enhancements/Modifications Phase and begin using it to support operations activities in the second year of the Operations Phase. EDS' Project Workbook is a unique approach to providing comprehensive project-related communication. It provides a comprehensive journal of all project documentation and includes status reports, work plans, change orders, deliverable specifications, test data, test results, and even sign-off documents. Through the linking features included in the Project Workbook, state and EDS personnel can gain an understanding of the current status of virtually any aspect of the project and of the meetings and decisions that have affected the project's current state.

The Web-based Project Workbook provides the following significant advantages:

- Timely access to project-related information for the state and EDS
- Rapid access to status reports, schedules, and documentation for authorized personnel when published
- Hypertext links from status reports to related documents such as sign-off sheets, specifications documents, and test criteria, thereby providing a more comprehensive picture of the status at the click of a mouse
- The complete Microsoft Project work plan published as a Web page for viewing by authorized personnel, thereby providing an additional level of status reporting

EDS has found in other large-scale implementations and operations that the Web-based workbook is the most effective, efficient, and timely way to communicate key information. No other bidder offers this access to project information at the level EDS provides in the Project Workbook.

Sample Reports

Following are sample reports and meeting minutes described above:

- Sample Weekly Status Report
- Sample Fiscal Agent Meeting Minutes
- Sample HIPAA Project Status Report
- Sample Drug Rebate Report
- Sample Draw Request Calculation Worksheet
- Sample Portions of Annual Provider Survey Results
- Sample Annual Quality Improvement Process Report Card

Sample Weekly Status Report

On the following pages, we include a sample Weekly Status Report.

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TO: Robert Butts
Medicaid Operations Administrator
Office of Health Access

FROM: Barbara H. Davis

DATE: February 3, 2003

CC: Gloria Jacobs, Pat House, Bill Kelly, Mark Davis, Roger Campbell, and Roger Trembley

SUBJECT: **STATUS REPORT**

Week Ending Friday, January 24, 2003
For Checks Dated January 31, 2003

1. CLAIMS PROCESSING	**Total**	**YTD**
A. Inventory		
Last Week's Suspense	31,102	
New Input	77,177	3,155,333
Medicaid Claims	77,350	3,134,150
Drug Transactions	70,102	2,144,875
Dispositioned Total	147,452	5,279,025
Deleted	74	
New Suspense	30,855	
Unkeyed Inventory	7,829	
Total Ending Inventory	38,684	
$ Paid in Checkwrite	10,400,451.20	383,405,646.84
Co-Pay	218,697.69	5,522,043.13
Weekly Postage Costs	$1,702.67	69,700.58

Quarterly Postage Costs:

1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
25,727.55	33,443.73	10,529.30	0.00

Oldest Claim in Suspense	112002227086004
Unresolved from last week	0
Numbers of claim files that erred this week	6
Number of errors resolved this week	6
Number of errors remaining at end of week	0
Number of ECS files not loaded within 24 hours	0

New Providers added to ECS: 22

1006033	Bruna Holmes
0005148	Johana Brakely
10005349	Lynn Luginbuhl
0VN1184	Morris Earle
0VN1189	James Splain
0VN1999	Sandra Jimmo
0005882	Donald Bicknell
0006488	Elizabeth Newman
0VN0029	Mark Hoffman
0VN1240	Timothy Bicknell
0007993	Maja Zimmermann
0VN0380	Elizabeth White
0VN1619	Lewis Holmes
0VN1949	Scott Smith
0VN1864	Jeffrey Wulfman
0004669	William Barrett
0004700	Alan Covey
0VN1275	Bradford Armstrong
0004610	Timothy Cope
0004729	William Fifield
0VN1853	Bruna Holmes
0004703	Bennington Internal Medicine

2. PROGRAM SERVICES

A. Provider Relations	Total	YTD
Phone Contacts	31	566
Professional Meetings	0	23
Provider Visits	1	246
Seminars/Workshops	0	5
Correspondence Received	174	

B. Provider Services	Total	YTD
a. Written Inquiry		
Beginning	0	
Received	87	3,674
Processed	87	3,690
Ending	0	
Date of oldest pending inquiry	n/a	
Number of inquiries over 14 days	0	
Comments:		
b. Telephone inquiry		
Calls received	1617	49,589
Callbacks scheduled	87	
Oldest Pending Phone Call	1/16/2003	
Number of Packets Mailed	3	
Number of Requests Pending	0	
Oldest Request Pending	n/a	
Number of New Enrollments	32	678
Number of Enrollments Pending	5	
Number of Providers Recertified	49	
Total Number of Calls Referred to Maximus	78	

Comments:

3. Cash

Beginning Inventory	115
Receipts	83
RTP Request	0
Sub-Total	198
Total Transactions Completed	126
Ending Inventory	72

Comments:

4. EDUCATION FIELD REPRESENTATIVE WEEKLY ACTIVITY TOTALS

	Total	YTD
Phone Contacts	53	1337
Professional Meetings	1	16
Visits	14	339
Correspondence Received	66	2033
Correspondence Sent	60	1498

Comments:

1/21/03	Rutland NE, Rutland Windsor, Windham SE, Franklin NW, Windsor Central
1/22/03	Rutland Central, Addison Rutland, Milton
1/23/03	Windham SW, Windham Central, Franklin W
1/24/03	Addison Central, Windsor SE, Rivendell

5. DRUG REBATE

	Total	YTD
Weekly Drug	$444,013.64	$18,879,355.08

Quarterly:

1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
$5,768,767.16	$8,442,344.81	$4,668,243.11	$0.00

6. ADJUSTMENTS

Previous Pending Research	8266
Total New Receipts	457
Total Mass Adjustments Entered	6426
Entered in System	6797
RTP's	17
To be Entered/Researched	8335
Previous Ending Adjustment Suspense	0
New Receipts Accepted	6797
Deleted	0
Dispositioned	6738
Ending Adjusted Suspense	59
Total Inventory (to entered + suspense)	8394
The oldest adjustment pending in system	02-210
The oldest adjustment to be entered in system	02-289

7. SYSTEMS

A. CSR/PLOGS Moved into Production

CL 0503 CHANGE ORDER OF CLARLCKV RE UNIQUE - MID
RE 0146 CREATE EMAIL - CHANGES TO CARRIER/COV TYP

B. System Availability

POS	VRS	POS CLAIMS	COMMENTS
100.00%	100.00%	100.00%	Good to 01/19/03

Fiscal Agent Meeting Minutes

Following is a sample set of Fiscal Agent Meeting Minutes.

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Fiscal Agent Meeting Minutes

Fiscal Agent Meeting

Sept 13, 2002

Barb Davis
Cherie Bergeron
Mary LeFebvre
Christine Brown
Cherie Benoit

Gloria Jacobs

Barb noted that Senator Peter Shumlin visited our account this past Wednesday. Barb introduced Peter to our staff and gave him a tour of the account. He had been invited to take a tour at a recent meeting that Barb and Peter had and he was most interested in coming to the account and viewing our operations. The tour focused on claim processing, provider services, our systems area and the services we provide to OVHA. Peter addressed the account and mentioned that he has heard very positive comments about the services we are providing the state.

Barb stated that First Health continues to submit claims for non-approved drugs for V-Script pharmacy, resulting in overpayments to the providers. EDS then has to write off the drug rebate amounts for those claims that were paid in error. Barb has sent an e-mail about this issue to Samantha Haley and Paul Wallace-Brodeur.

Barb noted that she and Cherie would be traveling to Boston Tuesday and Wednesday of next week regarding training for the upcoming MMIS recompete. Also, Barb will be attending the National Directors conference on October 8th and 9th.

Barb stated that Mary Simpson would be arriving at EDS on September 23rd. Mary is EDS' national Medicaid sales leader and will be involved in our submission for the MMIS recompete.

Cherie noted that she had an e-mail from Paul to revisit the proposed co-pay study project. Cherie's recommendations are to create a new modifier for HCFA claims and surgical procedure codes for institutional claims. The

modifiers/codes would be used to indicate whether or not the provider collected the copay.

Cherie stated that she is expecting to receive the final report for the E&Y SAS 70 Audit today. The report will be delivered to OVHA upon receipt.

Cherie noted that we received notification from Paul to increase rates for dental and hospitals. EDS had been sent a previous memo to implement the SFY03 rate increase as soon as possible and then make a mass adjustment for claims with dates of service July 1, 2002, or later. Paul was advised that this will not only consume many EDS resources but also will create accounting problems for the providers. Therefore, Paul has revised the request to have implementation of the dental and physician rates effective October 1, 2002.

Cherie noted that the outstanding adjustments for Alpha One were submitted today. The provider should see the adjustment on their next RA. There are a few remaining adjustments that are on hold awaiting a change to the associated PA.

Cherie met with James Lasponara this week regarding an issue with processing of GA Dental claims. The issue is that if a voucher is issued for a recipient who is a dual eligible, the claim will use the voucher to pay when in fact the recipient may still have money available under the Medicaid cap. To address this issue, we identified a process where we will put the voucher in a “review” status. Therefore, if there is money left on the cap, the claim will go to Medicaid first. If the voucher is necessary to pay the claim, then the voucher will be changed from (R) review to (A) approved. Judy Isham will be testing this approach and a decision will be made at a follow-up meeting next week.

Cherie provided Roger with the CSR estimate for the changes to chiropractic services.

Mary noted that ACCS claims adjustments for the Department of Aging and Disabilities would be entered next week; these adjustments are the result of a retroactive rate change request. Christine will include this information in next week’s Banner Page.

Mary stated that the weekly claim count status for Unkeyed claims 17,466, Reso 20,181 totaling 37,647.

Christine stated that a New Provider Claim Submission Workshop would be held at EDS on September 18, 2002 from 10:00 – 12:00. Christine Haskins is the facilitator and would be covering topics such as verifying eligibility, the required fields of the CMS 1500, how to read the Remittance Advice Summary, etc. Christine mentioned that they had a great response from the providers and that EDS will hold another new biller's workshop in the near future to accommodate more providers. It was also mentioned that Perry Melvin would be explaining the benefits of Electronic Claims Submission.

Christine noted that a draft letter had been sent to John Dick for review explaining to the providers the proposed changes for October 1st.

Christie noted that the Banner page that is to go out next week needed to be reviewed and signed by Gloria. Christine also mentioned that Paul decided that all scripts for vision providers be allowed to be billed until Sept. 30th.

Christine noted that she had several discussions with her team in light of the new provider enrollment processes, including backdating recertifications. Christine stated that both Margaret and Jocelyn would be manually reviewing the status of providers who were scheduled for recertification. Christine also noted that they would be using the Business Objects tool and would call the providers by the 15th of the month to remind them of their recert. Gloria mentioned that this process would be very effective in assisting us in complying with the KPMG audit requirements.

Christine stated that EDS was processing the increase to Skilled Nursing involving W-codes. These changes are to be effective with DOS September 23, 2002.

Christine noted that we have had a great response from local schools in applying for EDS' corporate annual award of three technology grants for $1,500. Christine also mentioned that we have had good response from our employees in volunteering for EDS' participation of Global Volunteer Day.

Roger stated that there were many changes regarding additional services or services no longer requiring PA. The Delmarva Foundation is the contractor who mandates the PA criteria. It was also noted that the technical scope of work would not require additional funding or contract modification. This information has been S-logged.

Gloria handed Christine a copy of the Medicaid program brochure and stated that if we need additional copies to let her know.
Gloria noted that John Dick sent an e-mail regarding a provider requesting Provider Services to identify and to run a BusinessObjects query to include the provider's denials. Provider Services had replied to the provider that EDS did not run queries and for the provider to review their RA for this information. Christine mentioned that the provider had misinterpreted the correspondent's response and she clarified that EDS did not run these reports for providers on a routine basis; however, we do use BusinessObjects as a tool to determine whether the providers have billing issues. This was truly a misunderstanding and Christine has taken this up with her staff so all phone correspondents are now aware of this and can explain it carefully to the providers.

Gloria noted that she received a memo from a licensed Mental Health Provider asking for a new code to be billed for study group services. Gloria stated that the provider needed to be contacted and told that Medicaid has a specific code already on file for these services.

Gloria noted that she was aware of claim denials for Shawn Carpenter billed by ARIS for no PA and other insurance. Gloria suggested Mary to review past claims history. Gloria's concerns were that other similar projects are in the making and wanted to make sure that claims processed without complications.

Gloria asked if EDS had been sent a copy of increase request for Skilled Nursing involving W-codes. Christine replied that she had received the request and that the changes are to be effective with DOS September 23, 2002.

Gloria noted that she received notice from Paul regarding hospital co-pay and that further clarification depended on what type admission code was billed. If the service is considered elective, then the provider could charge the recipient $50.00 co-pay. The VPAM meeting is scheduled for next week and Erica McNamara will be there. This information should also be included in the next Advisory.
Gloria stated that Brenda Metiever notified her that she had an abundance of requests from providers looking for an override of late billing. Gloria noted that providers need to submit no later than six months from the date of service and no other consideration is due.

Sample HIPAA Project Status Report

On the following pages, we include a sample HIPAA Project Status Report.

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Vermont MMIS HIPAA Phase One Implementation
Monthly Status Report

EDS STATUS for PERIOD: Tuesday October 1, 2002 – Thursday October 31, 2002

PROJECT STATUS SNAPSHOT

The project status snapshot provides a high-level overview of the project based on a monthly assessment by the project management team. This month's analysis indicates that progress continues to be made to overcome delays in project contract completion and the associated moderation of resource commitment prior to contract finalization. For the first month since projection initiation, we have moved project schedule to green (for phase 1 transactions).

	Red	Yellow	Green	
Schedule	Project Finish Date (schedule) is later than baseline Finish Date or the Project Plan is not approved (no sign-off) **Red**	Prior Phase was late **Yellow**	Completion of previous phase was on time, currently on schedule **Green**	With the exception of the translator infrastructure, which is not currently in the critical path, all project metrics currently indicate we are on target for a timely delivery of phase one tasks.
Scope	Increase in scope, no change in end date **Red**	Increase or reduction of scope **Yellow**	No change **Green**	No substantive changes scope identified under the amendment 7 statement of work. Amendment 8 is under development and will define the next phase ofwork to be completed.
Issues	Open Issue(s) > 30 days **Red**	Open Issues > 15 days and < 30 days **Yellow**	No late issue resolution **Green**	A modest number of issues are c urrently under review. However, none are impacted critical path at this time.
Overall	At least one red on schedule, scope, or issues **Red**	All the above must be yellow or green **Yellow**	All the above must be green **Green**	The overall project status is currently green. There is a reasonable probability that the financial construction deliverable scheduled for November may slip into December. This would put the project back into a yellow status. Also, with claims load still under development, very little integration testing can be performed to gain a better feel for results we will see in early system testing. We will be monitoring the transition to integrating and system testing carefully as it provides feedback critical to re-assess project health.

PROJECT STATUS SNAPSHOT BY PROJECT

HIPAA Phase One Project Snapshot

Vermont is the first Tri-State participant scheduled for implementation of the AIM system changes. All technical design work has been completed in Vermont, including claims load and translator map development.

Coding in Vermont has been completed for almost all change orders, with the exception of claims load and translator map development. Those tasks are the largest associated with HIPAA phase one and the lag behind other changes was anticipated. Unit testing in Vermont is well under way. However, a number of change orders cannot be fully unit tested until claims load is completed.

The Provider Electronics Solutions software development has been completed and the beta version has provided to the account team to begin preliminary system testing tasks.

Graphical User Interface (GUI) Project Snapshot

The team is now well into construction for Vermont with approximately 19 percent of the screens coded and unit tested. Coding, unit test case development, and unit testing is expected to continue in Vermont throughout the month of November.

Translator Project Status

Model office testing continues to be extended and will not be finalized until December. This represents a substantial delay compared to the baseline completion date. In part, this delay is associated with an upgrade to the Sybase mapping product to utilize the HIPAA addenda standard. This standard has recently been finalized and the North East Translator will be one of the first Sybase partners to implement the addenda standard. Because the translator platform implementation is being managed using an iterative development model, the functionality required to support unit testing with the AIM system is already in place and this delay is not anticipated to affect the critical path of the project.

MILESTONES

The attached Vermont Medicaid HIPAA Milestone Project Plan provides updated projections for milestone completion dates as well as a status for each milestone phase and deliverable.

ACHIEVEMENTS

HIPAA Phase One Accomplishments

- No deliverables were scheduled for completion during October.

Graphical User Interface (GUI) Accomplishments

- No deliverables were scheduled for completion during October.

Translator Accomplishments

- No deliverables were scheduled for completion during October.

Hardware Implementation

- The hardware installation was completed in October.

DELIVERABLES COMPLETED

The attached Vermont Deliverables Completed Invoice for October 2002 inventories contract milestones completed and delivered for state approval.

The Vermont Milestone Deliverables Report—Completed Deliverables included in the electronic monthly status provided on CD includes an inventory of all deliverable documents and outputs completed to satisfy the contractual deliverable requirement along with links to access each of the deliverable documents electronically. This report is cumulative and provides access to prior and current month's deliverables. New this month, a last change date column was added to the report to identify documents updated since the last monthly reporting cycle.

The Vermont Milestone Deliverables Report—Completed Deliverables includes the following contract task deliverables that were completed in October.

SCHEDULED TASKS/ACTIVTIES PLANNED FOR THE NEXT MONTH

HIPAA Phase One Scheduled Tasks

- Continued review and resolution of issues identified during the design phase of the project with an emphasis on the procedure code modifier issue.
- Continuation of construction in Vermont
- Construction of Vermont database fully populated to begin unit testing activities.
- Continue updates to the HIPAA toolbox to help repackage data content reporting in a way that may make it easier to answer some of the questions Elaine Veilleux had about data content using a more sophisticated reporting model that includes the consolidation of information sources.

Graphical User Interface (GUI) Scheduled Tasks

- The month of November will be dedicated to construction tasks in Vermont, including unit test case development, coding and unit testing.
- Vermont specific activities will be focused on Q/A support for the Departments DSD review.

OCR – Imaging Automation Replacement Scheduled Tasks

- Q/A support for the Departments DSD review
- Continue technical design and prototyping of the solution defined in the DSD

Translator Scheduled Tasks

- Continuation of model office testing and implementation of the addenda guide standard

ISSUES INVENTORY

The attached Project Issue Management Inventory itemizes issues outstanding that require customer input and collaboration.

Tri-State Update and Leveraged Delivery Summary

Implementation Sequence

Vermont has been selected as the first of the Tri-State participants to implement the HIPAA solution with New Hampshire and Rhode Island to follow.

HIPAA Phase One Tri-State Leveraging

We are beginning to see the leveraged benefit in construction as team member's transition from Vermont to New Hampshire. It will be difficult to quantify the benefit of the leveraged efforts until we are further into the unit testing process. However, the general feeling is that we continue to experience significant benefits from leveraging that are essential for a timely delivery.

Graphical User Interface (GUI) Tri-State Leveraging

We have not begun the process of migrating screens developed in Vermont to New Hampshire. The design results showed significant functional overlap and we continue to anticipate significant benefits from leveraging.

Translator Scheduled Tri-State Leveraging

The translator design team analyzed each state's requirements and then developed a single design that would accommodate all states. The development effort continues to provide leveraged benefits enabling the team to select a more robust solution than would have been possible with single states' resources.

Sample Drug Rebate Report

As a sample Drug Rebate Report, we include a reconciliation report for the VScript program.

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Drug Rebate
V-Script
By Financial Cycle

	Financial Transactions Posted Through Week-Ending 01/31/03	Quarter Ending 12/31/2002	Quarter Ending 9/30/2002	Quarter Ending 6/30/2002
Financial Cycle Run Dates	12-21-02 - 01-31-03	9-22-02 - 12-20-02	6-23-02 - 9-21-02	3-24-02 - 6-22-02
Beginning Balance	$ 366,339.14	$ 357,339.86	$ 366,070.21	$ 285,327.47
Write-Offs (030)	$ (5,861.38)	$ (18,444.93)	$ (11,007.14)	$ (11,305.15)
Over Payments (038)	$ -	$ -	$ 19,927.06	$ 10,868.22
Rebates Invoiced (035) & Adjustments (037)	$ 13,348.31	$ 195,738.25	$ 221,276.25	$ 199,183.22
Rebates Dispositioned (039)	$ (154,198.58)	$ (167,850.18)	$ (238,926.52)	$ (118,003.55)
Ending Balance	**$ 219,627.49**	**$ 366,783.00**	**$ 357,339.86**	**$ 366,070.21**
Variance Adjustment	$ (64.16)	$ (443.86)		
Adjusted Ending Balance	$ 219,563.33	$ 366,339.14		
CURRENT & PAST DUE TOTAL	$ 219,563.33	$ 366,339.14	$ 356,896.00	$ 366,931.30
Source - Business Objects				
Transaction Balance	$ (219,563.33)	$ (366,339.14)	$ (357,339.86)	$ (366,070.21)
Variance	$ -	$ -	$ (443.86)	$ 861.09
Reason For Variance	Entered as funding source A, in error			

Drug Rebate
V-Script
By Financial Cycle

Quarter Ending	Quarter Ending	Quarter Ending	Quarter Ending	Quarter Ending	Quarter Ending	Quarter Ending	Quarter Ending
3/31/2002	**12/31/2001**	**9/30/2001**	**6/30/2001**	**3/31/2001**	**12/31/2000**	**9/30/2000**	**6/30/2000**
12-23-01 - 3-23-02	9-23-01 - 12-22-01	6-25-01 - 9-22-01	3-25-01 - 6-24-01	12-24-00 - 3-24-01	9-24-00 - 12-23-00	6-25-00 - 9-23-00	3-26-00 - 6-24-00
$ 226,224.34	$ 231,471.81	$ 207,697.24	$ 148,402.64	$ 110,801.95	$ 61,011.76	$ 22,290.70	$ -
$ (4,528.22)	$ (5,693.26)	$ (200.92)	$ (210.82)	$ (58.69)	$ (33.97)	$ (48.23)	$ -
$ 7,266.42	$ 18,027.72	$ 9,624.50	$ 10,909.29	$ 5,652.21	$ 4,007.84	$ 444.38	$ 12.21
$ 180,184.57	$ 153,347.29	$ 140,127.15	$ 113,741.58	$ 100,323.14	$ 84,409.16	$ 51,770.64	$ 22,599.19
$ (123,819.64)	($170,929.22)	$ (125,776.16)	$ (65,145.45)	$ (68,315.97)	($38,592.84)	$ (13,445.73)	$ (320.70)
$ 285,327.47	**$ 226,224.34**	**$ 231,471.81**	**$ 207,697.24**	**$ 148,402.64**	**$ 110,801.95**	**$ 61,011.76**	**$ 22,290.70**

Sample Draw Request Calculation Worksheet

In this section, we present a sample Draw Request Calculation Worksheet.

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Draw Request Calculation Worksheet for
Checks Dated
March 14, 2003

	A	B	C	D	E	F	G	H
1	Fund	Net System	Manual	Adjustments	Refunds (always enter as negative number)	Voids (always enter as a negative number)	Suppressed	Number of PAID Claims
2	A-DSW	$8,542,575.57			($60,048.74)			39,720
3	G-DMH/MR	$2,546,337.75					$118,861.91	13,045
4	H-DOE	$3,774.00					$677,510.64	1,239
5	I-SRS							
6	J-Healthy Babies	$36,969.90					$2,343.00	468
7	K-OADAP	$75,846.16						490
8	L-DAD	$106,155.47						156
9	M-VHAP Uninsured							
10	N-CAID-Traditional	$540.00						1
11	O-VHAP Pharmacy	$498,969.68						9,530
12	P-VHAP Services	$92,480.75						1,318
13	Q-VHAP-Mental Health							
14	R-VHAP-OADAP	$14,034.96						58
15	S-DDMHS Case Rate	$76,749.30						227
16	T-Medicaid Expansion							
17	U-VHAP Uninsured PCPlus	$745,930.22			($89.51)		$96.36	12,299
18	V-CAID Traditional PCPlus	$3,029,727.09			($103.16)			44,758
19	W-PDP Pharmacy	$167.93						651
20	B-DR. D							
21	C-GA	$17,104.95						336
22	D-VScript	$50,332.77			($700.60)			2,164
23	E-HIV Drug	$2,618.99						27
24	F-HIV Ins.	$464.80						
25	Totals	$15,840,780.29	$0.00	$0.00	($60,942.01)	$0.00	$798,811.91	126,487

Draw Request Calculation Worksheet for
Checks Dated
March 14, 2003

Funding Source	Suppressed Checks	Medicaid Dollars	State Dollars	Manual Payouts	Total Funds Disbursed	Adjustments	Refunds and Voids	Draw Amounts	Number of PAID Claims
A-DSW	0.00	8,542,575.57		0.00	8,542,575.57	0.00	(60,048.74)	8,482,526.83	39,720
M-VHAP-Uninsured	0.00	0.00		0.00	0.00	0.00	0.00	0.00	0
U-VHAP-PCPlus	96.36	745,930.22		0.00	745,930.22	0.00	(89.51)	745,840.71	12,299
O-VHAP-Pharmacy	0.00	498,969.68		0.00	498,969.68	0.00	0.00	498,969.68	9,530
P-VHAP-Services	0.00	92,480.75		0.00	92,480.75	0.00	0.00	92,480.75	1,318
Total VHAP Funds	**96.36**	**1,337,380.65**		**0.00**	**1,337,380.65**	**0.00**	**(89.51)**	**1,337,291.14**	**23,147**
T-Medicaid Expansion	0.00	0.00		0.00	0.00	0.00	0.00	0.00	0
N-CAID-Traditional	0.00	540.00		0.00	540.00	0.00	0.00	540.00	1
V-CAID-PCPlus	0.00	3,029,727.09		0.00	3,029,727.09	0.00	(103.16)	3,029,623.93	44,758
W-PDP-Pharmacy	0.00	167.93		0.00	167.93	0.00	0.00	167.93	651
B-Dr. Dynasaur	0.00		0.00	0.00	0.00	0.00	0.00	0.00	0
C-General Assistance	0.00		17,104.95	0.00	17,104.95	0.00	0.00	17,104.95	336
D-V-Script	0.00		50,332.77	0.00	50,332.77	0.00	(700.60)	49,632.17	2,164
F-HIV-Insurance	0.00		464.80	0.00	464.80	0.00	0.00	464.80	0
Total State			**67,902.52**	**0.00**	**67,902.52**	**0.00**	**(700.60)**	**67,201.92**	**2,500**
DSW Grand Total	**96.36**	**12,910,391.24**	**67,902.52**	**0.00**	**12,978,293.76**	**0.00**	**(60,942.01)**	**12,917,351.75**	**110,777**
G-Dept. of Mental Health	118,861.91	2,546,337.75		0.00	2,546,337.75	0.00	0.00	2,546,337.75	13,045
Q-VHAP - Mental Health	0.00	0.00		0.00	0.00	0.00	0.00	0.00	0
S-CRT Case Rate	0.00		76,749.30	0.00	76,749.30	0.00	0.00	76,749.30	227
Total Mental Health	**118,861.91**	**2,546,337.75**	**76,749.30**	**0.00**	**2,623,087.05**	**0.00**	**0.00**	**2,623,087.05**	**13,272**
H-Dept. of Education	**677,510.64**	**3,774.00**		**0.00**	**3,774.00**	**0.00**	**0.00**	**3,774.00**	**1,239**
I - Social Rehabilitation	**0.00**	**0.00**		**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0**
J-Healthy Babies	**2,343.00**	**36,969.90**		**0.00**	**36,969.90**	**0.00**	**0.00**	**36,969.90**	**468**
K-OADAP	0.00	75,846.16		0.00	75,846.16	0.00	0.00	75,846.16	490
R-VHAP OADAP	0.00	14,034.96		0.00	14,034.96	0.00	0.00	14,034.96	58
Total K-R	**0.00**	**89,881.12**		**0.00**	**89,881.12**	**0.00**	**0.00**	**89,881.12**	**548**
E-HIV Drug	0.00		2,618.99	0.00	2,618.99	0.00	0.00	2,618.99	27
Total Dept. of Health	**2,343.00**	**126,851.02**	**2,618.99**	**0.00**	**129,470.01**	**0.00**	**0.00**	**129,470.01**	**1,043**
L-Dept. of Aging	**0.00**	**106,155.47**		**0.00**	**106,155.47**	**0.00**	**0.00**	**106,155.47**	**156**
Grand Totals	**798,811.91**	**15,693,509.48**	**147,270.81**	**0.00**	**15,840,780.29**	**0.00**	**(60,942.01)**	**15,779,838.28**	**126,487**

Sample Portions of Annual Provider Survey Report

In the following section, we provide sample portions of the Annual Provider Survey Results packet. These samples include:

- 2002 Provider Survey Results cover page
- Results cover letter to 2002 Provider Satisfaction Survey
- Cover letter to providers sent with the 2002 Provider Satisfaction Survey
- 2002 Provider Satisfaction Survey form
- Results summary from 2002 Provider Survey

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2002 Provider Survey Results

Vermont Title XIX Account

2002 PROVIDER SATISFACTION SURVEY

Introduction
Each year, the provider services department sends out satisfaction surveys to 1,000 randomly selected providers to offer feedback on the performance of the EDS Vermont Title XIX Account. Providers are asked to rate the services of EDS as the fiscal agent for the Vermont Medicaid program in four areas: provider services, provider relations, claims processing, and eligibility verification. The 2002 survey was sent out to providers on October 29, 2002. Of 1,000 surveys, 421 or 42 percent were returned to EDS by November 30, 2002.

Results
Overall, 88 percent of providers surveyed are satisfied with the performance of EDS, compared to 78 percent in 2001. EDS' overall rating increased from 3.4 to 3.6 in the past year. Providers rated our services better in 2002 in provider services, provider relations, eligibility verification, and overall performance.

This increase in provider satisfaction is a direct result of improvements made by the account during the past year due to comments/suggestions made by providers in the 2001 survey. For example, last year providers voiced concerns over long wait times, a lack of standardized training, and outdated provider manuals. EDS listened to this feedback and put systems and procedures into place to improve in these areas. For example, EDS installed new software to pro-actively monitor the phone wait times on the provider services help desk and pulled additional resources on the account to offer telephone support at peak times. This has resulted in a dramatic decrease in wait times on the phones. In the past year, the help desk has consistently averaged a wait time of 50 seconds. The Vermont Title XIX Account also took advantage of EDS' On-Line Education capabilities and established a standardized training program for all provider services staff, including implementing a series of customer service courses supported by EDS University. Lastly, EDS worked in partnership with OVHA to release updated versions of the provider manuals to assist the provider community in billing Medicaid. The updated provider manual, DME supplement, and prior authorization supplement were released in 2002. The CMS 1500 supplement, dental supplement, and independent lab supplement will be released in January 2003.

EDS greatly appreciates the feedback it received from the provider community in 2002. In the coming year, EDS will continue to strive to provide excellent, professional, and timely customer service to the provider community, as well as improve the timeliness of claim adjudication.

October 29, 2002

Dear Provider:

Enclosed is EDS' Annual Provider Survey, which we mail to a random group of 1,000 Vermont Health Access providers every year. I would greatly appreciate a few minutes of your time to complete the survey. As the program services manager, I will consider your responses when planning the next year of services to providers to better serve you.

Please read the following descriptions that clarify each of our departments before completing the survey. Remember, the survey relates to EDS, the claims processing agent for the Vermont Health Access Plan.

Provider Services: This unit responds to telephone and written inquiries and handles all aspects of provider enrollment and recertification. Please rate the assistance you have received from our PSU team: Niki Holton, Faith Burt, Brian Murphy, Mary Hall, Cortni Burns, Necia Nadeau, Margaret Dorsey, Jean Gadue and/or Jocelyn Ferdinand.

Provider Relations: Provider relations representatives meet with providers throughout the state, working to resolve complicated billing situations and address provider concerns on a personal level. Please rate the assistance you have received from Chris Haskins, Barbara Jackson, Jessica Monturo, or Sarah Johnson.

Claims Processing: This unit is responsible for receiving and sorting claims, keying data into the system, the resolution of claims, and mailing of the remittance advice report and benefit checks to providers. The unit also handles any post-payment processing, such as adjustments or refunds.

Eligibility Verification: This system provides our automated recipient service limitation and payment information to providers. It includes the Point-of-Sale (POS) devices, the Voice Response System (VRS) and the emulation software.

Please return the survey by November 25, 2002. I have enclosed a self addressed, stamped envelope for your convenience. Please do not use this return envelope for claims submissions.

Again, thank you for your time. I look forward to working with you in the coming year.

Sincerely,

Program Services Manager

EDS VERMONT
ANNUAL PROVIDER SURVEY - 2002

Provider Name:_____ Provider Number: _____

Please rate each area based on the following scale:

1 = poor 2 = fair 3 = satisfactory 4 = good 5 = very good

PROVIDER SERVICES

1. Accessibility of provider services telephone lines 1 2 3 4 5

2. Timeliness of response to written inquiries 1 2 3 4 5

3. Accuracy and clarity of information received from provider services staff 1 2 3 4 5

4. Courtesy and professionalism of provider services staff 1 2 3 4 5

PROVIDER RELATIONS

5. Accuracy and clarity of information received from provider relations representative 1 2 3 4 5

6. Courtesy and professionalism of provider relations representative 1 2 3 4 5

7. Relevancy of information provided in the Medicaid advisory newsletter 1 2 3 4 5

8. Billing assistance obtained from provider manuals 1 2 3 4 5

9. Relevancy of information provided on the OVHA Web site 1 2 3 4 5

CLAIMS PROCESSING

10. Timeliness and accuracy of claims processing 1 2 3 4 5

11. Timeliness and accuracy of claim adjustments and refunds as requested by your office..... 1 2 3 4 5

ELIGIBILITY VERIFICATION

12. Accessibility of eligibility verification phone lines 1 2 3 4 5

13. Accuracy and clarity of information received 1 2 3 4 5

OVERALL PERFORMANCE

14. General effectiveness of EDS as the claims processing agent for the Vermont Health Access Plan (VHAP) and Medicaid Programs 1 2 3 4 5

15. Comments:

_____

_____

_____

	VERY GOOD	GOOD	SATISFACTORY	FAIR	POOR	AVERAGE POINTS
PROVIDER SERVICES						
1. Accessibility of Provider Services telephone lines	67	156	120	57	11	3.5
2. Timeliness of response to written inquiries	25	116	109	64	33	3.1
3. Accuracy and clarity of information received from Provider Services staff	71	168	110	44	16	3.6
4. Courtesy and professionalism of Provider Services staff	168	165	65	10	6	4.2
PROVIDER RELATIONS						
5. Accuracy and clarity of information received from Provider	75	161	90	24	15	3.7
6. Courtesy and professionalism of Provider Relations Representative	123	159	64	15	5	4.0
7. Relevancy of information provided in the Medicaid “Advisory” newsletter	38	167	120	40	3	3.5
8. Billing assistance obtained from provider manuals	30	94	132	69	23	3.1
9. Relevancy of information provided on the OVHA Web site	13	62	86	21	10	3.2
CLAIMS PROCESSING						
10. Timeliness and accuracy of claims processing	61	146	100	66	49	3.2
11. Timeliness and accuracy of claim adjustments and refunds as requested by your office	33	99	101	91	76	2.8
ELIGIBILITY VERIFICATION						
12. Accessibility of eligibility verification phone lines	87	148	104	41	16	3.6
13. Accuracy and clarity of information received	88	157	105	25	20	3.7
OVERALL PERFORMANCE						
14. General effectiveness of EDS as the claims processing agent for the Vermont Health Access Plan (VHAP) and Medicaid Programs	61	176	117	39	14	3.6

Each answer is assigned a point value as follows:

Very Good = 5 points

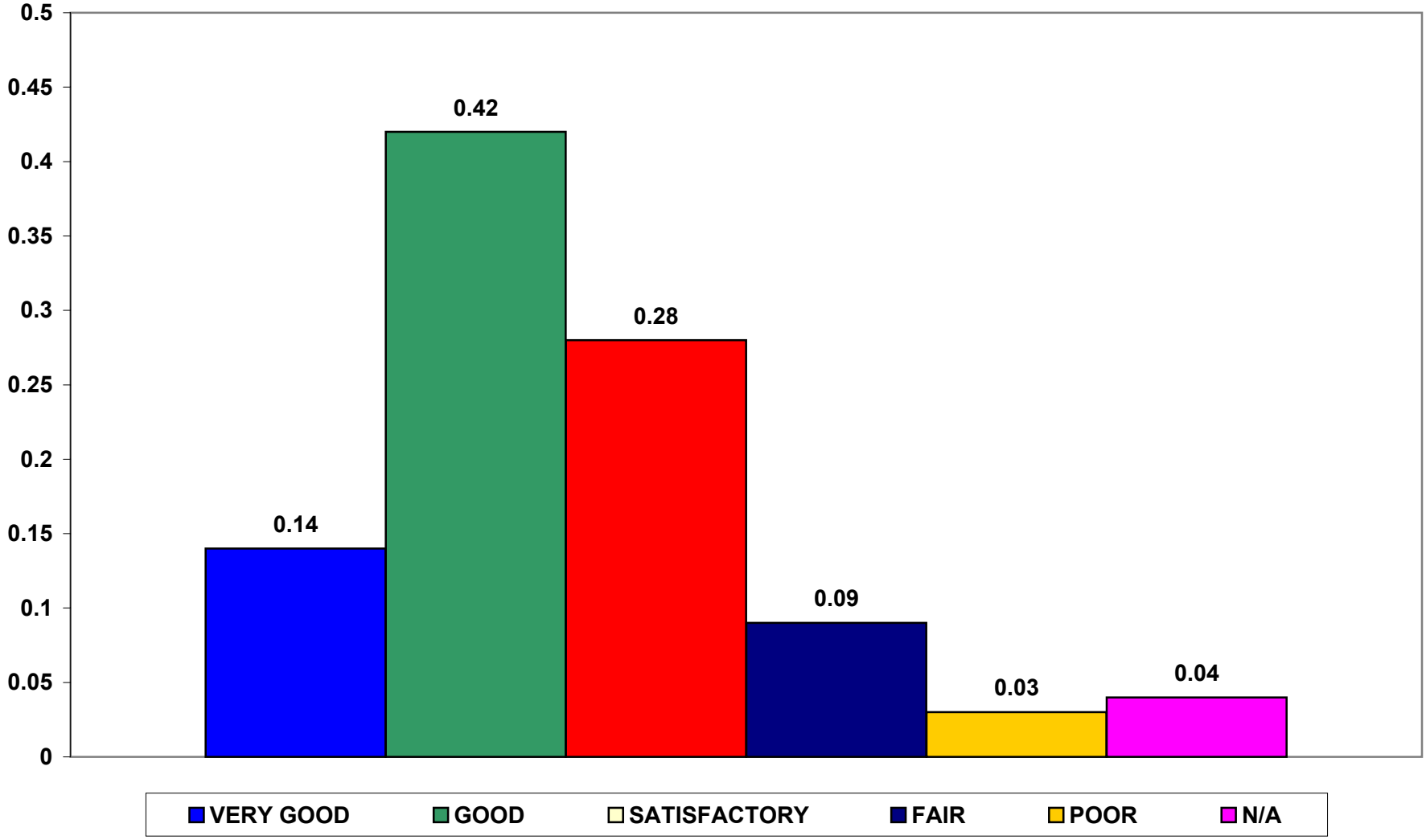
Good = 4 points

Satisfactory = 3 points

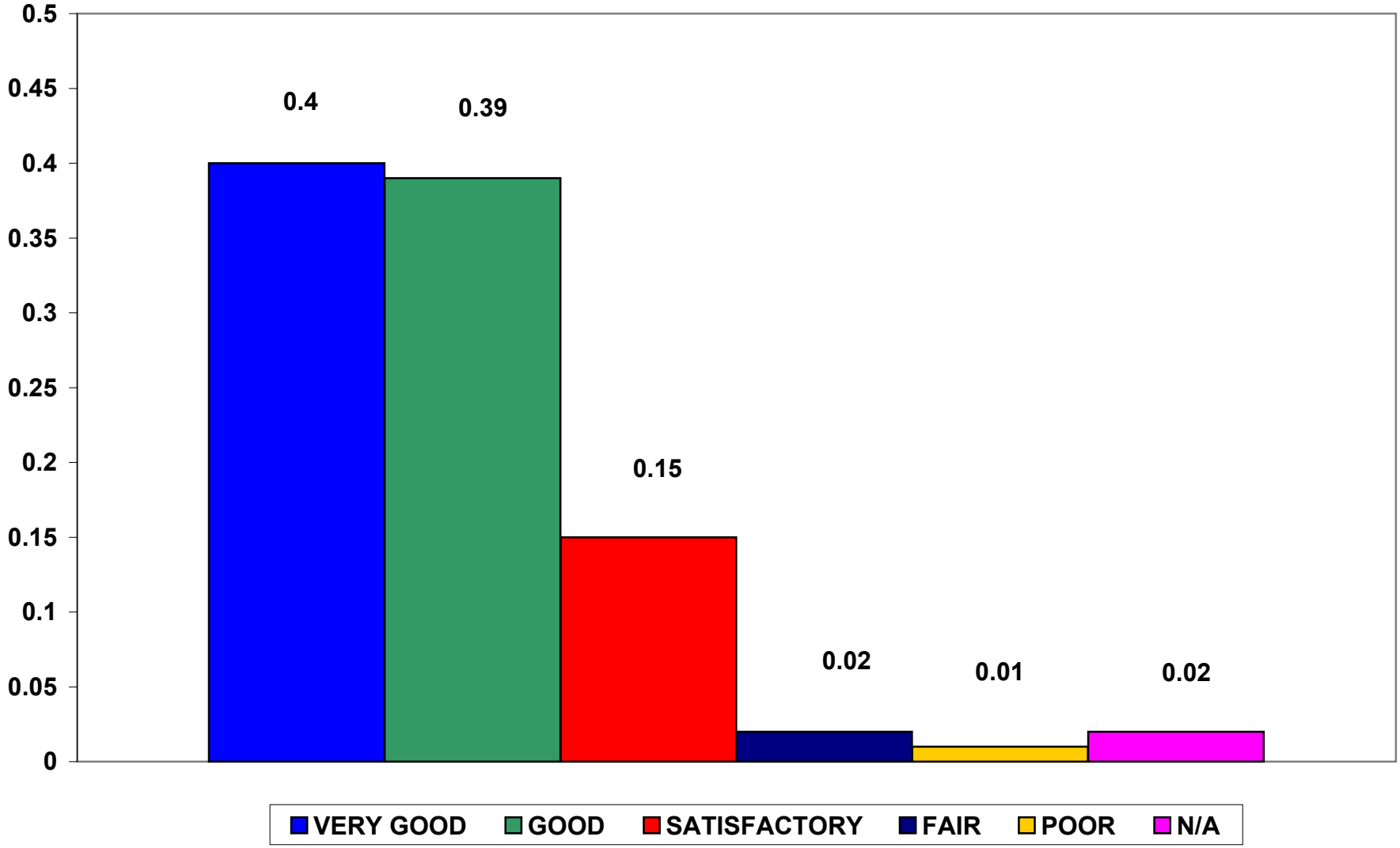
Fair = 2 points

Poor = 1 point

OVERALL PERFORMANCE
Effectiveness of EDS as the Claims Processing Agent for the Vermont Health Access Plan (VHAP) and Medicaid Programs



Courtesy and Professionalism of Provider Services Staff



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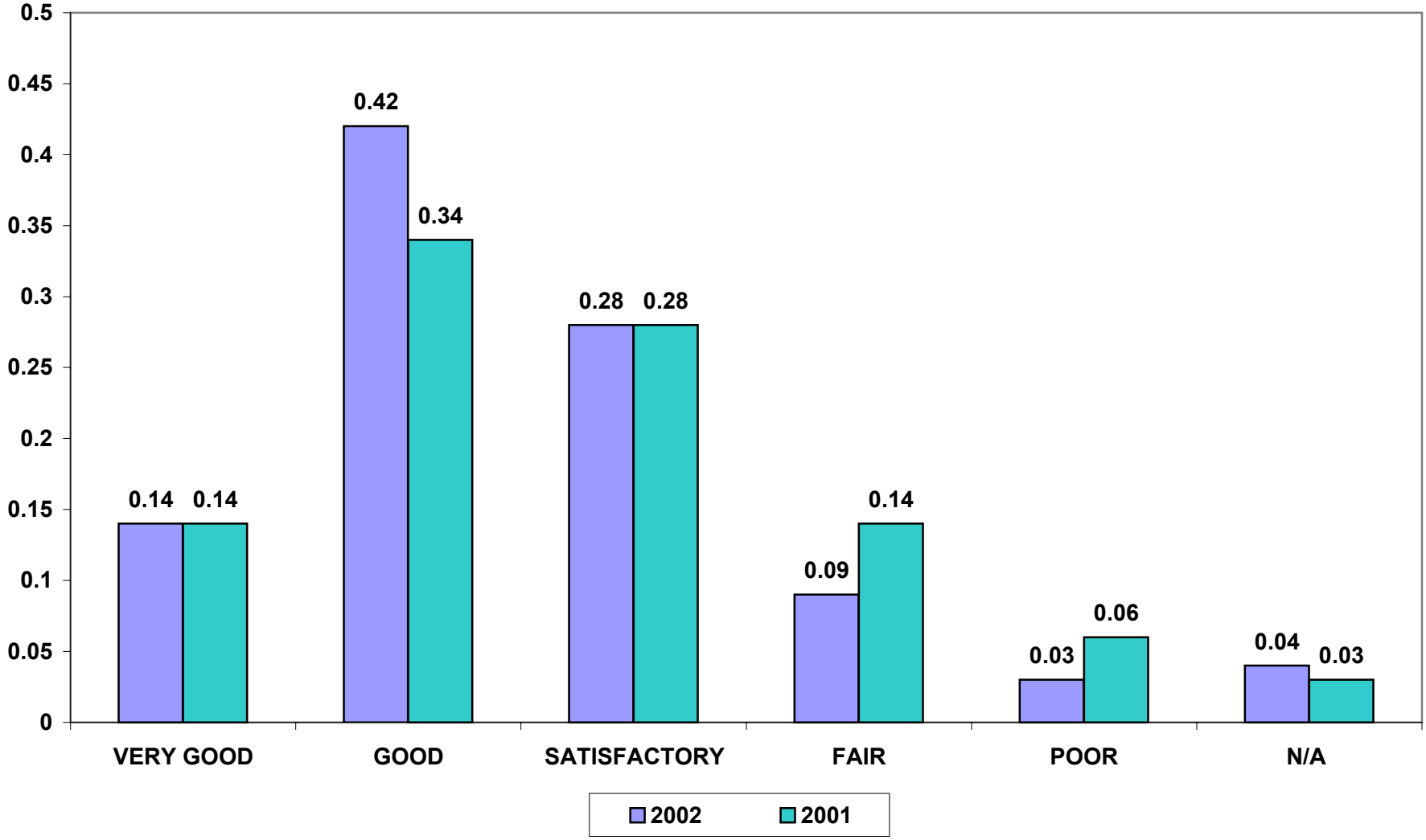

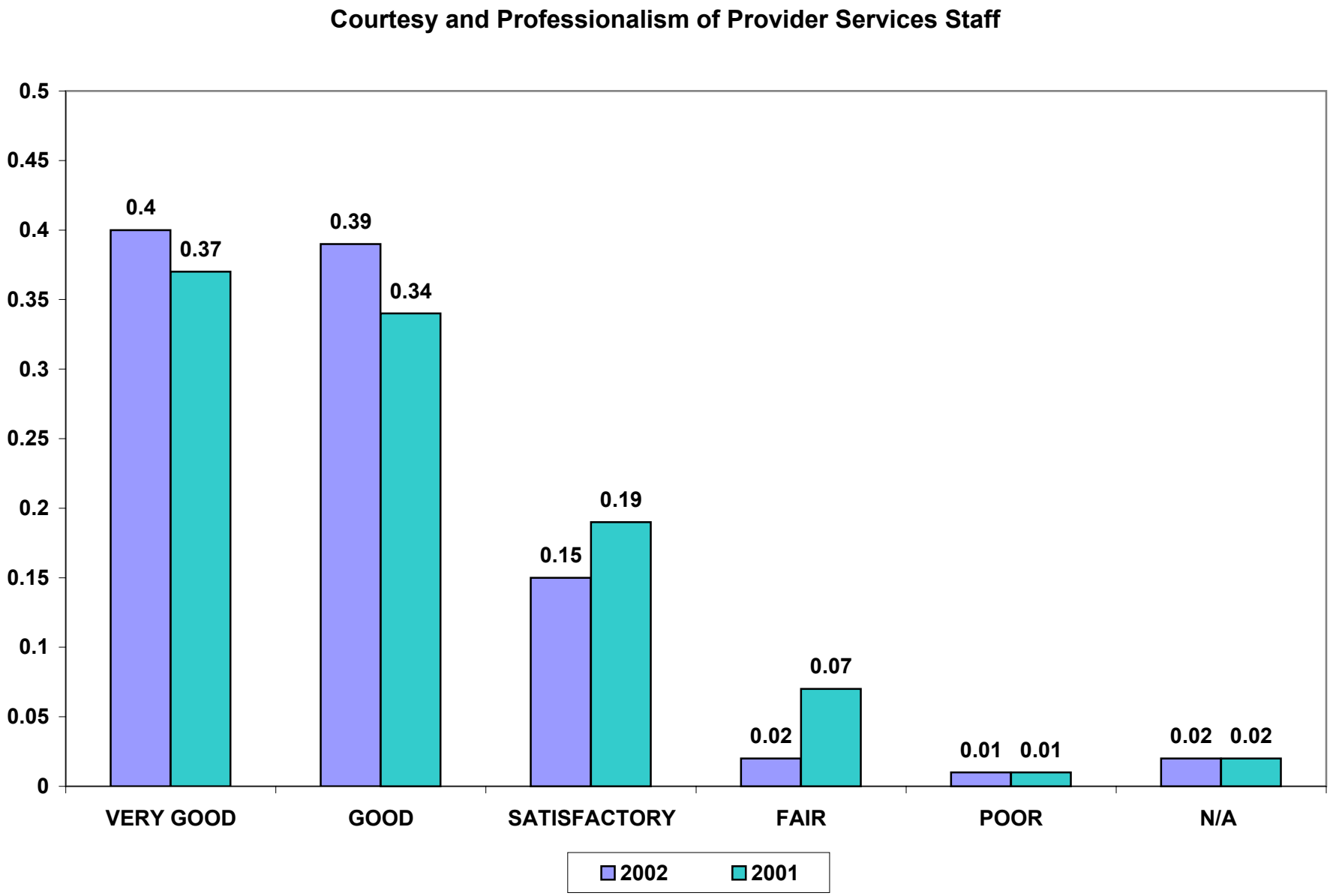
Courtesy and Professionalism of Provider Services Staff
0.5
0.45
0.4
0.35
0.3
0.25
0.2
0.15
0.1
0.05
0
0.4
0.37
0.39
0.34
0.15
0.19
0.02
0.07
0.01
0.01
0.02
0.02
VERY GOOD
GOOD
SATISFACTORY
FAIR
POOR
N/A
2002
2001

2002 PROVIDER SATISFACTION SURVEY COMMENTS*
"KUDOS"

Name of Practitioner	Comment Made
Cold Hollow Family Practice - Physician	Very professional - don't replace them!
Robert Vaillancourt - VT Supported Living - Rehab Facility	Overall, people are very nice and professional and want to be helpful.
Shaftsbury Medical Assoc., Inc. - Physician	My sincere thanks to Betty Parent for all her help.
Eden Park of Brattleboro - Repite	We haven't had a lot of respite care, but when dealing with EDS all services have been very good and provider services helpful.
Peter Lakatos, DMD - Dentist	Any phone relationship we have had with EDS reps have been professional and courteous.
James Wyllie, DDS - Dentist	I think you guys do well for the amount of questions we have.
Richard Schlein, DDS - Dentist	Overall, easy to deal with.
F.R. Michel, DMD - Dentist	Pleased overall.
Joseph Kress - Mental Health	The provider services staff have always been friendly, patient, and helpful.
Sylvia Fjeld - Independent Physical Therapist	Chris Haskins was very good at VHAP seminar.
Fairfax Pharmacy	You do a good job with DME claims.
Bettina D. Laidley, DMD - Dentist	You have some great provider services staff. Niki has always been very helpful and accommodating. She is a definite asset to your staff.
Timothy A. Sargent - Mental Health	Brian has been very helpful.

*Actual comments taken directly from provider surveys

2002 PROVIDER SATISFACTION SURVEY COMMENTS*
"KUDOS"

Name of Practitioner	Comment Made
Sean J. Heller, DC - Chiropractor	Most of my PSU experiences have been with Niki, Faith, Brian, Cortni and Necia, and I have to tell you that they have always been friendly, patient, kind and if they don't have an answer to a question, they will go and ask someone rather than say, "I don't know", or just sloughing the question off. This means so much to a provider's office to be made to feel like it is important to EDS that we as providers have the information that we need. It is also impressive that they can maintain this pleasantness in what has to be a difficult, difficult job. (People tend to want to "kill" the messenger.) Anyway, I just wanted to take a moment to let you and them know how much I have appreciated their kindness and excellent service - every time. I'm really sorry that Chiropractic will no longer be a covered benefit, but it was important to me to commend them on a job well done!
Caroline Sivaj Paletta - Mental Health	I would like to specifically rate the assistance I received from Necia Nadeau as excellent.
Robert Nist, DMD - Dentist	Keep up the good work! Thank you!
Lincare, Inc. - DME	Keep up the good work!
Elizabeth Nelson, DMD - Dentist	Cortni and Necia have been very helpful in clarifying our questions. We had a nice visit from John Mauk regarding concerns. In the meantime, Cortni cleared up the one complication that had been our current concern.
Laura Rabinovitz - Mental Health	No problems at all. Quick, easy and a generous amount of sessions given too.
Sandra Howell, M.S. - Mental Health	I look forward to working with EDS regarding the new regulations addressing confidentiality, and hope you will offer workshops, seminars, etc.
Kathryn C.S. Osborne - Mental Health	A pleasure working with EDS. Responsive and accurate information received in a timely way. Worlds apart from many other insurance companies! Keep up the great work!
E. Carbery Neal - Mental Health	Everyone has been very courteous!!! Brian especially!
Gilbert Rist, OD - Vision	Good job done.
Rutland Regional Health Services - Physician	Most of my contact is with Niki, Faith, Brian, Cortni and Necia and they are wonderful.

*Actual comments taken directly from provider surveys

2002 PROVIDER SATISFACTION SURVEY COMMENTS*
"KUDOS"

Name of Practitioner	Comment Made
Orleans/Northern Essex Family, Infant & Toddler Program	If I am having trouble with the program it is always reassuring that I can call and get the help I need and get friendly service.
Council on Aging South End	The support given by the Provider Relations Rep has been outstanding. I couldn't have resolved a major issue without her and her support.
Carol Hart - Mental Health	Staff has always been quite helpful and courteous when I've called with questions. Thank you!
Trevor Hanbridge - Mental Health	I appreciate the EFT option for payment.
Cynthia Hennard - Mental Health	Of all the "managed care" companies I work with, EDS is actually the best - least hassle, most efficient.
J. David Egner - Mental Health	Chris Haskins has invariably been thoroughly professional and competent - beyond the call of duty!
Vermont Oral & Maxillofacial Surgery Assoc. - Oral Surgery	Electronic claims turn-a-round and processing is great!
Martha Stretton, PHD - Mental Health	On-line billing works great - customer support for this service is also top-notch.
Mark Silverstein, MD - Physician	Most all of your representatives are very nice. We really appreciate all their help. Keep up the great work, everyone!
Justin and Charles Salem, DDS - Dentist	Thanks, Brian, for all of your help this year! You not only helped clarify a situation but actually helped us get reimbursement on a long overdue account! Thanks again for a job well done!
Eric Nichols - Mental Health	In my experience, EDS services to providers have improved dramatically in the past year. In the last few months, I have been able to reach live people who have been responsive, courteous, and helpful. Thanks.
Regina Roussin - Mental Health	No complaints! You are a rarity among insurance providers in your treatment of me.
Copley Hospital, Inc.	Overall, I think you do a great job. I feel that if there were more details in manuals it would make both our jobs easier.
Barry Shaw - Mental Health	I have found the staff at EDS to be very professional and helpful.

*Actual comments taken directly from provider surveys

2002 PROVIDER SATISFACTION SURVEY COMMENTS*
"KUDOS"

Name of Practitioner	Comment Made
Jane Sobel - Mental Health	Greatly appreciate how well you do your job.
Vermont Parent Infant Program	Jean Gadue and Perry Melvin have been terrific. So have the folks answering the phones.
Affiliates in OB/GYN	EDS is more accessible and efficient and accurate than most other companies.
Bennington Rutland SU - Dept of Education	I very rarely have any problems.
Psychologist - PHD	Keep up the good work!
Margaret McGuire, PHD - Mental Health	Good job!
Giordano Manor, CCH - ACCS	Everyone is so helpful to me. I don't really use a computer but am hoping to soon, but everyone calls back or writes with any questions on my written claims.
Carrol Otto - Mental Health	Provider rep has been helpful ++ on several occasions.
Keith Geissler - Physical Therapist	Brian has been extremely helpful and energetic when I have called to discuss a claim - he deserves a raise.
Loren Landis, MD - Physician	Most of the time information and lines are readily available. The staff is excellent and very helpful.
Carol Gibson Warnoch, Licensed Midwife	Thank you for your continued help while I learn this process. I appreciate you very much.
HIS Independence Project, Inc.	We have had very few problems and very helpful people when we needed help. Thank you.
Barbara Handelman - Mental Health	Good work!
Orleans Medical Clinic - Physicians	I've done medical billing for 25 years. In the past I've dealt with some wonderful knowledgeable people at EDS. Recently I took over the Medicaid follow-up for our rural health clinic - the Provider Rep, John Mauk, is a courteous wonderfully helpful person. Brian is wonderful.

*Actual comments taken directly from provider surveys

Name of Practitioner	Comment Made
Missisquoi Valley Rescue, Inc.	Greatly improved in accessibility; claims turn around also very good; very fast on crossover claims.
Douglas Speck, PHD - Mental Health	Great access of eligibility/benefits.
Yankee Medical - DME	It is wonderful working with OVHA and EDS, as everyone is very professional and courteous. We have a very good relationship with OVHA and EDS.
Clifford Langweiler - Physician	We love Malcolm!
Stuart Freyer, MD - Physician	Very pleased with EDS' handling of my phone inquiries - Lorraine Krulikowski, Practice Mgr.

Sample Annual Quality Improvement Process Report Card

In this section, we include the 2002 Annual Quality Improvement Process Report Card.

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Quality Improvement Process

QIP 2002 4th Quarterly Report Card - ANNUAL

In Attendance:

I. Prior Meeting Minutes:

No changes to prior meeting minutes.

II. Committee Update by Item:

The following is a review of the QIP Items from the Quarterly Meeting with comments and recommendations for action.

01 – **Customer Advocacy Project**: The EDS Task List is still being updated with recent staffing changes to PSA and Claims. It is anticipated that a new list will be complete by January. **COMPLETE.**

03 – **Availability of Provider Representatives During Peak Periods.** EDS continues to man the phones from 8 am to 5 pm, Monday to Friday. Provider Reps are on hand to assist with urgent problems. **COMPLETE**.

04 – **Bank Reconciliation Process**: Bank reconciliation process is effectively completed and reviewed monthly by the account manager prior to being sent to Deb Stempel. Three people are fully trained on bank recon and share the responsibility of completing the monthly reporting. **COMPLETE**

06 – **Provider Relations Staff Phone Etiquette Training**: Item continues to be monitored on a routine basis with no outstanding problems.

07 – **CRLD**: Continue working on the manual and waiting for the customer's direction on who needs the training to use it. **COMPLETE.**

08 – **Cross-Training of Staff**: A copy of the specific Cross-training Matrix was set to each manager last month requesting updates. The managers are still updating the current changes to job changes and cross-training assignments. It is anticipated that the task will be completed by January 2003. **COMPLETE.**

10 – **Document Control Procedure**: There are no changes to add to this Item at this time. Continue to Monitor. **COMPLETE**.

11 – **HCFA-64 Automation**: No changes to report. Continue to monitor. **COMPLETE.**

12 – **Mail Out Process**: PA notice process continues to operate well. No changes to report. **COMPLETE**.

13 - **Minutes of Fiscal Agent Meetings**: Item continues to be monitored on a routine basis. Meeting minutes have been written but not edited and mailed to the customer.

15 – **New employees Exposed to Customer office**: No new changes to report to date. Ongoing. **COMPLETE**.

17 – **Lack of Proactive Provider Visits**: This item will continue to be monitored to ensure that the goals are attained. **COMPLETE.**

18 – **Professionalism of Staff**: This item continues to be monitored on a routine basis with no outstanding problems. **COMPLETE**

19 – **Quality of Documents Sent out of Our Office**: The qipform folder on the R drive continues to grow with templates, forms, and documents. A spot review shows that the documents are appropriate to this folder and the documents reviewed are clear in regard to form and content. **COMPLETE.**

20 – **Refilming Process**: No big projects noted. The calendar continues to be maintained. **COMPLETE.**

21 – **RESOLUTIONS MANUAL UPDATE PROCESS**: This item continues to be monitored on a routine basis with no outstanding problems. As always, RESO pages are being undated daily. **COMPLETE.**

22 – **PA Forms**: This continuous/ongoing appears to be working well. This Item continues to be monitored.

24 – **TPL Backlog**: This Item continues to be monitored to control write-off backlogs and collections **COMPLETE**

29 – **Production of State Audits:** No report for this quarter. Continue to monitor. **COMPLETE.**

30 – **Customer Aim Training:** Currently in progress status as we have not had any requests from the Customer for training on the VT AIM System. There is a document on the r drive titled ovhatrng, doc that is an outline of the training for the future reference. It would be helpful to remind the customer that this training is available, since they may have experienced some turnover. Still looking into how to and who would be the best person to contact about AIM training.

31 – **Responsibility to Other State Departments**: EDS has taken great strides in creating consistent and open communication with partner state agencies. For example, the Department of Aging and Disabilities and the Attorney General's Office did training at EDS about their programs and areas of collaboration. In Addition, regular contact and relationships have been built with the DDMHS, DDS, OADAP, and the Department of Health. These contacts and relationships have Greatly enhanced consistent communication to the provider community among All entities with the Medicaid program.

33 – **Adjustments:** No Changes to date to report. Continue to monitor. Still waiting to begin new provider adjustment manual. Jeanne Rogers is the new adjustment coordinator **COMPLETE.**

34 – **Update of Procedural Manuals**: A couple of large folders have been compressed such as the user manual to make room for new additions. The next step will be to get staff to remove personal files and folders their home drive to free up more space. **COMPLETED**.

35 – **Improve Drug Rebate Process Timeliness**: The 3rd Quarter 2002 DR cycle went very smoothly without any concerns from Tom, Chris, or Julie. There were some initial printing issues that were quickly resolved. The report distribution was updated by Aaron and looks good. Continue to monitor. **COMPLETE**

36 – **Surveillance Utilization Review Process:** Turnover of SURS cycle and responsibility to Valerie Leopold as Primary SURS SE. However, I will now assume responsibility of secondary SURS SE and provide mainframe training, support and back-up to Valerie. Continue to monitor. **COMPLETE**

37 – **TPL Drug Rebate Tape Process:** The tape handling process has been updated for the drug rebate coordinator to attain a form to identify the DR CMS tape for the operator. Continue to monitor.

39 – **Phone Line Issues**: The phone line issues have been resolved. Administrative assistant is on point for any issues. **COMPLETE**

40 – **Enrollment type and Specialty**: have been working with Behavioral Health. Ongoing process.

41 – **Provider Manual Revisions**: Remains a work in progress with no changes. To be monitored on a routine basis.

43 – **CSR/Plog List Review and Update**: Continue to monitor this activity. Since CSR's and Plog's are being reviewed through the Impact Process (QIP 55), it is less likely that inappropriate CSR/Plogs will be entered into the system. Periodic review of CSR/Plogs are performed by Subsystem to check for any that may be old or in INFO Status without resolution. **COMPLETE.**

44 – **Increase Amount of Provider Visits**: The number of provider visits as exceeded all previous goals set and continue to rise. Continue to monitor. **COMPLETE**

45 – **Increase Planning/Management Activities**: No new changes to this Item. Continue to monitor.

46 – **Increase Account Understanding of Managed Care**: More proactive with reports. Use of Business Objectives to provider stats on usage for various groups.

48 – **Relook at Implementation of Data matches**…: Margaret to resume when staffing level is at full staff. **CANCELLED.**

49 – **Create inventory Process for Printer and Office Supplies**: Tasks **COMPLETE**. Continue to monitor; ongoing and up-to-date.

50 – **Create Inventory process for Provider Manual Supplies**: Manuals available in PSA area. Continue to monitor. **COMPLETE**

51 – **Bank tape – Review of Process to Make sure bank**: Continue to monitor. Cherie Benoit has a contact at the bank and gets the call if the bank didn't receive all the files properly. In that case files have to be sent again. **COMPLETE**.

52 – **Across the Team**: PSU and claims area try to have biweekly meetings to discuss changes/new things, get education and communicate to each other. No other changes to report at this time. **COMPLETE.**

53 – **Edit & Audit Review**: The Edit Audit QIP continues to be monitored on a routine basis. The team meets to discuss possible ways to improve the Edit Audit Review process to better serve our customer. Edits have been put in place to monitor the new timely filing rules, mom and baby claims, VHAP elective inpatient admissions, vision, etc. the process remains ongoing to improve the overall quality of the system.

54 – **R Drive Clean Up**: The r drive is being compressed to make room for new files and folders. Continue to monitor.

55 – **CSR Impact Process**: The Review Committee meets weekly as appropriate to review proposed CSR and Plogs. Submitters are held to a high standard of presentation and research to ensure that CSR/Plogs are clear and concise CSR/Plogs are more detailed and supported with documentation. **COMPLETE**

56 – **Provider Application Changes**: This item continues to be monitored on a routine basis without any problems.

58 – **Outstanding AR's**: This item continues to be monitored on a routine basis. **COMPLETE**

59 – **Disaster Recovery & Business Continuity Plan**: The Committee has now completed the body of the document and is working on the appendix. Once completed, the document will be turned over to Barbara Davis for review by the management team.

60 – **Edit Rules Committee:** No changes to report.

V. Old Business: Perry sent out a list of the 60 QIP Items with the names of the Team leader so staff will know more about the QIP Items and who the Team Leaders are.

VI. New Business: It was agreed that next year's goal should be to identify and create at least one new
QIP Item every month, based on issues and problems that each of us trips over every day in our activities.
Perry will remind all team leaders monthly of the goal.

VII. Adjournment
The meeting of the QIP adjourned at 1:45 p.m. The next meeting will be held on March 26, at 1:00 p.m.

LET US LOOK FOR WAYS TO ELIMINATE THE POSSIBILITY OF THE ABOVE AND TO AUTOMATE OR ELIMINATE MANUAL PROCESSES WHEREVER POSSIBLE!!!

Your continued participation in the QIP is of utmost importance. We do not want you buried in paperwork, but rather in control of your work environment. Your service supports our client and our organizational goals. Thank you for your hard work and dedication. It shows! If you are tripping over situations, problems, and issues, consider them for a QIP Item to be address in a team setting. Sharing is fun!

WORK PLAN AND SCHEDULE (OPERATIONS)

RFP Reference: 3.2.2.10, p. 3-15

The Department of PATH, citizens of Vermont, and Vermont health care providers have come to depend on EDS for reliability, service, results, and improvement. For the past 21 years as fiscal agent for Vermont Medicaid, it has been our pleasure to process claims, give provider training and education, provide meaningful reports for health care policy decisions, support the local economy by service contracts with local businesses, and expand career opportunities for Vermonters. Our approach to the Operations scope of work is one of consistent, reliable performance coupled with enhancements that demonstrate the value of the state's investment in the nation's first client/server Medicaid system.

To provide a logical sequence of events, sufficient detail for review, tasks, contractor responsibilities, milestones, and deliverables our Operations Work Plan and Schedule are defined in both Gantt chart and narrative description addressing the following requirements:

a. Understanding of, Response and Approach to Completing the Operations Scope of Work
b. Acquisition and Utilization of Staff
c. Utilization of Staff Resources
d. Approach to Infrastructure
e. Approach to Facilities and Infrastructure Acquisition and Installation
f. Approach to System Security, Backup, and Disaster Preparedness
g. Design and Development Approach
h. Implementation Approach
i. Testing Approach
j. Operations Approach to the Accomplishment of all Milestones and Deliverables in Section 2.6 of the RFP
k. Approach to Relations with State Personnel, Providers and Other Stakeholders
l. Use of Subcontractors

m. Cost Containment Mechanisms

n. Assumptions or Constraints in Developing and Completing the Work Plan and Schedule

o. Critical Path Diagram

p. Gantt Chart

q. How the Work Plan Provides for the Handling of Potential and Actual Problems

r. How EDS' Approach to the Operations Scope of Work Clearly and Unambiguously Accommodates Existing Technology and Meets Stated Technical Requirements

a. Understanding of, Response and Approach to Completing the Operations Scope of Work

RFP Reference: 3.2.2.10(a), p. 3-15

Working collaboratively with Vermont for more than 21 years, which represents more than 410 combined years of Vermont Medicaid Program and operational experience, Barbara Davis and her entire account team have dedicated themselves to building a solid system foundation focused on transforming health care for all Vermont citizens. The VermontAIM client/server MMIS not only fully supports Medicaid and other cross-agency programs but also positions the state to lead the MMIS evolution nationally.

With 10 years of VermontAIM experience, we have developed an understanding of the Operations scope of work that only comes from working *every day of the year* with program policy, claims processing procedures, Department of PATH personnel, and the state's 6,000 Medicaid providers.

In our response to this RFP requirement, we demonstrate our understanding of the Operations scope of work and summarize our approach to completing the scope of work in the following subsections:

- a.1. Understanding of Operations Scope of Work
- a.2. Approach to Completing the Operations Scope of Work
- a.3. Response to Completing the Operations Scope of Work

a.1. Understanding of Operations Scope of Work

The Operations scope of work includes the following major activities:

- Operating the VermontAIM
- Enhancing and modifying the VermontAIM
- Processing more than 8.5 million Medicaid claims and drug transactions each year for more than 135,000 beneficiaries
- Operating the Enhanced Vermont Ad Hoc (EVAH) system
- Offering proactive provider training and education across the state
- Providing local employment, training, and long-term career opportunities for citizens of Vermont
- Contributing to the state's economic development initiatives by procuring services from Vermont-based businesses

Our Williston-based team understands the criticality of the services we provide in support of the Vermont Medicaid Program. Our history of providing service to all program stakeholders is proof of this understanding. During our more than 21 years of providing fiscal agent services to the state, we have performed the following:

- Never missed a checkwrite payment to the providers
- Consistently maintained a 99 percent average for processing and paying all claims within 30 days
- Maintained system availability levels of 99 percent or better
- Enabled the state to implement the annual legislative changes, in which all are high priority

All Medicaid program stakeholders rely on our team's consistent performance. Following are examples of the support we offer to various program stakeholders:

- **Office of Vermont Health Access (OVHA)**—Quality claims processing and timely claim payments allow the OVHA to focus on program administration, future goals, and the evolution of the next generation of the MMIS. Based on a single-state audit that KPMG recently conducted, we received an accuracy rate that exceeds 99 percent, further documenting the quality of our processing staff.
- **Providers**—Maintaining a good reputation with providers is a powerful recruitment strategy. Therefore, timely reimbursement for medical services is critical to continued provider participation, especially for providers in regions, such as the North East Kingdom, that have high concentrations of program beneficiaries. In our recent provider survey, responsiveness of the Program Services team was one of the highest rated categories. This rating demonstrates strong support from the provider community.
- **Beneficiaries**—By processing beneficiary updates daily, we ensure that the beneficiary eligibility file includes accurate, up-to-date information that is available at the time of service. As a result, beneficiaries receive the services they need promptly and with no delays due to processing lags.
- **Other stakeholders**—Other contractors and program stakeholders need timely and accurate information to support their program responsibilities. By having established interfaces with both external contractors and numerous state agencies, combined with our updating procedures, we can effectively disseminate critical information. For example, our nightly transmission of updates to First Health's provider enrollment files helps ensure that its system runs smoothly and effectively.

In addition to the Medicaid program, other Vermont programs also rely on the VermontAIM. In the following table, we identify these programs and the support we provide.

VermontAIM Support for Vermont Health Care Programs

Vermont Health Care Program	EDS Support
Vermont Health Access Program (VHAP) and PC*Plus*	• Claims processing • Provider payment issuance • Program reporting • Provider and beneficiary file maintenance • Specialized provider enrollment procedure monitoring
1915 Home- and Community-Based Waiver	• Claims processing • Provider payment issuance • Program reporting, including CMS Annual 372 Waiver report
Breast and Cervical Cancer Treatment Program	• Claims processing • Provider payment issuance • Program reporting
Dr. Dynasaur	• Claims processing • Provider payment issuance • Program reporting
General Assistance	• Claims processing • Provider payment issuance • Voucher processing • Program reporting
Healthy Vermonters Program	• Storage of paid claims data received from pharmacy contractor • Provider payment issuance • Program reporting
School-Based Health Services Program	• Claims processing • Provider payment issuance • Five provider representatives assigned to interact with schools and other providers • Program reporting

Vermont Health Care Program	EDS Support
State Children's Health Insurance Program (SCHIP)	• Claims processing • Provider payment issuance • Program reporting
VHAP Pharmacy	• Storage of paid claims data received from pharmacy contractor • Provider payment issuance • Program reporting
VScript	• Storage of paid claims data received from pharmacy contractor • Provider payment issuance • Maintenance of separate manufacturers participation agreement for the VScript drug rebate program • Program reporting

Supporting MITA and the Future of Medicaid

We understand that the current procurement is for a takeover of the VermontAIM. We also understand the state's vision for a replacement MMIS. At a minimum, this "MMIS of the Future" will incorporate CMS' Medicaid Information Technology Architecture (MITA). The next generation of the MMIS is one of the most discussed topics in Medicaid today. Following are examples of information being discussed:

- An article in the November 2002 issue of the *MMIS Messenger* described the first MMIS summit, which was held in Vermont and led by Chairperson of the State Technology Advisory Group (STAG) and Commissioner of Medicaid Pat House. The summit was called, in part, because Ms. House and her MMIS staff want the design for the new MMIS to capitalize on Internet technology advancements.
- In that same issue of the *MMIS Messenger*, the writer of another article stated that future health care systems must include "key features that are designed to facilitate the flow and exchange of critical information throughout the Medicaid business enterprise and to promote leveraging of information resources between Medicaid and other programs that serve the same populations."
- At the Medicaid conference in Hunt Valley, Maryland, in the Fall of 2002, the MMIS Re-Design Work Group stated that the MITA must bring the following functions:
  - Monitor and assess trends in Medicaid delivery of care, expenditures, and outcomes
  - Guide prevention and intervention programs
  - Inform Medicaid policymakers

- Identify issues that need to be researched further, including additional data collection and analysis
- Provide information for community and program planning
- Protect confidentiality while providing information to those who need to know
- Enhance quality of care through better feedback to providers and users
- Provide information sharing instead of data sharing only
- Ensure Health Insurance Portability and Accountability Act (HIPAA) compliance
- Standardize data standardization across agencies and nationally
- Conduct real-time claims processing

The processing capability of the VermontAIM *already meets* many of the MITA objectives. Thus, the state's investment in the VermontAIM presents the OVHA with the opportunity to immediately implement enhanced processing capabilities while offering a solid foundation to integrate many of the goals set forth by MITA. For example, the Internet optional enhancement provides a wide range of Internet functions that address many of Ms. House's concerns noted at the MMIS summit. For more information about our approach to the Internet optional enhancement, please refer to our response to RFP requirement 2.8.3.1 in the "Work Plan and Schedule (Enhancements/Modifications)" subsection of the "J. Enhancements/Modifications Narrative" section.

We encourage you to continue to explore your options for enhancing the current system throughout the next contract period. You will find that many features of the "MMIS of the Future" can be implemented now, with the expected benefits put in place without the three-year wait for the replacement MMIS.

a.2. Approach to Completing the Operations Scope of Work

Our approach to completing the Operations Phase scope of work includes the following tasks.

Maintain project management office in Williston—Barbara and her team will continue to provide program support from the operations facility in Williston. This location is close to the state's offices in Waterbury and Burlington. By being in such close proximity to the state's offices, we can be present for impromptu meetings that the state schedules on short notice.

Maintain Vermont staff—Unlike other Vermont contractors who provide support from outside the state, our project plan provides jobs and opportunities for career growth for more than 60 Vermonters. The size of our Vermont-based staff will increase in the new contract period when we add an accountant, a database administrator, and other positions to the Williston team.

Maintain and enhance the VermontAIM client/server MMIS—The VermontAIM has proven its scalability and flexibility over and over again since its implementation. Since 1993, the system has easily expanded its processing and reporting capabilities to support the processing requirements of 10 other state health care programs, in addition to Medicaid. The following examples further demonstrate our ability to modify and enhance the VermontAIM:

- The implementation of the PC*Plus* managed care program allowed the state to retain its 1115 waiver program when all of the managed care organizations left the program.
- When General Assistance (GA) claims and the Department of Correction claims were added, we did not require additional staff to process them.
- With the very successful SCHIP implementation, the state was able to collect federal matching funds on more than $27 million of SCHIP claims in 2002.

Because we already know the VermontAIM, we can start to work immediately. Thus, we can work with the state to rapidly implement the legislative mandates passed each July. All of these mandates have a high priority and must be enacted without delay.

Today, the VermontAIM represents a significant investment by the state in funds and person-time. The system supports and enforces Vermont-specific program policy, which no other system can replicate. In July 2003, the HIPAA remediation will further enhance the VermontAIM by implementing advanced windowing capabilities. During the past 10 years, we have made a significant number of system modifications (including year 2000 remediation, automated cash control, addition of J-code drug rebate, and annual legislative changes) within each year's 5,000 modification hours that we provide to the state. As a result, you have incurred no additional costs while receiving a steadily improving MMIS.

This evolution will continue in the next contract period, as our team implements the mandatory enhancements and modifications. We are excited about the opportunity to present the optional enhancements and modifications contained in our proposal. To align with the state's goals for the Department of PATH, we must possess specific capabilities, including the following:

- **Nimble—**reflects the responsiveness of our team in adapting to changes in state government and the Medicaid program that improve the process for the beneficiaries
- **Adept—**describes our ability to develop excellent working relationships with all of the state's stakeholders and partners
- **Connected—**includes our ability to connect electronically not only between departments but also to the providers and beneficiaries

Steady improvement—Our Vermont team is always looking for better ways to serve the state. To support the efforts for steady improvement, we introduced the Quality Improvement Process (QIP) in 1999. The QIP provides a standardized approach for identifying targets for improved performance, plans for improvement, and regular checkpoints that involve state personnel and us. The QIP has led directly to improvements such as CMS-64 automation, increased drug rebate collections, bimonthly edit and audit review meetings, and increased cross-training of account staff.

As a result of the drug rebate QIP, for example, we identified a potential need for a pharmacist to contact manufacturers when they disputed invoices. After less than one year of having our pharmacist consultant working with our team, we collected more than $500,000 in previously uncollected older disputed rebates. We also implemented J-code processing, which generated more than $200,000 in drug rebate collections. We accomplished these tasks without requesting additional funding.

We understand the need for cost-containment and continue to look for ways to achieve benefit and administrative cost savings. We also continually work to improve our staff's productivity as demonstrated by the edit/audit QIP. As a result of this effort, we identified a productivity enhancement that reduced the number of pending worksheets by more than 5,000 in one weekend.

Reliable performance every year, 365 days—The Operations Scope of Work requires the steady, reliable performance of the required tasks, guided by proven procedures and knowledgeable personnel. The following list identifies the tasks performed by the Vermont team in support of operations:

- Paper claims processing (approximately 12 percent of total claims)
- Claims processing for multiple state departments, including the following: Medicaid, Department of Health, Department of Mental Health and Mental Retardation, Office of Alcohol and Drug Abuse, Social and Rehabilitative Services, General Assistance, State Pharmacy VScript program, Department of Corrections, Division of Dental Health, and Department of Education
- Modification of the VermontAIM to support PCPlus, the state's managed care capitated program
- Pharmacy financial transaction processing
- Drug rebate processing (in excess of $23 million collected last year), including manufacturer invoice generation and tracking
- Electronic claims processing for all other claim types, including tape, diskette, and electronic transmission
- Rural health clinic and federally qualified health care processing
- Monthly random sampling of recipient services
- Provider enrollment, biannual recertification
- Provider file updates
- Provider help desk support
- Provider outreach
- Provider education, training, workshops, bimonthly newsletter, and provider group meetings

- Provider call tracking system, includes all calls captured and reported by category
- Provider mailings
- Provider directory maintenance
- Claims processing, provider enrollment, training, and education for SCHIP
- Early and periodic screening, diagnosis, and treatment program (EPSDT) reporting and support
- Federal tax reporting, 1099 generation
- CMS waiver reporting, 372 generation, 416 reporting
- Financial processing, weekly remittance advice, check generation, bank reconciliation, and weekly draw reporting
- Electronic funds transfer (EFT), which includes 98 percent of all funds transferred
- Adjustment processing, including payouts, recoupments, cash receipts, and dispositions
- Systems enhancement and modification (includes 5,000 systems engineer hours annually)
- Systems administration, including local area network and wide area network
- Systems network setup and maintenance, systems monitoring and upgrade of software and hardware
- Joint application design work with client
- Project management, generation of computer service requests (CSRs)
- Eligibility automated voice response system (AVRS) maintenance
- Eligibility swipe boxes (POS device) maintenance
- Nightly eligibility file update
- Eligibility ID card generation
- Monthly eligibility reconciliation with OVHA system
- Third-party liability (TPL) collection and processing
- TPL recipient insurance processing, includes Medicaid paying for recipients' insurance to save money
- Retroactive eligibility claims facsimile generation and tracking for TPL recovery
- Ad hoc reporting through BusinessObjects database
- Ad hoc coordinator that generates complex reporting
- Tax assessment processing
- Disproportionate share processing
- Annual SAS audit report (Level I and Level II have been completed with no findings.)

- Reference file updates, including ICD-9, HCPCS, and state procedure codes
- Price files, maintaining multiple pricing mechanisms for different provider types
- Processing of capitated payments to providers
- IBM Content Manager OnDemand system support for permanent storage and retrieval of reports
- Management and administrative reporting (MAR) production
- Surveillance and utilization review (SUR) reporting production
- Maintenance of the automated prior authorization system
- AIDS and smoking cessation program support

Buy Local—In addition to contributing to Vermont's economy through the employment of our 65 local Vermont employees, we also support the local Vermont economy by buying facility support services from local companies whenever possible. As with any wise shopper, Barbara Davis' top priority is always selecting the best possible candidate for the job. We're glad to say that she is able to find the best in Vermont. Barbara fulfills her office needs from the following list of Vermont businesses:

- Hillside Properties
- Vermont Electric Coop
- Burlington's Best Office Cleaning (a woman-owned business)
- Life Safety Systems
- OnSite SecurShred
- Burlington Free Press
- D&B Electrical
- Farrell Vending
- Vantage Press
- Contact Communications
- All-Cycle
- Essex Mini Storage
- Freedom Jeep/Chevrolet
- Topsham Communications

This is just a partial list of local businesses that have benefited from EDS' commitment to supporting our local communities. As we continue our service to Vermont, we will continue to look for new opportunities to support Vermont economy and local businesses.

Supporting the Entire Vermont Community

For our Vermont team, the Operations scope of work means much more than the work we do to support Medicaid and other state programs. Our expanded definition of operations means we support our state, schools, and communities with time, money, and a spirit of volunteerism.

While EDS may be recognized as a world leader in providing information technology solutions, our Williston-based team focuses its skills and contributions here in Vermont. We believe that giving back to the communities in which we do business is vital for the future of our company and our state. We are committed to improving the lives of people in Vermont by providing local leadership and community service and by promoting educational initiatives for children throughout the state.

Our Vermont team members take very seriously their responsibility to give back to the community. Our employees volunteer their time and contribute financially to improve the quality of life and economic prosperity for the citizens of Vermont. The events described below represent some of the initiatives our Vermont team supports.

Vermont Food Bank—Our team made one of the largest donations received this year to the Vermont Food Bank during its recent food drive, collecting more than 890 pounds of food for the needy. When we delivered the donations, Vermont Food Bank CEO Deborah Flateman stated, "It is always so significant when people in our community join the fight against hunger by becoming involved with the Food Bank, which is what EDS has done. It means a great deal to the Food Bank and to the community."

Chittenden County United Way—Our team has supported the United Way program for the past four years by raising more than $7,200 to support individuals in our community. As a result, we earned the Bronze Award for Outstanding Service.

AIDS Ride for the Cure—Carrie Marchant, one of our systems engineers, completed a 490-mile bike ride from Montreal to Portland, Maine, last fall to raise money and awareness for a cure for AIDS. She joined more than 2,000 cyclists in the ride, raising more than $3,500 for research about an AIDS vaccine.

SERVE—Barbara Davis supports Barre SERVE, a program targeted at wiping out world hunger. This volunteer organization distributes food to needy families locally. Barbara has been the distribution coordinator for this program for the past six years.

Cochran Ski Area—When Bob Randall, one of our Vermont systems engineers, heard about the difficulty a local ski area was having attracting skiers, he volunteered to assist them. Bob designed, authored, and maintains this local non-profit ski area Web site. The Web site can be viewed at http://www.cochranskiarea.com.

Boy Scouts—Chris Haskins organized an account "Jeans Day" to raise money to help the local Cub Scouts build a float for the Fourth of July parade in Richmond.

Vermont Youth Orchestra—Seventeen of our employees supported the Vermont Youth Orchestra by participating in the organization's Haunted Forest at Halloween this past year. Our employees served refreshments, conducted tours, and painted the scenes for the Haunted Forest.

Williston family sponsored at Christmas—We "adopted" a mom and her two young sons this past Christmas and provided them with a surprise Christmas package of gifts and a complete holiday dinner.

March of Dimes—For the past four years, we have participated in the annual March of Dimes Walk in Burlington to raise money to help prevent birth defects. Since 1999, we have raised almost $4,800 by receiving sponsorships, walking, and holding special raffles.

These local efforts are complemented by our corporate initiative that promotes the use of technology in Vermont's elementary schools. The annual EDS Technology Grant Program provides $1,500 grants issued to the winning elementary schools in Vermont. Vermont educators complete the grant application process, outlining classroom projects and disclosing how different technology tools support their educational initiative.

Demonstrated Vermont Commitment

Each year, we award three technology grants to Vermont schools as well as to numerous other activities throughout the year.

At the most recent grant awards held in January 2003, newly elected Governor Douglas joined us as we gave three $1,500 grants to the following schools:

- **Lena Hodge of Waits River Valley School—**She will use the money to provide the Kidspiration program for special needs students to help them with spelling, grammar, and writing.
- **Vicky Trombly and James Barry of South Royalton Public School—**As part of their science and computer classes, these educators will purchase computer-aided design (CAD) software and a digital camera to build an electric car and to visually track wetland areas.
- **Robert Stone of Westminster Central School—**He will purchase a computer and digital microscope for field studies of woodlands, mountains, and the Connecticut River watershed.

Community involvement activities do more than improve the neighborhoods in which we live. They also strengthen our business relationships, support diversity and employee recruiting, improve company image, and promote positive employee morale. As illustrated by the diverse cross section of local and statewide initiatives outlined in this section of our proposal, our commitment to Vermont touches many individuals throughout the state.

a.3. Response to Completing the Operations Scope of Work

In the remainder of our response to Work Plan and Schedule for Operations Scope of Work, we will provide detailed responses to Operations Phase responsibilities.

The response to requirements (b) and (c) will show how EDS maintains staffing at the levels required to perform all operational responsibilities.

- b. Acquisition and Utilization of Staff
- c. Utilization of Staff Resources

The response to (d), (e), and (f) will show our understanding of the infrastructure requirements and associated topics like security, backup, and disaster recovery.

- d. Approach to Infrastructure
- e. Approach to Facilities and Infrastructure Acquisition and Installation
- f. Approach to System Security, Backup, and Disaster Preparedness

The response to (g), (h), and (i) will describe the design and testing process we follow to implement enhancements and modifications into the VermontAIM.

- g. Design and Development Approach
- h. Implementation Approach
- i. Testing Approach

Paragraph (j) is called "Operations Approach." We are using this paragraph to respond to the 26 subsections in section 2.6 of the RFP.

- j. Operations Approach Section 2.6, Operations

Paragraph (k) describes our approach to maintaining positive work relations with the state, provider community, and other stakeholders.

- k. Approach to Relations With State Personnel, Providers, and Other Stakeholders

The response to (l) identifies the subcontractors that will support the Operations Scope of Work.

- l. Use of Subcontractors

The response to (m) identifies cost containment mechanisms for the state's consideration.

- m. Cost Containment Mechanisms

The responses to (n), (o), (p), and (q) provide the required work plan information.

- n. Assumptions or Constraints in Developing and Completing the Work Plan and Schedule
- o. Critical Path Diagram
- p. Gantt Chart
- q. How the Work Plan Provides for the Handling of Potential and Actual Problems

The response to (r) states clearly and unambiguously that our approach accommodates existing technology and meets technical requirements.

- r. How the EDS Approach to the Operations Scope of Work Clearly and Unambiguously Accommodates Existing Technology and Meets Stated Technical Requirements

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b. Acquisition and Utilization of Staff

RFP Reference: 3.2.2.10(b), p. 3-15

EDS has successfully managed the fiscal intermediary responsibilities of the Vermont Medicaid Program for more than 21 years and has a management team uniquely qualified to provide experience in management and technical operations. All of the proposed individuals are the same **dedicated personnel with whom the state has developed strong working relationships**.

c. Utilization of Staff Resources

RFP Reference: 3.2.2.10(c), p. 3-15

The use of staff resources during the Operations Phase is represented in our work plan. EDS proposes 83 full-time and two part-time staff committed to Vermont during operations. Fully trained and dedicated staff will be available to work closely with you. EDS staff will continue to work from the local office on Hurricane Lane, as well as staff from the Provost Technical Solution Center support center.

EDS is familiar with the state's people, policies, systems, and operations. The state knows EDS, our record of timely and accurate claims processing, and our responsiveness to the dynamic environment of the program. EDS managers and staff will continue to **meet and exceed expectations and maintain a high level of service**. During the Operations Phase, staff will be involved in numerous activities including the following:

- Review scope of operations and develop operations work plan
- Create systems documentation
- Write and finalize procedures and manuals for claims, provider services, beneficiary, financial, and VermontAIM windows reference, long term care, MARS, ad hoc, and operating procedures
- Develop new software documentation
- Design education plan for state personnel
- Implement HIPAA translator services
- Maintain and update the Business Continuity and Disaster Recovery Plan
- Make changes to telephone and e-mail setup based on your requirements

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d. Approach to Infrastructure

RFP Reference: 3.2.2.10(d), p. 3-15
2.9, p. 2-179
2.10, p. 2-184
2.10, p. 2-184

We will continue to provide the state of Vermont excellent infrastructure support by continuing to use the existing hardware and software configuration to support the VermontAIM. Using the existing platform brings the following advantages to the state's Medicaid program:

- **No disruption to VermontAIM system processing—**We will not have to install the VermontAIM on a new platform. Therefore, we will not be required to freeze the system, make the transfer, and then perform the required system and operations testing tasks that other contractors must perform.
- **Unique ability to make ongoing enhancements—**Because the VermontAIM is not transferring to a new contractor, we do not require a learning curve to make needed enhancements and modifications.
- **High priority legislative mandates will be implemented immediately—**The OVHA and EDS know that each July the Legislature mandates changes to the Medicaid program and other Vermont health care programs. Because we are working with the installed infrastructure, our experienced VermontAIM systems team can implement these high priority modifications without delay.

In this subsection, we describe the infrastructure, including hardware and software requirements, as well as the network interfaces.

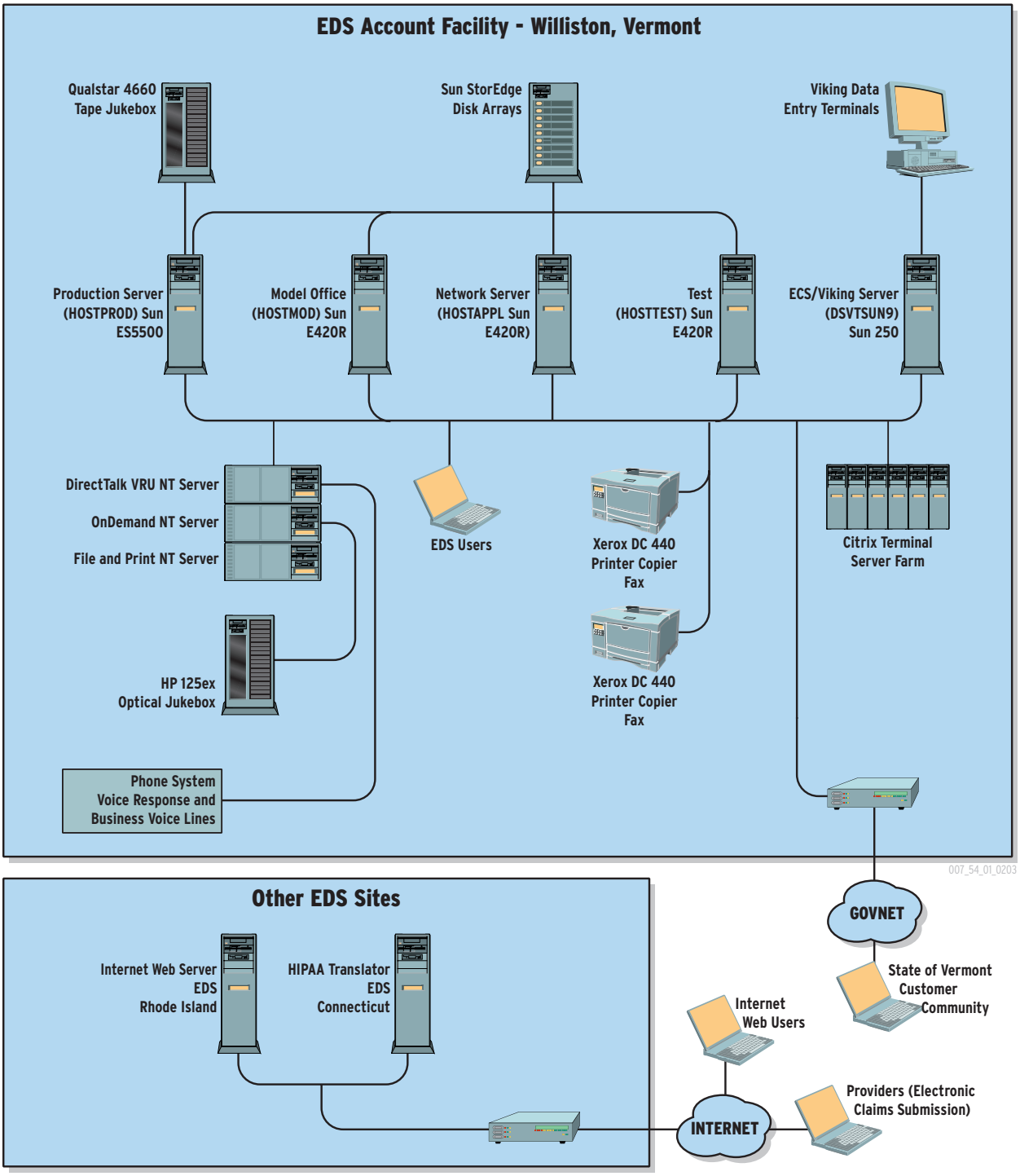
Equipment Purchases/Leases

During the Operations Phase, we will continue to provide the same excellent level of support to the VermontAIM that we currently provide, and we will continue to use the existing infrastructure to provide that level of support.

Overall Architecture

The following diagram graphically depicts the existing architecture with the addition of the Citrix server for the HIPAA implementation occurring in July.

Existing and Post-HIPAA Architecture



This architecture provides the state of Vermont with the technology needed to meet its current MMIS needs.

Hardware

We will continue to use the following network servers and configurations, which are located at our facility in Vermont, to support the production MMIS at the start of the Operations Phase:

- HOSTPROD—Sun ES5500 system running Solaris 9 and Ingres 2.6 supporting the MMIS
- Advanced Vermont Ad Hoc (uses IBM DB2 Universal Database) and management and administrative reporting (MARS) subsystem
- HOSTAPPL—Sun E420R system running Solaris 9 and Ingres 2.6 supporting domain name servers (DNS) primary, NIS master, and the backup eligibility database
- DSVTSUN9—Sun 250 system running Solaris 9 and supporting Viking data entry
- HOSTMOD—Sun E420R system running Solaris 9, Ingres 2.6 and DB2 V7.2 supports the model office test environment and application development, DNS Secondary, and NIS Slave. At the start of the Operations Phase, this server will support base systems engineer work.
- HOSTTEST—Sun E420R running Solaris 9, Ingres 2.6 and DB2 V7.2. At the start of the Operations Phase, this server will support enhancement systems engineer work.
- IBM Netfinity 5000 server running NT 4.0 with service pack 6.0A. This server supports automated voice response (AVR).
- IBM Netfinity 5600 running Windows NT 4.0 server. This server supports our local area network (LAN) in Williston with local file and print services as well as Dynamic Host Control Process (DHCP) services.
- IBM Netfinity 5600 server, running NT 4.0, is the intranet Web-based content manager OnDemand server.
- IBM xSeries 342, running Microsoft Windows 2000 server, is used as the BusinessObjects Broadcast Agent Server.
- Dell PowerEdge 2650 servers will be used as the Citrix MetaFrame Xpe servers.
- Sun Sunfire V880, located off-site, will be leveraged with three other Northeastern Medicaid accounts (New Hampshire, Connecticut, and Rhode Island) to host the HIPAA translator. Additionally, two Compaq and three IBM Netfinity servers, located off-site, will be used as Web servers in support of the HIPAA translator. To most efficiently provide services to the state, we propose installing the optional Internet enhancement defined in this RFP on the same hardware supporting the HIPAA translator Web sites.

Recovery and Disaster Preparedness

We use Legato Networker and a Qualstar 4660 tape jukebox to accomplish full network backups each week. For disaster recovery purposes, we produce a copy of the weekly tapes for off-site storage. At any given time, we have three sets of media tapes for off-site storage that we update weekly. We also perform incremental tape backups daily, which remain on-site at Williston. In January, we will begin taking complete daily backups, which will be stored off-site.

We installed a 20KVA APCC Silicon uninterrupted power supply (UPS) on-site for additional backup power support in the case of a disaster**.** The power to all server, periphery, and telecommunication equipment goes through the UPS. This capability allows us to continue operations for up to one hour if we have a power surge or short-term power outage. If we experience an extended power outage, the UPS provides us with enough power to shut down the servers in a controlled and effective manner, which will eliminate the possibility of data corruption.

Software

The Vermont MMIS is based on Ingres 2.6 with an online environment currently written in CA Vision. As part of the HIPAA project, we will replace the existing CA Vision screens with screens written in Sybase PowerBuilder by July 2003.

Our facility in Williston currently uses the following software:

- Sun Solaris 9
- CA Ingres 2.6
- IBM DB2 Universal Database V7.2
- CA Vision (to be phased out in July)
- PowerBuilder (to be implemented in July)
- Microsoft Windows NT workstation and server edition 4.0, service pack 6.0A
- Windows 2000 server
- Citrix MetaFrame XPe feature release 2. This software facilitates a server-based computing (SBC) environment in support of our new (as of the HIPAA updates) PowerBuilder screens. When Metaframe XPe is being used, published Microsoft Windows applications (such as PowerBuilder) are executed on the Metaframe servers. Users can interface with these applications.

  The Metaframe XPe SBC includes three components:

  — A multiuser operation system. We will use a Microsoft Windows 2000 terminal server.

  — Citrix MetaFrame XPe application server software

  — Citrix client software and devices

- VermontAIM
- IBM Content Manager OnDemand V7.1. This software interfaces through the Internet Information Server (IIS) to authenticate users and provide reports through any of the common Web browsers. We will extend this capability to also provide images of paper claims and attachments (as well as other documents) by replacing microfilm with electronic document scanning.
- Remote Eligibility Verification System (REVS)
- Business Objects—Enhanced Vermont Ad Hoc (EVAH) query tool. This tool allows authorized users to perform ad hoc queries as well as schedule queries or reports and disassociate them from the workstation.
- BEA Tuxedo 6.5
- Viking Data Entry
- CA-Autosys 4.0 for batch job scheduling
- Microsoft Office 97 and 2000

Interfaces

The foundation of the Vermont MMIS LAN consists primarily of fast Ethernet connectivity with a few Ethernet connections configured in a star-bus topology. The state provides 10MB link point of presence on their wide area network (WAN), commonly known as GOVNET, from Montpelier to Williston. This connectivity makes it possible for us to provide excellent response-time performance of the VermontAIM online screens to the state users of the system.

Our account site in Williston connects with the EDS corporate intranet through a Cisco 25XX router and a frame relay network. All connections, such as telephone and T1, enter and leave the site through a trunk switch network.

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e. Approach to Facilities and Infrastructure Acquisition and Installation

RFP Reference: 3.2.2.10(e), p. 3-16

By maintaining operations at our existing site in Williston, Vermont, we can eliminate potential disruptions caused by moving account operations or the hardware infrastructure. By retaining EDS as fiscal agent, the risk and time required to test, validate, and approve the hundreds of build-out tasks required of another contractor is avoided.

We have also procured additional space within the existing facility, which is separate from the current account and space. We can use this area during implementation of enhancements/modifications to further eliminate any interference with existing operations. If facility upgrades are required, the EDS real estate department will assist in the procurement of additional space or the reconfiguration of existing space. Additionally, we will continue to use the current infrastructure as described in the "Approach to Infrastructure" subsection of the "Work Plan and Schedule (Takeover)" section to provide ongoing operational support for the MMIS.

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f. Approach to System Security, Backup, and Disaster Preparedness

RFP Reference: 3.2.2.10(f), p. 3-16

The adjudication of Medicaid claims involves the use and production of vast amounts of sensitive, personal information and large amounts of money. Recognizing this fact, EDS' security controls are among the most stringent used by Medicaid fiscal agents. Having safeguarded the operation and integrity of Medicaid data, Medicare data, national security data, and financial services data for more than 30 years, we are highly skilled at applying advanced and appropriate security technologies, systems access restrictions, and security procedures that fully address your concerns about data access, restoration, and disaster preparedness.

We demonstrated our disaster recovery capability by restoring the MMIS at our recovery site and performing critical functions in the first quarter of 2002. The disaster recovery exercise was extremely successful. We are confident in our ability to restore the Vermont MMIS in the event of a disaster.

Security Administration

We recognize your need to monitor our security administration activities to determine if features built into the system are effectively used. We fully support your intent to conduct periodic reviews of our processing sites and monitor the required periodic password changes. Upon obtaining state approval of our security plan, we will continue to maintain the plan throughout the life of the contract, ensuring continuous effectiveness to protect the MMIS.

System Access Controls

Data access is controlled through software called NIS by Sun and Computer Associates' Autosys product. This sophisticated security software controls access to data, logs any attempted violations, and provides the ability to terminate requests that would breach security. Additionally, the software allows users to access and share authorized data. Only the technical manager or designated personnel may approve access to data.

The following table presents the information security features that protect Vermont's MMIS data.

Information Security Features

NIS Security Databases With CA-Unicenter Support	
Logon ID database	• Contains an entry for each user—The logon ID identifies the user and status, whether the user is an OVHA, vendor, or EDS employee. • Validates all user information upon entry to the system • Allows common user identification for all application environments using the logon ID • Matches the logon ID with appropriate logon ID record and password • Uses passwords controlled by authorized network personnel

User Access

Our network security management team issues user IDs to all OVHA and EDS staff needing access to the EDS network and to the VermontAIM applications. The EDS security administrator processes all state authorization user ID requests. The IDs restrict access to the network itself, to individual VermontAIM environments, and to the specific applications within each environment that the user has authorization to access.

The IDs have associated passwords, and we will implement a process to require users to change passwords every 30 days. Should the need arise to change a password unexpectedly, the user can request a new password from the network security help desk, or a member of the EDS or OVHA management can authorize the issuance of a new password to the user. In the event that the user should no longer have access, the EDS or OVHA leader can immediately request that the user ID be deleted.

Users' access to data is controlled by their access to specific applications. If the user is not a member of the systems teams that are supporting the MMIS, the user's access is restricted to production applications only. Most users have read-only access to the applications for which they have authorization. The Department of PATH and EDS will designate the staff members who can access operational readiness testing functions.

System Support Access

Systems teams that are supporting the VermontAIM have broader access to the files and software libraries needed to fulfill their responsibilities. These team members include both the on-site and off-site programmers who are part of the project staff and the technical teams who support operations in Vermont.

Only the team members who actually support the VermontAIM can access those files and programs. In addition, those team members are restricted to the functions and files for which they have authorization from the systems manager.

Online access is also restricted to read-only access for systems support team members to view file and library contents, but not to modify them. EDS grants separate access to selected individuals for actual modifications of volumes and libraries solely for data management functions. These functions consist of such tasks as creating backup volumes on a routine basis, restoring them as requested by the EDS project leadership team, and moving files to different volumes as needed to gain additional space. We also grant access to selected individuals for production code promotion. All production program libraries are protected, and documented promotion procedures are in place to ensure that only approved changes are made.

EDS continually researches and reviews innovations in security tools and features. We work with security development companies to perform analyses and beta testing at our data security lab in Plano, Texas. EDS corporate recommendations influence industry products and allow us to have ready access to the latest developed and best security tools that protect your critical business data.

Integrity and Confidentiality

Our underlying philosophy in the area of program integrity is to focus on your requirements for business operations. For the Department of PATH, our employees will abide by state and federal rules and policies related to confidentiality and program integrity through strict adherence to security and audit trail processes and procedures. Moreover, they sign agreements to that effect. No one on our staff releases information without authorized consent. This compliance ensures that all data is adequately protected. For more information on the confidentiality of the MMIS and related data, please refer to our response to RFP requirement 2.6.10 in the “Privacy, Security, and Confidentiality” subsection of the “I. Work Plan and Schedule (Operations)” section.

Backup and Recovery

Protecting Vermont information is a fundamental goal for both the state and EDS. Avoiding potential disasters while building data processing reliability begins with comprehensive planning. The resulting configuration for on-site processing, off-site processing, and backup facilities emphasizes advanced communications linkages; data centers; and reliable, alternative processing contingencies.

We recognize the significance of effective backup and recovery procedures to quickly restart operations and reconstruct the system and affected data in the event of an unexpected interruption in the delivery of MMIS services. EDS has a disaster recovery plan that incorporates procedures to follow for backup and recovery situations, including the following examples:

- A major disaster in which the central computer installation and resident software are destroyed or damaged
- A problem that is system- or application-dependent, resulting from network failure, software error, or operational errors in which one or several days' processing is invalid, making data on the master tables also invalid
- System downtime caused by the failure of one or more components of the MMIS application software

Our procedures maximize system availability for MMIS users. EDS distinguishes unplanned system downtime for failure and error recovery from scheduled downtime for maintenance. Our approach to maximizing system availability includes the following features:

- Scheduling routine preventive maintenance activities to occur during nonworking hours
- Maintaining access to corporate resources for replacement servers, monitors, terminals, and controllers should the equipment fail
- Maintaining service agreements with our major vendors, such as Sun, which enables us to receive rapid on-site service should one of our pieces of equipment fail
- Rerouting network communications as needed to bypass component failures

Localized, preventive activities allow us to avoid most potential disasters and establish up-front corrective action plans to minimize or correct problems before operational capacity is lost.

EDS meets the RFP requirements for backup and recovery by following stringent disaster prevention practices and developing and strictly adhering to the proven disaster recovery plan. EDS establishes disaster prevention procedures for on-site processing, such as complete daily backups of server data. Standard backup procedures require keeping copies of software with the backup files at a secure off-site disaster recovery location.

The primary off-site location selected to process MMIS data in a disaster situation is at EDS corporate headquarters in Plano, Texas. EDS maintains all of the necessary hardware, software, and network infrastructure to restore operations of the Vermont MMIS as quickly as possible in the event of disaster. EDS periodically performs recovery testing and full recovery. Furthermore, the EDS disaster recovery data center is equipped with uninterruptible power supply systems, which allow operations staff to perform controlled shutdowns of equipment.

In the event of a software failure, our computer operators can restore libraries within hours. The operators restore and verify the integrity of each file and database before allowing user inquiry and update.

EDS' unique position in the marketplace enables us to provide superior backup and recovery solutions. We have the computing resources and available personnel to respond quickly. We develop custom contingency plans for each component of the MMIS with the approval and guidelines of the OVHA. EDS has a reputation for responding to customer needs in unusual circumstances and an outstanding record of providing uninterrupted service in the MMIS market.

Our approach includes appropriate disaster prevention recovery plans, corresponding actions, assigned responsibilities, and comprehensive support resources. These full disaster prevention and recovery plans include procedures for EDS on-site and off-site processing locations and the EDS backup processing site. Our disaster recovery activities, discussed later in this section, facilitate the fastest possible recovery from unavoidable disasters. We provide you with the right resources and apply the necessary procedures to correct the problem and meet contractual performance requirements.

Disaster Preparedness

As described in our response to RFP requirement 2.6.15 in the "System Reliability" subsection of the "Work Plan and Schedule (Operations)" section, we have developed a Business Continuity and Disaster Recovery Plan that will quickly restart operations and reconstruct the system and affected data in the event of an unexpected interruption in the delivery of MMIS services. We have established the system security portions of a Security Plan and a Contingency Plan to instruct the Department of PATH in responding to a system emergency or the unavailability of the system. Our work plan contains details about our proven and thorough business continuity planning process and how it applies for you.

EDS will continue to provide the high standards of security, backups, and disaster preparedness that we provide to you today. As part of this preparedness, we commit to performing the following:

- We will maintain the exceptional level of privacy, security, and confidentiality required by federal and state regulations, which we perform today. As new regulations arise, we will implement them in a fashion similar to the recently completed HIPAA activities.
- Physical site and data security, which safeguards the operation and integrity of the MMIS, will continue to be as integral a part of our solution as it is today. We already use swipe card readers on all entrance doors and keypad electronic locks on the server room doors. We will continue to use motion detectors that cover key areas and access points. In addition, we will continue to use temperature and humidity alarms in the server room and use the services of a security company to monitor the alarm system.
- The MMIS audits all online and batch update transactions, either through database audit processes or batch reporting processes.
- The MMIS includes appropriate checkpoint/restart capability and other features to ensure reliability and recovery.

- We will take complete daily and weekly backups that are housed off-site for all software and operating programs, data, files, and the database. Restoration of lost data currently takes at most two days (much less depending on the size and complexity of what needs to be recovered) for data that must be recovered from off-site backups.
- The EDS Vermont team maintains a Business Continuity and Disaster Recovery Plan to facilitate restoring normal operations of the MMIS in the event of a catastrophic or other serious disaster event. EDS maintains a recovery site with adequate infrastructure to restore critical operations, such as claims processing and paying providers.
- We currently perform disaster recovery drills twice per year. We last demonstrated our disaster recovery capability by restoring the MMIS at our recovery site and performing critical functions in the first quarter of 2002. The disaster recovery exercise was extremely successful. We are confident in our ability to restore the Vermont MMIS and perform critical processes within two days of a declared disaster.

Protecting Vermont's Medicaid information is a fundamental goal for both you and us. Avoiding potential disasters while building data processing reliability begins with comprehensive planning. The resulting configuration for on-site processing, off-site processing, and backup facilities emphasizes advanced communications linkages; data centers; and reliable, alternative processing contingencies.

On-Site Processing

Our extensive backup capabilities for MMIS files, programs, and system software prevent your sensitive data from being lost in the case of a disaster. EDS provides data backups that are consistent with the OVHA's business requirements. We will perform complete daily and weekly backups of each server. Standard backup procedures require keeping copies of software with the backup files at an off-site disaster recovery location. This precaution provides access to data if the corruption of a file dictates the need for its restoration or if an on-site disaster occurrs.

Backup Facilities

EDS has assigned a secure disaster recovery area (DRA) for all VermontAIM backup files, programs, system software, and documentation in case of loss of primary data through an unforeseen disaster. The primary off-site location selected to process MMIS data in a disaster is in Plano, Texas. EDS maintains all necessary hardware, software, and network infrastructure to restore operations of the Vermont MMIS as quickly as possible in the event of disaster. EDS periodically performs recovery testing and full recovery. The EDS disaster recovery data center is equipped with uninterruptible power supply systems, which allow operations staff to perform controlled shutdowns of equipment.

We maintain current copies of files through the use of daily backups of MMIS databases and files, ensuring that the DRA contains the most current copies of MMIS databases, files, and code. Our system administrators back up MMIS programs and system software daily and weekly. We store these backups in the off-site DRA. The environment in the recovery area is climate controlled to protect the integrity of the data, and all media are periodically checked for readability.

Periodically, we review the existing procedures for MMIS operations backup and recovery, verify their completeness and accuracy, and add new procedures to complement the data center and LAN components that the procedures should include. Should discrepancies appear in the procedures for the existing MMIS, we work with you to define requirements for modifications to the procedures and to establish priorities for the completion of these modifications.

Service Interruption Recovery Plan

If disaster strikes, we are ready. Our business recovery procedures provide guidelines for restoring service at any site that supports the VermontAIM. EDS' recovery procedures prepare our personnel to replace sites, equipment, networks, and documentation as rapidly as possible. The EDS leadership team verifies that the plan meets requirements for federal certification, EDS' corporate standards, and your requirements for routine error recovery and disaster recovery procedures and plans.

We provide you with a detailed service interruption recovery plan that identifies all databases, files, data sets, scripts, and prerequisites. Our plan includes all elements necessary to conduct business after a worst case scenario that results from operator error, system failure, or a disastrous event at our data center or at the Vermont fiscal agent facility. The plan includes the following elements for all sites where we conduct MMIS operations, store data, or both:

- Checkpoint and restart capabilities
- Retention and storage of backup files and software
- Backup hardware for the servers, LAN, and data-entry equipment
- Network backup for telecommunications
- Specific steps to continue operations in the event of a component failure at potential failure points with corresponding backup operating procedures
- Detailed file backup plan and procedures with the following components
  - Off-site storage of crucial transaction and master tables
  - Detailed schedule for backing up critical files and rotating them to off-site storage
  - Maintenance of current system documentation and source program libraries at an off-site location

Upon receipt of your approval of the plan, we will maintain the plan in the then-current form throughout the term of the contract. In the next subsections, we describe our approach to assessing levels of disaster and administering the plan.

Disaster Recovery

The service interruption recovery plan identifies all individuals and their responsibilities in terms of specific recovery actions. These individuals identify files, libraries, system software, and critical data sets. They also establish a schedule for duplication to restore VermontAIM data up to the date of physical loss at the data center or at EDS' Vermont fiscal agent facility. The service interruption recovery plan also includes names of individuals responsible for executing the recovery and formatted instructions for recovery procedures.

The plan also considers the data center resources necessary to recover data and continue processing. Such resources include server sizing, total tapes, total disk space, and total execution time necessary to recover data and process Medicaid claims. This consideration enables our data center staff to accurately assess the VermontAIM resource requirements in the event of a disaster and to arrange for recovery and continued processing at the backup data center.

Disaster Assessment

Prompt and accurate damage assessment is essential to a complete recovery in the event of a disaster. EDS defines three levels of disasters.

Three Levels of Disasters

Level One Disaster

Disrupts processing for less than 24 hours. Prompt assessment by experienced technical staff establishes the tasks necessary to return to normal operations, ensuring service can be restored within 24 hours.

Level Two Disaster

Disrupts processing for 24 to 72 hours. Again, proper assessment is critical and allows management to allocate the necessary resources to restore normal operations.

Level Three Disaster

Disrupts processing for more than 72 hours. A level three disaster is the result of a catastrophic event and causes all processing activities to be relocated through the use of backup facilities. Once the disaster has been assessed as Level Three, key personnel identify the materials needed to recover from the disaster, place an order to have them retrieved from off-site storage, and ship the data to the backup facility where restoration can begin.

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The state benefits from planning for a complete and timely recovery for all three levels of disasters.

As a result, in the event of a disaster, all databases and activity files necessary for restoring service are identified. We also establish a duplication schedule with the DRA.

On-Site Disaster Recovery Procedures

In the event of a disaster at EDS' Vermont fiscal agent site, we can resume the image and entry function by transferring it to another site. Vermont-specific image and entry functions are maintained on disk and can be quickly shipped to another EDS Medicaid project site. Normal production rates are maintained with overtime and additional shifts at these alternate sites.

We further promote a timely return to accurate processing by temporarily transferring necessary data entry personnel to an alternate site. Claims adjudication and other manual functions will be performed at the temporary processing site in Pennsylvania or may be performed at another EDS facility in the region, such as New Hampshire.

In the event of a telecommunications failure, data entry equipment features allow data to be stored on disk until service can be restored. Server backup processes are used to back up data. These backup files are created daily and weekly, allowing files to be restored to their most current version in the event of processing difficulties. This ability to restore files on a daily basis reduces the chance that data will require re-entry.

The following table presents an overview of the plan we will follow in the event of a disaster at the EDS Vermont fiscal agent site. The plan is designed to recover full operational capability for the VermontAIM.

Key Elements of
Project-Site Service Interruption Recovery Plan

Task	Description
Provide Disaster Recovery Management	EDS provides management and controls the disaster recovery process at the local facility and processing center. The management team monitors the disaster recovery process to completely and accurately recover data files according to the specified time frames.
Notify Disaster Recovery Team	The EDS management team notifies appropriate managers, programmers, and disaster recovery specialists that a disaster has occurred. Disaster recovery specialists address recovery for facilities, communications, and telecommunications.
Notify the Department of PATH of Disaster	EDS' management team notifies the Department of PATH that a disaster has occurred and continues to keep the Department of PATH informed throughout the recovery process. The management team describes the disaster, the steps being taken to resume operations, and the impact on the provider community.
Assess Scope of Disaster	Our managers and programmers carefully evaluate the extent of the disaster and begin planning for recovery of operations. We assess the scope of the disaster, rating it as a Level One, Level Two, or Level Three disaster.
Implement Service Interruption Recovery Plan	Our managers and programmers review the service interruption recovery plan and use it to guide the recovery process. Managers assign specific personnel to the tasks detailed in the service interruption recovery plan to provide for the complete and accurate recovery of VermontAIM operations.
Estimate Recovery Time	Our managers estimate the time required to recover VermontAIM operations. This estimate depends on the scope of the disaster and the tasks required for recovery. We inform the Department of PATH of the scope of the disaster and the time required for recovery.
Provide Temporary Image and Entry	We provide temporary processing, as well as entry of claims and file update transactions, at our assigned backup facility. This temporary arrangement allows EDS to continue the imaging and entry of claims while recovering the local facility.

Task	Description
Locate Alternate Facility	The management team identifies and secures a temporary backup facility. We maintain project management at this temporary facility until the existing facility can be repaired.
Obtain Equipment	The EDS management team obtains the necessary equipment from our hardware planning group or local vendors to resume operations at the temporary facility. In an emergency situation, EDS can obtain equipment in short periods of time, as our contracts with equipment suppliers include provisions for disaster-level reaction.
Establish WATS and Local Lines	EDS contacts the telephone company to install wide-area telephone service (WATS) lines and local telephone lines at the temporary facility. These lines allow the continuance of provider relation services and telecommunications at the temporary facility.
Relocate and Install Equipment	Our hardware planning group receives and installs equipment at the temporary facility. Equipment from office furniture to computer processing equipment is installed to make the temporary facility totally operable. We relocate our various groups to the temporary facility.
Establish Mail Room	We install mail room equipment and organize the mail room in preparation for claims receipts. Once the mail room is set up, we can process all mail and claim receipts at the temporary facility.
Prepare for Operations	We install all data processing equipment necessary for operations at the temporary facility. Data processing equipment includes printers, a minicomputer, disk packs, tape drives, and terminals for data entry and online access.
Maintain Systems	We relocate all systems personnel to the temporary facility. The systems personnel can then maintain MMIS operations from the temporary facility.
Perform Claims Processing	We relocate all claims processing personnel to the temporary facility. Claims processing personnel include all data entry, mail room, and adjudication personnel. The relocation of these personnel allows claims entry and processing to be performed at the temporary facility.
Support Provider Relations	We relocate all provider relations personnel to the temporary facility. Provider relations personnel resume services to Vermont provider inquiries.
Begin Operations	The disaster recovery process is complete at this point; EDS performs all VermontAIM functions at the temporary facility.

Our comprehensive disaster prevention and recovery approach assures you that all reasonable measures will be taken to continue VermontAIM processing in the event of a disaster at the local processing center. Within 48 hours of a disaster, our goal is to have processing restored in a backup data center.

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g. Design and Development Approach

RFP Reference: 3.2.2.10(g), p. 3-16

Because we face an ever-changing health care industry, we know that you need a dedicated, resourceful fiscal agent capable of accommodating new legislative directives, updated program guidelines, and new program implementations. When faced with such challenges, we have and will continue to demonstrate our ability and eagerness to work with you to ensure the proper design and development of all requested modifications. In the following sections, we outline our proven processes for handling requests for both minimal modifications and full implementations of new program policies.

Supporting the Vermont team's best practices for project management and control is EDS' deep corporate commitment to maintaining and continually improving a methodology architecture that supports all EDS projects, including all design and development projects. Many of the templates, tools, and practices adopted as best practices for Vermont were selected from the larger body of EDS' project management and system development methodology architecture, which is incorporated in EDS' Global Solutions Management System (GSMS).

GSMS takes the best of EDS' corporate methodologies and combines them into a single proven, documented, and repeatable project management approach. GSMS is a common global solution process set for application/information engineering and operations work. GSMS is a system of global processes, based on existing corporate methods and tools and incorporating the best practices EDS uses around the world. The scope of GSMS is operational, and software comprises application development, implementation, and support. GSMS comprises multiple corporate methods that are integrated into one process set:

- Project Management Version 2.3
- Systems Life Cycle Version 3
- Production Support Method
- Enterprise Testing Method
- Requirements Determination Process
- Estimating

We will use the flexible GSMS approach to globally and consistently increase our process and organizational maturity to ensure that we continue to sustain superior execution in our delivery to you. **We look forward to applying the best of project management and control methodologies to support reliable, timely operations that meet the state's expectations.** For more information on these methodologies, please refer to our discussion of GSMS in the "Project Management and Control (Operations)" subsection of the "Operations Narrative" section.

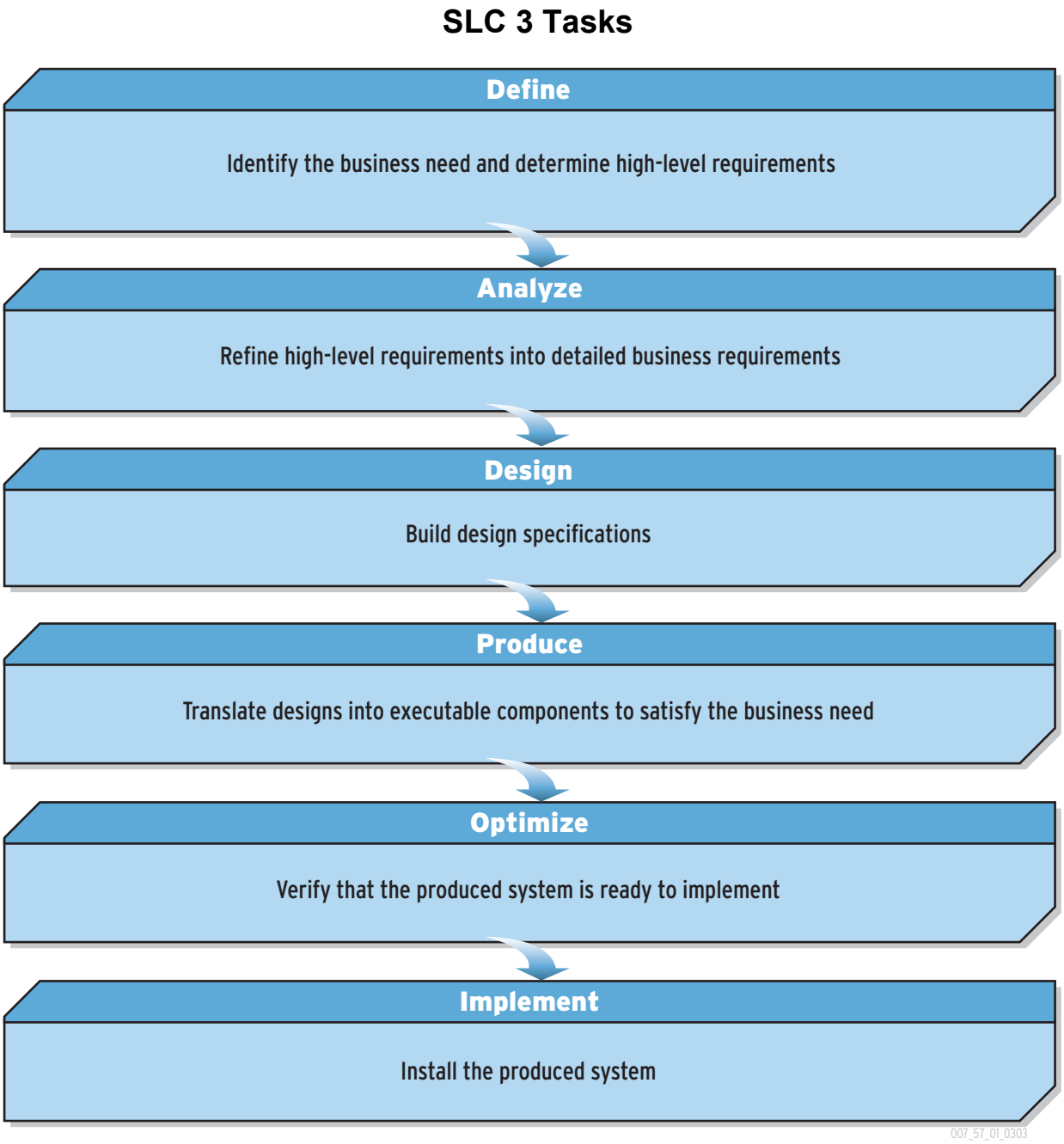
System design and development involves two components: (1) managing and communicating the status, issues, and changes affecting the Vermont MMIS and (2) the actual system development methodology used to deploy and change components of the VermontAIM to specifically address your needs. We will follow our proven, regular communications plan and channels to ensure prompt, effective communication between you and the Vermont-based team. For most of our design and development projects, the key component of the GSMS methodology that we will apply is System Life Cycle 3 (SLC 3).

SLC 3 is a highly comprehensive tool set that systematically addresses every step needed for successful systems development and deployment. The methodology offers information regarding major work to be done, work products to be produced, and participants involved in a programming engagement. The methodology does not replace the experience or skills of a programming team, but it serves as a stimulus for decision-making inherent to programming. Our approaches to design and development that the Department of PATH is accustomed to today are based on the SLC 3 methodology. However, we have adapted each process to meet your specific needs.

SLC 3 presents a complete and integrated approach to supporting the Vermont MMIS design and development tasks. Because our systems engineers and managers are trained and experienced in the use of this methodology, you can continue to expect on-time, accurate implementation of system change requests and enhancements.

The SLC 3 methodology emphasizes your involvement throughout the process and supports iterative development, client/server computing, and advanced human-computer interface design. It also offers practical guidelines and procedures, proven techniques, and suggested templates and examples to help the programming team successfully complete MMIS design or development projects.

As depicted in the following graphic, each system change involves completion of the activities within each of the six SLC 3 tasks.



SLC 3 establishes standards and control methods that provide our technical staff with guidelines for designing, developing, testing, implementing, and maintaining system changes.

The first four phases will be repeated as a group to produce intermediate results for your verification, approval, and validation. This phased repetition, or iteration, helps focus on different areas and requirement levels as the system evolves. The last two phases are performed when the iterative portion is complete. Each phase includes individual plan and test components. Additionally, all phases have an underlying component, called manage, which enables continuous monitoring and control of process resources and results.

Benefits

SLC 3 offers many benefits that help EDS provide superior products and services to you:

- Aligns information technology with your business requirements
- Strengthens communication with you
- Delivers the best practices from all of EDS
- Reduces risk by applying iteration to verify and validate intermediate results
- Facilitates process customization to meet your unique needs
- Reinforces consistent, repeatable processes and therefore allows continual improvement
- Facilitates continual improvement as EDS develops, field tests, and deploys new practices and technologies throughout the company
- Establishes a common basis for communication with you and throughout EDS
- Assists the project team in blending its requirements with engineering discipline and proven best practices from across EDS
- Provides a foundation for increasing systems engineering process maturity
- Reduces time and effort expended on retraining personnel about processes when the personnel transfer from one team to another

Our SLC 3 methodology will provide you with a formally documented, top-down, structured, repeatable, and measurable approach to managing and controlling system maintenance and modification activities. SLC 3 is a proven methodology that offers low risk to the state. In addition, SLC 3 documents EDS' collective experience of the best ways to conduct specific phases of system design and development projects.

While the SLC 3 methodology provides an overall approach to the design and development function, the actual day-to-day approach incorporates automated software tools and a specific process to manage the projects. This process consists of eight main steps to provide tracking, version control, testing, and status reporting to ensure the success of modifications to the existing MMIS. We describe these steps under the following subsections:

- Document Requests
- Submit Requests for Review
- Enter Requests Into the Tracking Log System

- Obtain State Approval
- Prioritize Requests
- Perform Change Management and Promotion
- Modify Modules
- Perform Testing

Document Requests

Ideas for improvements and new programs requiring enhancements emerge on a regular basis. The process you know today to implement these new programs and innovative ideas will remain in place in this new contract period. This process begins when a state or EDS user documents the need for the change and outlines the requested modifications. For example, if a user requires the addition of an "allowed amount" field to a weekly report that currently specifies only the paid amount per claim type, this person would document the business need for the request and create a sample of the report that shows where the new field should be incorporated. To facilitate this process, we have created and will continue to use a request form with a series of questions that helps users take into consideration as many relevant issues as possible.

Submit Requests For Review

During our years of working together, we have implemented both individual requests and large projects. From these experiences, we understand that no area of the MMIS functions independently of the others. Because of this interdependence, we have put in place a review board consisting of key team members from all areas of the MMIS. This team consists of the business analyst, the systems manager, a systems engineer, and individuals from the provider services and claims processing units. In addition to these individuals, the requestor is asked to be present to answer any questions regarding the request. On a weekly basis, this team meets to review and discuss all new modification requests submitted and any supporting documentation provided by the requestor if he or she is unable to attend. The team reviews the request form, which includes a detailed description of intent, an impact statement, supporting documentation, and steps for testing. Upon review, the committee approves the request, requests further clarification, or denies the request. If the request is rejected, the submitter can rewrite or make suggested changes to the request or terminate the request. For all state-approved requests, Cherie Bergeron signs the request form and assigns a systems engineer and a tester to complete the modification.

Enter Requests Into the Tracking Log System

After the request is approved, we begin the process of entering them into our Tracking Log (TLOG) system. This process allows us to monitor all outstanding requests and provide status reports to you on a weekly basis. To begin this process, the business analyst enters all approved requests as either a customer service request (CSR) for an enhancement or a production log (Plog) for a correction to current MMIS logic.

Next, an e-mail is sent to the assigned systems engineer, copying the systems manager, noting that the request is ready for an estimate of hours of work to complete the request. A systems engineer then updates the TLOG with a time estimate and notifies the business analyst that the estimate is complete. We file all supporting documentation in a central location.

Obtain State Approval

No request can proceed without PATH approval. Each week, we submit all requests approved by the review team to a representative from your office for final approval. The business analyst compiles all documented requests and a cover sheet with any information pertaining to new requests. This information is provided to the systems manager for review with your representative. During this review, you decide which requests will move forward for completion and the priority in which they will be completed. You also retain final authority to reject or approve the request. You can also request more detail in the test plan, documentation, or impact statement. You have the final say in how the MMIS is modified and the acceptable means for testing the modification before implementation. All approved requests are returned to the business analyst for final processing. In the event the request is rejected for further revision, it is routed back to the submitter for completion.

Prioritize Requests

To ensure the most important modifications are completed first, we work with you to compile a priority list of all CSR and Plogs either on an individual basis or based on an overall project. At your direction, the systems manager creates a listing to distribute to all systems engineers and business analysts, notifying them of the current workload. This priority listing includes the CSRs and Plogs by systems engineer, with the associated project, if applicable, and estimated hours.

Once the request has reached a systems engineer's priority list, the systems engineer begins researching the steps required to make the requested modifications. At this point, the systems engineer will identify any modules, such as source code, job, control files, or report layouts that will be modified to meet this request.

Perform Change Management and Promotion

Once the modules have been identified, the systems engineer begins the process of checking out the file into a secure directory structure to begin modifications. The Change Management and Promotion (CHAMP) system controls the movement of source members between development and production data sets. This tool ensures that only one systems engineer is working at a time on a module, eliminating any possibility that modifications will be overwritten or corrupted by another systems engineer. CHAMP also provides audit trail reporting to track changes by systems engineer, file, or directories.

The following table outlines the primary functions of CHAMP.

Function	Description
Create a Change Group	This option creates a new directory in the systems engineer's home directory with all required subdirectories for modifications. This function allows the systems engineer to modify multiple files as they relate to a single modification request and to store them in a central location.
Check Out a File From Production	This option checks out the most current version of the module. If another user has already checked out the module, the systems engineer performing this function receives a notification message.
CHAMP Info for a File	This option displays the current location/status of a file. It also shows the change group, who moved the file to the new location, and when it was moved.
CHAMP History for a File	This option displays the location of the file along with historical modification information, such as the Plog/CSR number. This option is cumulative for all updates to each individual file.
Promote a Change Group to Test	This option moves every file listed in the change group file into the test area. CHAMP prompts the systems engineer for a change group number and Plog number for audit trail purposes.
Promote a Change Group to Model	This option moves every file listed in the change group file into model office if it is to be tested. When this feature is executed, CHAMP prompts the systems engineer for a change group number for audit trail purposes.
Promote a Change Group to Production	This option moves every file listed in the change group file into production if it is in model office. The systems engineer will be prompted for the change group number for audit trail purposes.
Abort a Change Group From Test or Model	This option allows a systems engineer to abort the change group for either the test or model level if further modifications are identified during the unit test or business analyst testing phases.
Report All Files/All IDs	This function creates a report of all file locations, the person initiating the move, and the date of move.
Report All Files/Specific ID	This function creates a report of all file locations and date of move by specified systems engineer.
Report All Files/Specific Directory	This function creates a report of all files and moves for a specific directory—test, model, or production.
New Moves (MOD or PROD)	Creates a report of all new file moves into the model or production locations.

The CHAMP application assists systems engineers in maintaining version control of the modules required for the MMIS. When a systems engineer is required to change a module, he or she will need to check out the file from the CHAMP application. The process of checking out a file ensures that another systems engineer is not currently editing the file and that the most recent version of the file is downloaded for modifications.

If a systems engineer requests a file currently checked out by another systems engineer, the systems engineer will receive a message stating who has the file. In these cases, he or she will need to coordinate with the other systems engineer to obtain access to the modules. These safeguards are put in place and used frequently in large-scale projects in which many modules must be modified.

Modify Modules

After checking out all modules required to complete the request, the assigned systems engineer is ready to begin modifying the modules. At this point, the systems engineer reviews all modules and identifies the exact changes required to meet the request. A review of the proposed modifications is completed with another systems engineer on the team. Upon approval, the assigned systems engineer begins to update the modules accordingly. On occasion, the requested modifications to the modules will require further research by the systems engineer. It is in cases such as this that our longstanding relationship and open communication has proven to be so beneficial. Our systems engineers know whom to contact at the state for further clarification. Open communication and our in-depth understanding of your programs and the industry over the last 21 years has allowed us to provide guidance when needed and the ability to understand your requirements. We have teamed up successfully on a number of occasions to complete major modifications.

Upon completion of the updates to the required modules, the assigned systems engineer begins to complete the implementation process flow outlined in the next section. Through careful, step-by-step review of all aspects of the modification process, we eliminate any unnecessary impact to the production MMIS while implementing modifications. Our many projects completed together have enabled us to determine the best approaches for working together. Our current process has been successfully used on many recent projects, including Year 2000 validation, cash controls, Enhanced Vermont Ad Hoc (EVAH) DB2 database migration, and the Health Insurance Portability and Accountability Act (HIPAA) remediation. We are eager to continue to apply our proven processes in support of your goals.

Perform Testing

When a systems engineer has completed all required modifications to the designated files, he or she will then proceed to unit testing to ensure the accuracy of the changes completed.

A model office environment supports testing without impact to the day-to-day processes in the production MMIS. The model office environment is an exact replication of the production MMIS database, which allows for thorough testing of all aspects of the change. Any potential issues can be identified and corrected before the modifications enter the production MMIS environment.

If during the course of the testing we identify an issue, the systems engineer will return to the designated files and make modifications as needed. Upon completion of the changes, the systems engineer resumes the process of unit testing. Only when the systems engineer is able to test all changes successfully will the Plog or CSR be turned over to the business analyst for further testing.

Once we have successfully completed all in-house testing, we can schedule user acceptance testing. You have already participated in this process with us during large implementations and modifications to the MMIS, such as cash controls, EVAH database migration, and the upcoming HIPAA remediation. This process is available to you for any modification, regardless of the size or complexity. In addition, we consider your approval for promoting the changes to production to be just as important as ensuring the request is documented correctly and fully understood by the systems engineer assigned to the modification.

h. Implementation Approach

RFP Reference: 3.2.2.10, p. 3-16

Upon your approval, we begin implementing the requested modification or enhancement. In the following section, we discuss the current procedures in place for implementations. The key steps in the implementation process include:

- Systems engineer walkthrough procedures
- Promotion procedures in CHAMP
- Final promotion in TLOG/notification of state and EDS staff

Systems Engineer Walkthrough Procedures

After the systems engineer and the business analyst complete testing, we initiate a final walkthrough. Each modification, whether a Plog or a CSR, requires a walkthrough with the systems engineer assigned to the modification, a reviewing systems engineer, the requestor, the business analyst, and subject-matter experts that may contribute to the walkthrough.

We use a formal walkthrough document to ensure consistency with all modifications and documentation. Each walkthrough must contain the following information:

- Plog/CSR number
- Systems engineer and business analyst assigned to the modification
- Description of the change
- A listing of all modules affected by the modification
- A listing of participants attending the walkthrough

At the walkthrough, the systems engineer presents all changes made to the modules, highlighting all modifications and the impacts of the changes. The team reviews all test cases to ensure full compliance with the Plog/CSR. We also review any updated documentation for accuracy and clarity. After all modules, test cases, and documentation are reviewed, the walkthrough participants answer a series of questions. These questions assist in identifying and preventing any unintended consequences on other areas. Each question has a “Yes,” “No,” or “N/A” option for sign-off. A sample listing of these questions follows:

- Have the changes related to this promotion been thoroughly reviewed by another systems engineer?
- Have the test results been reviewed by another systems engineer?
- Have the test results been reviewed by the account?
- Were walkthroughs with the database administrator conducted?
- Has a contingency plan been reviewed?

- Has the timing of this change been considered?
- Has the system documentation been updated?
- Have vision screens been affected by this change?
- Has the management and reporting subsystem (MARS), surveillance and utilization review subsystem (SURS), or EVAH been affected by this change?
- If a payment process changes, will the claims be included in the weekly extract file? If not, has the EVAH systems engineer been notified?
- Will outside vendors be affected by this change?
- Has the account been notified of the promotion date for this change?
- Has the customer been notified of the promotion date for this change?

If any of these questions identifies the need for further work, we assign the walkthrough a status of "Rejected, Another Review Required." If the walkthrough demonstrates that the modification has been successfully completed and all areas of consideration have been taken into account, then we assign to the walkthrough a status of "Accepted As Is." When we identify minor changes during the modification review, such as additional documentation changes, we assign the walkthrough an "Accepted with Modification Required" status and document the required change on the walkthrough document.

The walkthrough is complete when the assigned systems engineer, the approving systems engineer, the business analyst, and the subject-matter expert provide the required sign-off.

Promotion Procedures in CHAMP

Upon completion of the walkthrough document, the assigned systems engineer can begin the promotion procedures within CHAMP. Once promoted to production, the systems engineer will ensure all current modules are in place in the production MMIS environment. At this point, the modules are once again available for other systems engineers to check out and modify.

Final Promotion in TLOG/ Notification of State and EDS Staff

The promotion of modules from model office status in CHAMP to production status generates a daily report of CSRs moved out of CHAMP. Business analysts compare the daily reports with the weekly listing of CSRs moved to production. In addition, we generate a weekly CSR/Plogs Moved to Production report that identifies when Plogs and CSRs are ready to be implemented in production in the MMIS. Business analysts verify that Plogs and CSRs moved out of CHAMP have also been moved from the model office to production in the TLOG system. A two-week implementation period is in place to review the modification in the production MMIS environment. If further work is identified during this two-week period, the Plog or CSR can once again be moved to a work or test status to complete the required changes. All Plogs or CSRs

returned to a work or test status are required to repeat the walkthrough procedures. If after two weeks the modification successfully meets the requestor's original intent for the change, the business analyst will change the status to complete in the Tracking Log History window of the TLOG system. For security reasons, once a Plog or CSR has been moved to a completed status, it cannot be reopened or have additional hours assigned to it.

i. Testing Approach

RFP Reference: 3.2.2.10(i), p. 3-16

Because we are the current fiscal agent processing Medicaid claims for the state of Vermont, the state and EDS do not need to develop a full-scale test plan to demonstrate our readiness for meeting the requirements in the RFP. Our approach will save time and effort for the state, providers, other state contractors, and EDS staff, allowing us to devote the time that would have been spent on testing to more productive activities, such as creating the test work plan for scheduling and implementation of enhancements and modifications.

We have an established work plan for the scheduling and implementation of all enhancements (CSR) or modification (Plog) requests received. Our team follows the same steps, regardless if the request is for an enhancement or a modification to an existing function. However, the type of the request influences the complexity of the testing required. A request for a minor change, such as adding an end date to an existing edit to eliminate chiropractic services for adults as of July 1, 2002, as occurred with ESC 254, required a test plan to verify procedure codes, beneficiary aid program and age, and the dates of service before and after July 1, 2002. A request to add new aid categories to the database involves a more intricate test plan and schedule that allows for more testing time because this program change affects more components than the change to the edit. The various areas of the database requiring changes to be tested in this case could involve edits for program limitations, funding sources and program assignments, federal and state category of service, reports specific to the service or agency responsible for the funding, voice response system, and pricing methodologies. In either case, **EDS' understanding of the current system and processes allow us to provide a more thorough testing approach and better identify how changes to one area can affect another area.**

We recently established an in-house work group that meets every Wednesday at 9 a.m. to review all CSRs and Plogs to ensure that the requests are supported with clear documentation of the change to be performed, an effective date if applicable, and the impact the change will have on the customer or provider community. In addition to reviewing the validity of the request, this team decides what provider notification, if any, is required. This team consists of a business analyst (BA), the system engineer responsible for backup duties for the week, a member of the claims team, a member of the provider services team, and the system manager. By including people from all of these areas, we carefully consider all relevant issues that could affect processing integrity. Should any questions arise during these reviews, our policy is to contact the appropriate state personnel for verification of state policy or clarification of your request.

The following is a description of the life cycle of a CSR/Plog.

CSR/Plog Life Cycle

Step	Description
1	A request is generated. The request can originate from a variety of sources, either internal or external.
2	A written request on a CSR/Plog request form is presented to the Wednesday work group for review of requirements and identification of issues for resolution. To determine if a CSR or Plog should be created, the work group asks if the work to be performed involves a new process, screen, or report or if it involves a modification to existing code. This group reviews all the documentation and discusses what needs to occur to meet the request. Some of the concerns that are considered include the amount of time needed, verifying that all current documentation is in order, ascertaining if the policy is clear, and determining if there is an effective date associated with the request work before a schedule and estimate can be given. The systems manager approves the change and determines who will be assigned the task.
3	Once a decision has been made that all the documentation is in order and approval has been obtained, Cherie Bergeron, the systems manager, signs the request. A BA then enters the new request into the tracking system under the appropriate subsystem, where a tracking number is assigned to the request. The request is then sent to a systems engineer for an estimate of time to complete the request. If the request is a Plog, Cherie will assign the request to a systems engineer and determine the priority,
4	If the request is a CSR, the BA enters the estimated time, changes the status to HOLDA, and gives the systems manager a copy of the CSR along with an approval cover letter to be presented to the customer at the weekly fiscal agent meeting for discussion, signature, and determination of priority.
5	Once approval is received, the assigned SE commences work on the request. When the coding has been completed and the unit tested, the status is changed to TEST status and is deemed ready for the BA to set up a test plan along with test cases that will be processed through the model office and reviewed for accuracy. Test results may be shared with subject-matter experts (SMEs) for verification of accuracy when appropriate.
6	When test results are positive, we schedule a walkthrough between two systems engineers and the tester to verify that the change was implemented as requested and that testing scenarios were appropriate and sufficiently extensive. This walkthrough also allows for discussion of reference file changes, documentation updates, and provider notification to be issued as the changes are promoted to production. Once the status of the CSR/Plog has been changed to production, the BA sends out an e-mail with a Microsoft Excel spreadsheet detailing the CSRs/Plogs promoted to production for that week.
7	We store the CSR/Plog requests along with the test plan and results for future reference.

The Vermont-based team will agree upon all test cases that will be executed for validating the system functionality, including reports, software, and others. Testers will evaluate and document the actual results for each test case, and the state will review this information. The Department of PATH staff can address questions and concerns to the appropriate tester involved.

We evaluate test results by providing the test cases, test description, and expected and actual results for each agreed-upon test plan for all subsystems. Information available to the state for review at any time includes displays of computations, special reports, input data, expected output or outcome, and actual output or outcome. If any discrepancies are identified, we will discuss them with you and make the necessary corrections.

We will also document test case results, and if system modification is needed, developers will take the necessary steps to make appropriate corrections. We will communicate all system modifications with you and deliver a modification testing work plan. Our team will perform thorough testing, including unit, subsystem, and system integration tests to ensure that the VermontAIM properly performs these functions:

- Interfaces with all other systems
- Processes and pays claims appropriately
- Performs all types of system updates
- Produces all types of reports and other outputs

We emphasize the importance of communication throughout the testing process. As such, we will conduct weekly test meetings to keep you informed of current testing activities. Additionally, we will provide detailed documentation, such as test case scenarios, expected test results, and test schedules. We commit to working closely with you to identify any additional documentation that may be required.

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j. Operations Approach

RFP Reference: 3.2.2.10(j), p.3-16
2.6, p. 2-15

Our approach to supporting Medicaid program operations is based firmly on the procedures and processes we have developed with the state. Starting with this established body of procedures and fully trained staff provides a solid foundation for ongoing operations, allowing the state to focus its full attention on the following topics of great interest:

- Identifying and implementing cost-saving mechanisms
- Planning for the MMIS of the Future, the next generation of MMIS based on CMS' Medicaid Information Technology Architecture model

From our base of operations in Williston, the EDS team will perform the following operational activities:

- Operate the VermontAIM MMIS and process more than 8.5 million Medicaid claims and drug transactions each year on behalf of more than 135,000 beneficiaries
- Operate the EVAH ad hoc system
- Enhance and modify the VermontAIM MMIS
- Offer proactive provider training and education across the state
- Provide local employment, training, and long-term career opportunities for citizens of Vermont
- Contribute to the state's economic development initiatives by procuring services from Vermont-based businesses
- Recommend and implement cost-saving mechanisms

To make sure that we fully respond to the state's expectations for an in-depth discussion of our Operations Approach, we have prepared responses to the 26 subsections of RFP section 2.6, Operations. In most cases, the personnel in Williston who support, perform, or monitor the functions being described have written these responses. For example, Nancy Gagne wrote the response to electronic claims submission, and Niki Holton wrote the responses to data entry, resolutions/suspense, and the mailroom. Using this approach allows us to provide up-to-the-minute, current descriptions with absolute accuracy.

The following table identifies the 26 subsections that make up our response to the Operations Approach.

RFP Section 2.6, Operations, Responded to in (j) Operations Approach	
2.6.1 General Operations and Administration	2.6.15 System Reliability
2.6.2 Contract Administration and Management	2.6.16 Customer Service Requests
2.6.3 to 2.6.5 Operations Documentation	2.6.17 MMIS Access Requirements
2.6.6 Turnover	2.6.18 Electronic Claims Submission (ECS)
2.6.7 Certification and Re-certification	2.6.19 System and Acceptance Testing
2.6.8 Medicaid Laws and Regulations	2.6.20 Timeliness of Processing
2.6.9 HIPAA Translator Services	2.6.21 Correctness of Payments
2.6.10 Privacy, Security, and Confidentiality	2.6.22 Data Entry
2.6.11 Statement on Auditing Standards 70 Report	2.6.23 Resolutions and Suspense
2.6.12 Accounting Requirements	2.6.24 Financial Management
2.6.13 Records Retention	2.6.25 Mailroom Support
2.6.14 Contractor Staff Requirements	2.6.26 Communication Tools

General Operations and Administration

RFP Reference: 2.6.1, p. 2-15

Having worked with you for many years, we have established a history and business relationship with you that clearly led to success. We come without a learning curve and without surprises. We look forward to continuing our relationship and working together to meet your general operational requirements.

EDS brings proven technology insight into Vermont Medicaid operations, and extensive experience in operating technologically advanced Medicaid systems. As your fiscal agent, we propose to operate an MMIS with the following characteristics:

- Federally certified
- HIPAA compliant transaction processing
- Web-enabled and providing enhanced system capabilities
- Adaptable to meet changing program priorities and business needs

In this section of the proposal, we highlight our approach to meeting RFP requirements for ongoing contractor and MMIS-related operational activities. Subsequent topics describe the operational characteristics that demonstrate EDS' commitment to maintaining an operational, reliable, and stable environment that is fully accessible by the Department of PATH and that meets the growing and changing demands of the Vermont Medicaid Program.

Contractor Responsibilities

RFP Reference: 2.6.1.2, p.2-16

To eliminate redundancy in our response to contractor responsibilities, we provide brief answers in this section and cross-reference the fuller discussions in other sections of the proposal, as appropriate. This section, however, provides the only opportunity to discuss provider services. As a result, the response to provider services is unique in its depth and breadth.

a. **Claims Processing: The Contractor receives all claims submitted by providers. The Contractor prescreens paper claims to separate acceptable claims from those lacking data which prohibits payment. When deemed acceptable, claims are logged and entered into the MMIS within 24 hours of receipt. After processing, if a claim is deemed non-payable because of omitted or invalid data, the claim is returned to the provider. Acceptance of Electronic Claims Submission (ECS) claims follows the same principles of responsibility.**

In our response to RFP sections 2.6.22, 2.6.23, and 2.6.25 in the "Work Plan and Schedule (Operations)" section of our proposal, we provide a detailed response to our claims processing capabilities. Please refer to this section for EDS' approach to meeting the specified contractor responsibilities.

b. <u>Provider Services:</u> The Contractor performs provider enrollment, relations (including responding to written, faxed, e-mail and/or phone questions from providers) and education/training by phone, mail, onsite visits, workshops and bulletin and provider manual distribution.

EDS has supported Vermont providers' needs for information and education since 1981. **In 1999, the EDS provider relations staff made 224 on-site provider visits. In 2002, the team made 1,231 on-site provider visits—a more than five-fold increase in three years.** We understand the importance of maintaining open communication with the provider community. Solid communication is vital to establishing a good working relationship with customers, and it has been EDS' key to serving as the liaison between the OVHA and the provider community.

Praise for Provider Relations Staff

The provider relations staff are "very professional—don't replace them!"

--Cold Hollow Family Practice

Our provider relations services have expanded with the program and today provide outreach, education, and research services to Vermont's more than 6,000 Medicaid providers. Program Services Manager Valerie Lewis guides the provider team at EDS. Valerie and her staff perform a wide range of services for the Vermont Medicaid provider community, including:

- Telephone and written correspondence
- Provider enrollment activities
- On-site provider visits
- Publication of up-to-date provider manuals
- Proactive training sessions
- Participation in professional association meetings
- Creation of provider notices and bulletins

The following table describes the makeup of the current Vermont EDS provider relations team.

Position	Number of Staff
Provider representatives responsible for an assigned geographic territory	5
Enrollment specialists, with one specialist focused on each of the following areas: • New enrollments • Recertifications • PC*Plus* enrollments	3
Call center representatives, one of whom is a team lead	7
Publications coordinator	1
SCHIP representatives, one of whom is a team lead	5

The call center representatives assist the provider community with routine billing inquiries over the phone and through written correspondence. The provider enrollment specialists are responsible for provider enrollment activities that range from mailing the enrollment packet to notification or rejection of the provider's request for enrollment with the Vermont Medicaid Program. Our five provider representatives assist providers with more complex billing issues and are available to make on-site visits for one-on-one training. Our provider representatives also conduct scheduled workshop sessions throughout the state. The publications coordinator will coordinate the development of the provider bulletins, billing manual updates, and bulletins. This individual will work directly with the state in obtaining approval for the various provider publications prior to their being published. Our SCHIP representatives assist the Vermont schools and supervisory unions with billing.

Our team of highly trained personnel will continue to serve the state, ensuring our full support of Vermont's Medicaid Program.

Provider Enrollment

A strong medical assistance program begins with a growing community of qualified professionals who offer health services to eligible Vermont residents. In support of your objectives for provider enrollment, our Vermont-based team will work with the Vermont MMIS to accomplish the following:

- Encourage provider enrollment by operating a timely, efficient enrollment process and continual tracking of enrollment status in the Enrollment Tracking System (ETS)

- Ensure providers are certified and licensed by maintaining regular communication with applicable state agencies regarding certification and licensure information
- Maintain provider data in easy-to-use windows for easy online access to the most recently updated information

The enrollment process is most providers' first interaction with the Vermont Medicaid program. EDS knows that first impressions are lasting impressions, and the enrollment team works hard to make sure that each provider's first impression of Vermont Medicaid is a favorable one.

EDS understands the importance of maintaining a quality provider network for Vermont beneficiaries. Our automated enrollment processes make provider enrollment extremely efficient, which helps establish a strong positive first impression of the Vermont Medicaid Program for providers. In addition, we work to maintain this quality provider network by communicating regularly with the state to keep you informed of our status and activities. This communication takes place in the form of online training sessions, updates to the provider database, and timely report distribution. As part of the communication process, we will rely on use of the provider database, which is an invaluable tool in researching provider history, including enrollment, provider group data, and on-review indicators.

The EDS enrollment team enrolls an average of 500 providers per month. This is a combination of new enrollments and recertifications. From beginning to end, the recertification process takes less than a week to complete and a new enrollment takes only two to three weeks. Today, our total stands at more than 6,000 providers enrolled in the Vermont Medicaid Program.

EDS continues to streamline the enrollment process by identifying opportunities for improvement. Our Provider Enrollment team recently had the opportunity to present suggestions to OVHA that would make positive changes for new and current providers, including the following.

- Reduced re-enrollment from annually to biannually for most provider types
- Created a user friendly enrollment form
- Identified billing providers not currently enrolled
- Created a smooth process for completing file maintenance in a timely manner

These significant accomplishments come from our thorough understanding of the eligibility requirements. In the following subsections, we describe the well-established set of procedures that our team follows for enrolling providers in the Vermont Medicaid Program.

Responding to Prospective Providers

Before a provider can receive payment for services rendered under the Medicaid program, the provider must be enrolled in the Vermont Medicaid Program. When we receive a request from a prospective provider or the OVHA or as a result of network outreach activities performed by the provider relations team, we promptly mail out provider applications. Requests can come by telephone or through written correspondence.

EDS mails provider applications within one business day of receiving the request. The ETS tracks all of the requests once the provider enrollment specialist enters the following information:

- The date on which we received the request
- How the request was received (phone or written correspondence)
- The date we sent the enrollment package to the prospective provider

The enrollment packet contains the following materials:

- An enrollment form
- An electronic funds transfer form
- An electronic claims submission form

In the coming months when HIPAA requirements are implemented, the enrollment packet will also contain the following:

- Trading partner agreement
- EDI registration form

These forms will also be available to through the Web site and from the EDI coordinator or provider relations.

These materials were specifically chosen to be part of the enrollment packet to support the provider in the enrollment process and provide the information necessary to make an informed decision about enrolling in the Vermont Medicaid Program.

The recertification packet contains only an enrollment form.

Processing Completed Provider Enrollment Applications

After the prospective provider has completed the enrollment application, the provider enrollment specialist reviews it for completeness and accuracy. Our specialist uses a checklist to verify that the application contains the required information for each specific enrollment type. We forward all completed applications to OVHA for approval. If the specialist determines that the application is incomplete, we return the application to the provider with a letter requesting the appropriate information.

We process all applications in the order they are received. We date-stamp applications upon receipt and then enter them in the Enrollment Tracking System, where the request is tracked at each stage of the process. The tracking system is updated with the date we send the application to OVHA for approval or the date it was returned to the provider for additional information.

When you approve the enrollment application, we update the tracking system to reflect the date of approval and provider number assigned. If you reject the enrollment application, we enter the date of the rejection into the tracking system along with the reason for the rejection.

Entering the Provider into the Provider Database

The EDS provider enrollment specialist is responsible for the daily maintenance of the provider database within the Vermont MMIS. These updates occur through online windows. Online edits ensure that we enter only valid information into the provider database. An example of invalid data would be a provider type that is not valid for the Vermont Medicaid Program. We only enter providers into the database after receiving OVHA's approval for that provider's participation in the Vermont Medicaid Program.

Welcoming a Provider into the Program

Once the OVHA has approved an enrollment application, we assign the provider a unique provider number. The provider enrollment specialist then sends the provider an approval letter that includes the provider's Vermont Medicaid provider number. In addition to the letter, we include a welcome packet that includes billing instructions specific to that provider's type and specialty and a billing manual. If the OVHA has rejected a provider's application, we send a letter to the provider informing him or her of the reason for the rejection.

Once accepted into the program, providers will work with members of the EDS provider relations staff for education and inquires. We describe these additional services in the following subsection.

Helpful, Accommodating Staff

"Niki has always been very helpful and accommodating. She is a definite asset to your staff."

--Bettina D. Laidley, DMD

Provider Relations

To provide superior service, we offer advanced capabilities that support your goals. An example of this was EDS' installation of new software to proactively monitor the telephone wait times on the provider services help desk. Using this new software, EDS can adjust the resources on the account to offer telephone support at peak times. This has resulted in a dramatic decrease in provider telephone wait times. We welcome the opportunity to continue refining standards in our customer assistance and training philosophies and to increase access to these services.

Our provider relations team will provide timely, efficient telephone responses to provider inquiries from the provider relations call center, using up-to-date enrollment status, claims denial, claims status, procedure code pricing, and 1099 information in the MMIS.

Vermont providers have expressed confidence that when they contact our friendly and knowledgeable provider services team, they receive the help and support they require in a timely manner. In response to the 2002 annual provider satisfaction survey, 88 percent of the provider community said they are satisfied with the customer service they receive from EDS. This is a 10 percent increase in the satisfaction over the 2001 results.

Under the supervision of Program Services Manager Valerie Lewis, our team of six help desk representatives and Team Lead Nicole Holton respond to providers' telephone inquiries between 8 a.m. and 5 p.m. Eastern time.

Our Vermont-based team provides the following types of assistance:

- One-on-one call support
- Response to written inquires
- Response to dental fax inquires
- Point-of-sale system assistance
- Voice response system assistance

One-on-One Call Support

Using the automated call distributor (ACD) telephone monitoring and reporting software system, the Provider Service Help Desk answers all incoming calls from providers and assists them with the following types of inquiries:

- Billing questions
- Eligibility inquiries
- Policy changes
- Information on any benefit limits
- Claims status
- Requests for manuals and forms
- Prior authorization guidance
- Procedure coverage inquiries

Team Lead, Nicole Holton monitors call volume and wait times from the computer terminal at her desk. We handle unexpected surges in call volume and seasonal peaks by assigning more team members to assist with the increased call volume.

EDS took 33 percent more calls at the provider services help desk in state fiscal year 2002 than in state fiscal year 2001. In December of 2002, the average wait time was 44.5 seconds. EDS handled the increased call volume while decreasing provider wait time by using new telephone monitoring software and without additional staff.

Written Inquiries

Written inquiries consist of requests for information such as the following:

- Claims status
- Denial clarification
- Requests for manuals or forms

The provider services team lead batches these inquiries daily and logs them for reporting purposes. While we process the majority of requests and return a response the next day, we research and respond to all inquires within two weeks. On average, the call center receives 200 written inquiries every week.

Dental Fax Inquiries

Because adult Vermont Medicaid beneficiaries are subject to a yearly benefit limit, providers must verify eligibility and the amount of the remaining benefits prior to delivering services. To simplify this process, the provider services unit offers a Dental Fax form on which providers may list the beneficiaries they intend to treat. We return the form with eligibility, limits used, and other insurance information indicated. Eligibility information can be given up to nine days prior to the service date.

Point-of-Sale System Assistance

In verifying eligibility before performing services, providers may use beneficiaries' identification cards and a card-swipe POS system. Eligibility information for the beneficiary appears on the POS device within seconds of swiping a card. Eligibility, service limits, and other insurance information is available 23 hours a day, 7 days a week, allowing for a maintenance window.

Our entire provider services team has been trained in assisting the provider community in using and understanding their POS devices. Team members routinely help with maintaining the devices, ordering new ones, and validating the accuracy of information received.

Voice Response System Assistance

Providers also have access to beneficiary information 23 hours a day, 7 days a week, allowing for a maintenance window, through the fully automated voice response system (VRS). Using a touch-tone phone, providers can enter their Vermont Medicaid provider numbers to access the following types of information:

- Beneficiary eligibility
- Remaining service limits
- The current week's claims paid amount
- Third-party liability information
- Beneficiary's primary care provider

During normal business hours, providers who are having difficulty or need clarification for a response can reach a representative by pressing "0." Providers who do not have a touch-tone telephone can also use this option to reach call center representatives for assistance during normal business hours.

Education and Training

Provider representatives are ambassadors for the Vermont Medicaid Program, conducting on-site provider visits, presenting workshops and training sessions, marketing the electronic claims submission options, and attending various provider conferences and advisory meetings. Provider representatives also handle the more complicated provider inquiry issues. They work closely with claims personnel and other MMIS operation units. The provider services team ensures that providers receive the support they need to effectively serve Vermont beneficiaries.

Our provider representatives work with the call center staff as the front line of communication with the entire Vermont Medicaid provider community. From making presentations during provider workshops and large medical association meetings to working with providers in one-on-one sessions, the provider representatives serve as the primary source of program education.

In addition, our provider relations staff develop and distribute manuals, newsletters, notices, bulletins, and other correspondence with input from claims personnel and OVHA liaisons. They make sure that all material sent to providers is easy to read and communicates essential information effectively. Annually, the provider services manager, along with the provider representatives, develop and present to you the upcoming year's workshop training plan.

As part of our provider education efforts, the representatives conduct weekly on-site provider visits. Some of the factors used to determine which providers would benefit from on-site visits are the frequency of claims denial, referrals from the provider services help desk, and requests from OVHA and providers. Each provider representative is responsible for all the providers in his or her geographical territory. Provider representatives schedule visits with providers, research provider claim and billing history in preparation for the

visit, provide software and billing training, document key topics discussed, follow up on any open issues, and monitor provider claims to ensure the resolution of issues discussed.

We prepare, print, and distribute provider bulletins to inform all enrolled providers of upcoming changes, clarifications, or informational topics as determined and approved by you. We also send the bulletins to provider associations in the state, designated state staff, area OVHA offices, and other organizations and individuals as directed by the OVHA. Examples of the materials distributed are:

- Weekly remittance advices
- Provider billing manuals
- Vermont health access advisory
- Notices and bulletins

The EDS publications coordinator will work closely with you to communicate program changes. Strong, easy-to-read publications facilitate a smooth transition during the implementation of program changes. These publications also serve to provide clarification of existing policy.

EDS also recognizes that while most of the provider community does not perform the actual billing, this group of individuals must be kept informed of information related to payment for their treatment services. For this reason, we have created and produced a Medicaid newsletter as another form of communication for the billers and providers. As specified by the state, this newsletter contains articles from both OVHA and EDS, and offers program and provider information that is valuable to the provider community.

Coming Months' Challenges

Our unique relationship with the Vermont provider community is a hallmark of EDS' outstanding service and commitment to you. In the months ahead, the provider relations team will use our strong ties to the Vermont provider community as the basis of a successful implementation of the HIPAA standards into the Vermont Medicaid Program.

The implementation of HIPAA standards will not be an easy task for even the most astute of providers. However, EDS has proactively reached out to the provider community during the last two years to inform providers of upcoming changes and to help prepare them for the changes. As part of this effort, EDS has taken an active role in the New Hampshire/Vermont Strategic HIPAA Implementation Plan's education and awareness team. This team has developed training materials, such as the Small Practice Implementation Guide, and spoken at provider association meetings, such as New Hampshire Medical Group Managers Association and the second annual New Hampshire/Vermont Strategic HIPAA Implementation Plan Vendor Fair.

Using these strategies, we will continue to support OVHA and the Vermont provider community through the upcoming implementation of HIPAA rules and other changes, such as the implementation of ClaimCheck and the Internet provider access enhancement.

c. **<u>Financial Management:</u> The Contractor performs management of cash received, provider receipts, disbursement, accounting and reporting.**

For a detailed response on how we will meet this contractor responsibility, please refer to our response to RFP section 2.6.24 in the "Financial Management" subsection of the "Work Plan and Schedule (Operations)" section of our proposal.

d. **Perform system enhancements and modifications (as described in section 2.8) after Takeover. Modification may result from a determination that a deficiency exists within the operational MMIS or that an additional requirement is needed.**

EDS agrees to perform system enhancements and modifications as described in our response to RFP section 2.8 in the "J: Enhancements/Modifications Narrative" section of our proposal. For an in-depth discussion of our approach to correcting deficiencies or meeting additional requirements, please refer to our response to RFP section 2.6.16 in the "Work Plan and Schedule (Operations)" subsection of the "I. Operations Narrative" section of our proposal.

e. **Not charge for any computer resources, modifications to provider manuals, bulletins, newsletters or any other cost items associated with implementing improvements or modifications without prior approval. Charges for computer resources shall be approved in advance by the Department of PATH, and in accordance with the agreed up on change orders and/or amendments, and contract amendments.**

We will comply with this requirement and not charge for any computer resources, modifications to provider manuals, bulletins, newsletters, or any other cost items associated with implementing improvements or modifications without prior approval. We will also obtain the Department of PATH's approval for charges for computer resources, and in accordance with the agreed-upon change orders and amendments and contract amendments.

f. **Maintain regular communication with the Department of PATH and providers.**

We will continue to maintain regular communication with the Department of PATH and providers, as currently occurs on a daily basis.

g. **Ensure user (providers, State personnel and contractor staff) understanding of MMIS and AIM system capabilities.**

We will ensure that all personnel who have access to VermontAIM will understand the system capabilities of MMIS and VermontAIM. As your current agent, we have a solid foundation of experience and understanding of the system from which to provide training and support.

h. **Correct all system deficiencies identified by the Department of PATH or the Contractor, at no charge to the Department, and within Department-approved time frames.**

Please refer to our response to RFP section 2.6.16 in the "Work Plan and Schedule (Operations)" subsection of the "I. Operations Narrative" section.

i. Submit a Corrective Action Plan once approved within the time frame established in the Plan.

EDS will submit a Corrective Action Plan once approved within the time frame established in the plan. For more information on the Corrective Action Plan, please refer to our response to bullet f: "Approach to Problem Identification and Resolution" in the "Project Management and Control (Operations)" subsection of the "I: Operations Narrative" section.

j. Implement the Corrective Action Plan once approved within the time frame established in the Plan.

We will implement the approved Corrective Action Plan within the time frame established in the plan.

k. Acquire, maintain and retain the option to purchase, terminals, PCs, printers, furniture and all other office equipment necessary for the Contractor to adhere to the Contractor Responsibilities, meet Milestones and produce the Deliverables specified in this RFP. The State prefers that the Contractor acquire, maintain and retain equipment in a manner that results in the best return on investment for the State. The Contractor shall ensure that the State has the option to purchase all equipment at the end of the contract.

We agree to acquire, maintain, and retain the option purchase terminals, PCs, printers, furniture, and all other office equipment necessary to adhere to the contractor responsibilities, meet the milestones, and produce the deliverables specified in this RFP. We commit to continuing to provide the best return on investment for the state. The Department of PATH will have the option to purchase all equipment at the end of the contract.

l. Receive, process, and adjudicate:

- **Valid claims and drug payment transactions.**
- **Adjustment requests.**

We will receive, process, and adjudicate valid claims and drug payment transactions as well as adjustment requests. For more information on how we perform these processes, please refer to our response to RFP sections 2.6.22, 2.6.23, and 2.6.25 in the "Work Plan and Schedule (Operations)" subsection of the "I: Operations Narrative" section of our proposal.

Milestones

RFP Reference: 2.6.1.3, p.2-18

We will submit and obtain state approval of the Operations Work Plan.

Deliverables

RFP Reference: 2.6.1.4, p.2-18

We recognize that the Operations Work Plan is the primary deliverable resulting from the Operations Phase. We will submit the deliverable within the time frame specified by the state.

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Contract Administration and Management

RFP Reference: 2.6.2, p. 2-18
2.6.2.2, p. 2-20

With more than 30 years of experience in Medicaid program and system operations, EDS has had the opportunity to develop, implement, transfer, take over, operate, and turn over hundreds of systems and operations. Our reputation and future in the health care industry rely on successful completion of all our responsibilities to each of our customers. We commit to fulfilling our responsibilities under the renewed contract with Vermont, which includes the contract administration and management task. As part of our approach to meeting these responsibilities, we will provide the following:

- Performance monitoring tools and project management procedures to ensure on-time delivery of contractor milestones and deliverables as well as adherence to all contractor responsibilities
- Staff to participate in issue resolution process; status and planning meetings; and state and federal audits, certifications, and performance monitoring activities
- Timely access to all MMIS data, windows, reports, and technical system documentation
- Notification to the Department of PATH of any security breach attempts
- Development and testing of a Business Continuity/Disaster Recovery Plan for the MMIS

We discuss these items in greater detail under each requirement specified as part of the contractor responsibilities listed in the RFP.

Contractor Responsibilities

a. Provide the State with unlimited access to:

- **Monitor and observe all Contractor Responsibilities.**

The Vermont-based team is committed to providing the state with unlimited access to monitor and observe all contractor responsibilities. State personnel are welcome at the account at any time during business hours or as arranged. We also provide dedicated office space at our Williston site for use by state employees.

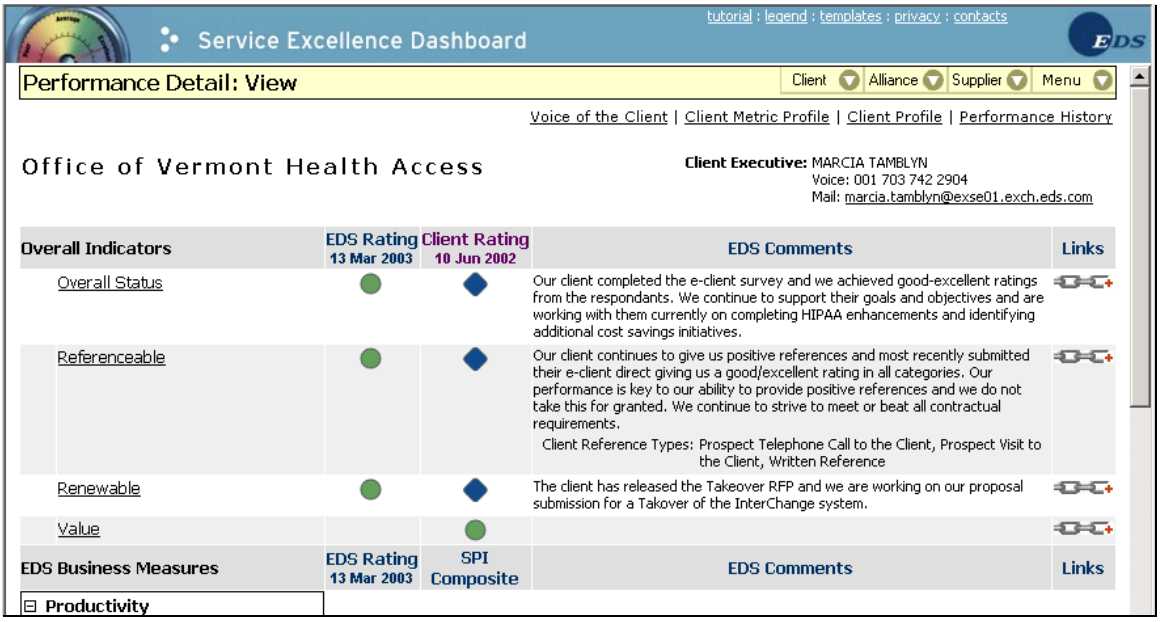
In addition, we will use the EDS Service Excellence Dashboard, which enables EDS employees and customers to monitor customer satisfaction based on customer input and review. The Service Excellence Dashboard is a highly visible, global communications vehicle for the consistent reporting of customer relationship status. It enables EDS leaders to focus on problems and attend to them quickly.

As a key component of the service excellence initiative, the Service Excellence Dashboard provides graphical, up-to-the-minute status of how EDS is performing on delivery to each of our customers. Every account has its own client detail page, which displays customer satisfaction levels among the service offerings in the company. The Service Excellence Dashboard accommodates management comments and customer feedback. It enables EDS leaders to focus on problem areas and ensure that we are addressing them appropriately. At a glance, senior leadership, client executives, and their support teams are able to see which customer support teams need assistance. The Service Excellence Dashboard allows calls for help to be answered very quickly.

As customers provide feedback on the Client Survey, their results are posted on the Service Excellence Dashboard next to the EDS client executive's ratings. This allows a comparison of the EDS client executive's assessment of our performance to that of the customer's view.

The Office of Vermont Health Access has consistently ranked its satisfaction with the Vermont account's performance in the two highest categories, good or excellent.

Service Excellence Dashboard Window



The Service Excellence Dashboard gauges EDS' customer service ratings based on customer feedback.

- **All records and documentation required to monitor Contractor Responsibilities, Milestones and Deliverables.**

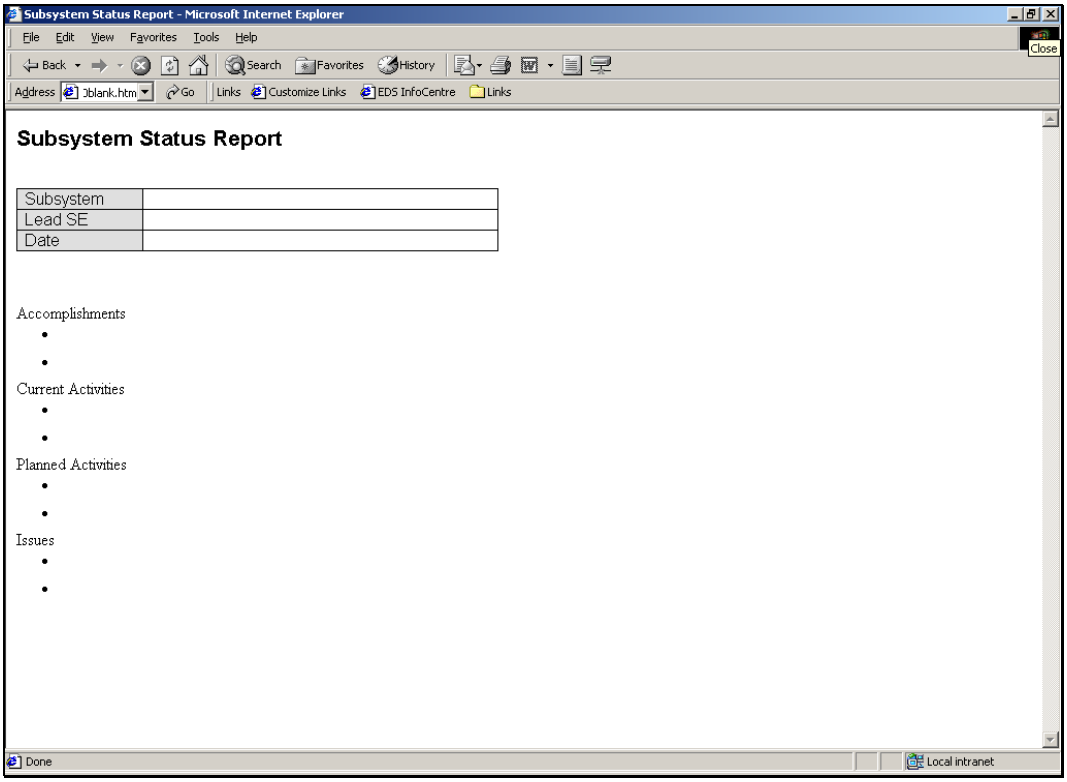
Throughout every project, we produce a variety of status reports to provide project updates and document progress for the archive records, including issues requiring action and attention.

In preparing the reports, Client Delivery Executive Barbara Davis observes, evaluates, and appropriately incorporates verbal and written briefs from other EDS project team members. We will combine this information with the output from automated project tracking tools, such as Microsoft Project and the Tracking Log (TLOG) system. We will also maintain all key documents in the Web-based Project Workbook. Our leaders will prepare a written status for each major functional area, including claims, provider, systems, LAN, quality, and general administration. These individual reports document:

- Progress to work plan tasks
- Key decisions made or needed
- Key personnel additions or changes
- Key project measurement statistics

Each functional area report documents actions and progress from the prior week and identifies planned actions and issues for the current week. The status report serves as the discussion tool during the weekly status meeting. All status reports are published to the Project Workbook as shown in the following sample of a status report.

Project Workbook Subsystem Status Report Window



The Subsystem Status Report window records actions and progress from the previous week.

In an ongoing effort to provide the state with unlimited access to all records and documentation required to monitor contractor responsibilities, we currently send a weekly status report to Robert (Bob) Butts, the Medicaid operations administrator. Several key OVHA staff members also receive a copy of the report, including Acting Deputy Director Roger Tremblay and the school-based health services coordinator, Gloria Jacobs. We also maintain physical copies of this report at our account. These reports include detailed statistics from each area of the account. During our fiscal agent meetings, we will also continue to provide you with documentation on the number of CSR hours used for that week, as well as the claims processing counts.

Effective communication management allows stakeholders to receive the necessary information for decision-making, in a format that allows them to take action. We use communication management to determine the kind of messages to send, who should receive them, when to send them for effectiveness, and how to compose them. Our PM 2 methodology supports the creation and use of a solid communication plan.

b. Maintain:

- **Contract management applications (e.g., Microsoft Project) that supplement the State's contract monitoring staff.**

EDS will continue to provide any currently available, product supported, contract management applications, such as Microsoft Project, that supplement the state's contract monitoring staff. Project management tools and a communication plan approved by the OVHA accompany our open approach to communication. Our systematic approach to status meetings and written status reports will help us produce quality deliverables for consistently updating you about the project status. Our comprehensive communication plan will encompass the Takeover, Operation, and Enhancements/Modifications Phases as well as a plan for generation, documentation, storage, transmission, and disposal of all project information.

- **Automated access to all MMIS files.**

Automated access to all MMIS files is a key element in maintaining the solid foundation we have created in working with the state. Through our Quality Improvement Plan (QIP), we have developed a process to ensure that state employees have access to and are trained in using the VermontAIM. When employees are given access to the VermontAIM, Chris Haskins is available to train your employees in either a one-on-one or group setting. Additionally, all reports for an OVHA-specified timeframe and generated by the VermontAIM are available for retrieval through the IBM Content Manager OnDemand system. Statistical information can be obtained through our EVAH tool, BusinessObjects. We offer specialized training, including a "Claims 101" overview for users who have access to BusinessObjects. Our reporting specialists, Louise Brooks and Ann Markle, are available to assist users with the BusinessObjects functions, training, and query generation.

- **Up-to-date standard report lists and the status of edits and audits.**

All reports generated by the VermontAIM are available for retrieval through the OnDemand system. These reports are updated on a weekly, monthly, or quarterly basis following the regular weekly financial cycle.

Our system has a dedicated window for users to review the status of edits and audits. The Edit/Audit Disposition window details how each error status code is handled in the system based on claim type and submission method.

c. Respond to all State internal and external monitoring findings.

The Vermont-based team will continue its history of responding promptly to all internal and external state monitoring findings. From May 2001 to the fall of 2002, the independent auditing firm of Ernst & Young, chosen by the state, performed a Statement on Auditing Standards 70 (SAS 70) Level 1 and Level 2 audit. The state also asked Ernst & Young to assess the quality and effectiveness of our processes and procedures. During the Level 1 review, Ernst & Young verified that the master file data, such as beneficiary, provider, reference, and claims data, used in Medicaid system processing is authorized, complete, and valid, and that correct versions are used in production processing. They also verified that system security, physical access, adjudication of claims, and Medicaid payments were accurate and timely. Ernst & Young filed a "no findings" report with the state, further assuring you of EDS' effective quality control methods. During the Level 2 review, auditors conducted actual tests of various procedures. Again, Ernst & Young filed a "no findings" report with the state. We included a detailed account of these audits in our response to RFP requirement 2.6.11, "Statement on Auditing Standards 70 Report" in this section.

In addition, the independent auditing firm of KPMG-Peat Marwick was hired by the state to perform an on-site review of the claim administration operation and the readjudication of a random sample of claims. A sample of 400 claims paid during January 1, 2000, and June 30, 2001, were reviewed to:

- Assess the accuracy and consistency of claims processing
- Benchmark the performance of EDS in the areas of financial accuracy, payment accuracy, processing accuracy, and turnaround time
- Review the interpretation and application of benefit plan provisions
- Assess the limitations of the claims adjudication system

The following chart lists the findings submitted as a result of this audit.

Claim Audit Results

Performance Measurements	EDS Results	Industry Standards
Net Financial Accuracy	99.9%	99.0%
Absolute Financial Accuracy	99.8%	99.0%
Payment Accuracy	99.0%	97.0%
Processing Accuracy	98.5%	95.0%

Although initial findings from KPMG-Peat Marwick identified six claims processed in error, we were successful in providing documentation and explanations supporting the accurate processing of all six claims. For example: On two claims, EDS paid the total allowable amount without applying the deductible, which resulted in an overpayment. These claims related to nursing home stays where patients were discharged before the last date of the month. According to EDS' claims procedures, deductibles are applied to nursing home claims inclusive of last date of the month. **Through our extensive knowledge of your intricate state policies, we were able to verify that these claims had been accurately processed in support of your policies.**

d. Reprocess all claims with Contractor-caused errors at no cost, and reproduce corresponding reports and documentation to demonstrate corrective action.

Our team is fully committed to you and to ensuring the quality of our work. When we identify an issue, we will use the adjustment process currently in place to identify whether EDS, the state, or the provider initiated the adjustment. We will reprocess all claims with contractor-caused errors at no cost, in addition to reproducing all corresponding reports and documentation to demonstrate the correction. Our reports always cite the financial reason code for initiating an adjustment as well as documentation to demonstrate the corrective action taken.

e. Ensure that State security policies are followed.

Protecting your data and confidential information requires sound physical security measures and stringent system security. Our history with you demonstrates the soundness of our approach as we have successfully prevented any security breaches during our more than 21 years of managing Vermont's claims input MMIS processes. We will implement and maintain effective physical security measures for all proposed MMIS equipment sites, processing areas, including the mail room and secured storage areas, in adherence with the OVHA's security policies.

EDS understands the importance of effective physical security measures and therefore implements and maintains such measures for all MMIS sites. We restrict access to equipment sites, processing areas, and storage areas through the use of a card lock system, which records all access attempts, including unauthorized access attempts. Only Client Delivery Executive Barbara Davis or her backup can authorize the issuance of a card key to an employee. We apply our security measures to all system functions, staffing, and both on-site and off-site facilities. We protect these resources by embedding proven security practices throughout all business processes.

Local EDS property managers develop security plans with the assistance and direction of EDS corporate security experts. Our approach to physical security focuses on restricting access and safeguarding processor sites. EDS enacts access restrictions through EDS employee and visitor security procedures, keys, card keys, and combination locks. For example, all guests to the EDS location who have not been issued a card key will be required to sign a guest log when entering the facility reception area. We will not permit the guest to access any other areas of the facility unless the guest is accompanied by an EDS employee at all times.

In addition, EDS safeguards processor sites with comprehensive disaster prevention measures for hardware, MMIS files, programs, and system software at state sites, off-site processing sites, and EDS' backup site. Our security measures prevent against disasters caused by electrical power failures by using surge protectors and uninterruptible power supply (UPS) equipment and training our staff on emergency procedures. Fire-protection equipment and procedures ensure uninterrupted operations in the event of a fire. Our processor sites include fire-retardant capabilities, and security personnel continually monitor smoke and electrical alarms.

EDS' security group, the largest in the Medicaid industry, supports our wide range of security services. Qualified personnel in this dedicated unit are professionally trained in security techniques and practices. Through experience and long-term success in providing physical security to restrict perimeter access to equipment sites, processing areas, and storage areas for hundreds of customers, our solid qualifications offer the best approach and full compliance with the OVHA's security policies.

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Operations Documentation

RFP Reference: 2.6.3, p. 2-21
2.6.4, p. 2-30
2.6.5, p. 2-30

Each project creates changes. However, EDS does not consider a project complete until we have updated our documentation to reflect each change. In fact, as we implement each project, we consider whether the changes will affect the documents maintained at the account, including the following:

- Resolutions Manual
- Provider Billing Manual
- Operating Procedure Manual
- User Manual
- Tables Manual

Following are the standard steps we follow to update documentation:

Updating Documentation

Step	Action
1	Check out the affected document from the document coordinator.
2	Update the document.
3	Return the document to the coordinator for review and approval.
4	Distribute updated document. **Note:** All updated documents are forwarded to users who have hard copies and saved on the R:/drive.
5	Refer to the distribution lists in the Best Practices Document for information on whom to notify regarding each type of change. The Best Practices Document contains the Vermont team's customized processes for project management. These best practices are based on EDS' corporate methodologies.

We will update or create new documentation, as appropriate, according to the classifications specified in the RFP. We will make revisions to the following types of documentation:

- VermontAIM MMIS System Documentation
- Provider Manual
- Business Continuity and Disaster Recovery Plan

In addition, the following is a list of new documents we will create for the Office of Vermont Health Access (OVHA):

- User Manuals for AIM Screens
- Software Development Documentation
- Systems Test Document
- Operating Procedures Manual
- State Personnel Education Plan

When creating new documentation, we will provide the same level of quality to which you are currently accustomed. Furthermore, we have a broad base of experience from which to draw for the creation or revision of documentation. In supporting 26 Medicaid programs in 20 states, EDS has in-depth experience in creating and revising numerous types of documentation in support of Medicaid operations. With the Vermont-based team's understanding of your current processes and business needs, we will provide clear, easy-to-use documentation that meets your goals for Vermont Medicaid Program operations.

Building information technology (IT) solutions that meet business needs is complicated by changing business requirements and by advancing technology. To meet this challenge, EDS has developed the Systems Life Cycle Version 3 (SLC 3), the most recent version of EDS' preferred systems engineering methodology. Using SLC 3, teams can customize, continuously improve, and reuse their business processes for specific unit and client needs. It also offers practical guidelines and procedures, proven techniques, and suggested templates and examples to help the programming team successfully complete VermontAIM projects, including software development. Each system change involves completion of the following activities within each of our nine SLC 3 tasks:

- **Information Planning—**The initial formula of implementation strategies for software development and modifications
- **Definition—**The definition of all customer requirements for maintenance and modification changes
- **Analysis—**The analysis of requirements and the development of a requirements analysis and specifications document
- **Business Design—**The initiation of window and report designs, inputs, and documentation
- **Technical Design—**The determination of which subsystem(s) will be affected and how to approach coding and programs development
- **Construction—**The construction of the technical approach into codes and programs
- **Testing—**The verification of system requirements as defined in the analysis phase through unit testing, model office testing, and user-defined testing
- **Implementation—**The movement of modifications into production
- **Production Support—**The update, enhancement, operation, and control of the system through the continued use of appropriate SLC 3 phases

The Business Design task of our SLC 3 methodology incorporates the step of creating documentation, including software development documentation. As part of this step, we will perform a walkthrough with you and obtain your review and approval of any documentation we create or modify as a result of software development. Our SLC 3 methodology will provide you with a formally documented, top-down, structured, repeatable, and measurable approach to managing and controlling software development activities. SLC 3 is a proven methodology that offers you low risk. In addition, SLC 3 documents EDS' collective experience of the best ways to conduct specific phases of software development projects.

In this section of the proposal, we discuss our understanding of and approach to providing clear, easy-to-understand, complete documentation to meet the state's needs. Under each type of documentation, we describe its function on the account, our agreement to the contractor responsibilities, and the process for revising or creating the documentation. However, in accordance with RFP Section 3.2.2.(j), we have not included samples of existing documentation that is currently available to you as part of the current contract.

VermontAIM MMIS System Documentation

RFP Reference: 2.6.3.1, p. 2-22

The system documentation includes a detailed description of each aspect of the MMIS that we have developed, tested, converted, and modified to meet requirements of the VermontAIM.

The following list identifies the subsystems included in our VermontAIM system documentation:

- Recipient
- Provider
- Reference
- Claims
- Management and reporting subsystem (MARS)
- Surveillance and utilization review subsystem (SURS)
- Early and periodic screening, diagnosis, and treatment program (EPSDT)
- Third-party liability (TPL)
- Financial
- Extract

The documentation for each subsystem contains the following components:

- Subsystem narrative
- Subsystem flow charts, job flows, UNIX scripts, and program module documentation
- Subsystem window and report documentation

Contractor Responsibilities

RFP Reference: 2.6.3.1.1, p. 2-22

Requirement	Comply
The nomenclature and descriptions must be consistent	Yes
Written to be understandable by nontechnical users whenever possible	Yes
Adherence to the systems development life cycle or other commonly recognized systems development approach with structured: • Analysis • Design • Prototype testing • Programming • Acceptance testing • Implementation	Yes
Standard naming conventions	Yes
Software development protocols and standards	Yes
State-specific documentation standards	Yes
Database documentation (e.g., data dictionary)	Yes
a. General system narrative with system and data flow and operation environment descriptions. All AIM™ subsystems must be referenced	Yes
b. Documentation for each AIM™ subsystem with: • Comprehensive description and process specifications, functions and features (e.g., code, integrated Custom off the Shelf (COTS), data flow, tables) • Identification name and number • A flow diagram and lists identifying all files, input and output with cross-reference to program identification • Job streams within each AIM™ subsystem identifying programs, frequency(ies), input and output, control, job stream flow, job control language (JCL), operating procedures, and error and recovery procedures • Edit and audit listing as applied to each input item, calculated data elements or combinations of data elements, detailed criteria for each edit and audit, and corresponding error and display messages • Inputs with ID, descriptions, media type, frequency and samples including form, screen, data and other standard inputs	Yes

Requirement	Comply
• Outputs with ID, descriptions, media type, frequency and samples including report, screen and other standard outputs • Internal and external interfaces with file layouts, media type, and frequency • Program documentation with frequently-called programs • Database and non-database files • Cross-reference to *State Medicaid Manual* • Glossary • Screen/Report Index • File descriptions and record layouts with reference to data element numbers, for all files including intermediate and work files • Standard report distribution listing with report number, name, number of copies, frequency, media, distribution destination by position and location • Value tables with code value listing and descriptions • Cross-reference – Data element to table cross-reference – Table to program cross-reference – Non-database file to program cross-reference	Yes
g. A data element dictionary with the data element: • Name • Number order • Unique number • Standard name • Description • Input/output matrix • Table of values • Source • Primary use	Yes

Process for Revising or Creating

The VermontAIM system documentation was created in December 1993. As part of the Tri-State Health Insurance Portability and Accountability Act (HIPAA) project, we will make major revisions and modifications to the VermontAIM system document. Using our standard procedure, we will perform walkthroughs of all changes and will obtain approvals before implementing the changes. We will also update and modify the system document to provide it in a user-friendly Web-based format.

User Manuals for AIM Screens

RFP Reference: 2.6.3.2, p. 2-24

The user manuals for VermontAIM windows will contain descriptive terms and be structured for ease of comprehension by both nontechnical and technical users. The manuals will include step-by-step instructions, along with graphical samples, to assist users with accessing and updating relevant subsystem information.

We will include user manuals for VermontAIM windows for the following subsystems: claims, provider, recipient, financial, reference, long-term care, drug rebate, and MARS.

Users will be able to quickly and easily access the user manuals directly online through WebHelp, an HTML-based application designed to run on a wide variety of platforms and browsers, including Windows, UNIX, Macintosh, and Linux. WebHelp has one of the most feature-rich formats available and does not require a server.

Contractor Responsibilities

RFP Reference: 2.6.3.2.1, p. 2-24

We will write each manual to meet the following contractor requirements.

Requirement	Comply
a. Be written to be understandable by non-technical users	Yes
b. Establish a base upon which user education sessions and materials are built	Yes
c. Include detailed instructions for: • Source file maintenance with code value descriptions and data element numbers for reference to the data element dictionary • Performing online updates • AIM™ subsystem functions by the actual activity flow • Report field definitions with an explanation for calculations	Yes

Requirement	Comply
d. Contain visuals of: • Screens with sample data, and input forms identified by name and number	Yes
e. Include • Procedures for screen updates • Error message descriptions for all fields including edits with recommended resolution procedures	Yes
f. Use consistent language and code definitions	Yes
g. Detail AIM™ subsystem standard report production, including: • Instructions for interpretation and an explanation of their utility • Content descriptions, schedule, format, recipient listing and distribution channel	Yes

Process for Revising or Creating

After creating the new user manuals, we will continuously maintain, update, and distribute comprehensive user manuals for each VermontAIM subsystem or major module. As each change is implemented, our documentation specialists will update the appropriate manual.

Systems Test Document

RFP Reference: 2.6.3.3, p. 2-25

System testing provides a roadmap for the state and us to validate that the system is ready for production, ensuring that the modified system functions as mutually agreed upon. The systems test document will describe the tests we perform on the VermontAIM and help to validate modifications. In the new contract, the systems test document will serve the same purpose as the one we created to test system modifications to support transaction and code set standards defined by HIPAA.

Contractor Responsibilities

RFP Reference: 2.6.3.3.1, p. 2-25

Our systems test document will include all elements required to meet the contractor responsibilities specified in the RFP.

Requirement	Comply
a. Testing protocol including acceptance process and expected outcome	Yes
b. Detailed test plans including expected outcomes of test transactions	Yes
c. Copies of all test data	Yes
d. All test results, including screen prints and reports	Yes
e. Corrective Action Plans	Yes
f. Retest documents and corrective action measures taken	Yes
g. Certification that the MMIS has been thoroughly tested, found to be complete, and ready for user acceptance testing	Yes
h. Updates in conjunction with Integrated Test Facility Contractor Responsibilities	Yes

Process for Revising or Creating

Every update or modification to the VermontAIM must undergo thorough unit testing and model office testing before it is ready for the user acceptance testing. During the first two stages of testing, all components of the modification, including process description, testing data, and expected and actual results are documented for internal walkthroughs and approval will be required before the next phase of testing can commence. After unit and model office testing, we will perform user acceptance testing and conduct formal walkthroughs to meet your approval. Our system test document will include all steps to occur and records of the results of testing as we conduct the tests.

Operating Procedures Manual

RFP Reference: 2.6.3.4, p. 2-26

The VermontAIM Operating Procedures Manual will provide a detailed description of our day-to-day processes and procedures for all standard and nonstandard operations from daily report distribution list to emergency system outage communication procedure.

Contractor Responsibilities

RFP Reference: 2.6.3.4.1

In the two complete hard copies of the Operating Procedures Manual, we will update and maintain the required information. This Operating Procedures Manual will meet the following RFP-specified contractor responsibilities.

Requirement	Comply
a. Define practical working relationship between the Contractor and the State to accomplish operations (automated and manual) and fiscal agent services	Yes
b. Describe processes and procedures for effective and efficient operations	Yes
c. Identify positions, corresponding responsibilities and accountability with telephone and email contact information	Yes
d. Dispute resolution	Yes

Process for Revising or Creating

We will create the Operating Procedures Manual and obtain your approval in a walkthrough and review of the draft and final versions. As our operational processes change, we will update, maintain, and distribute new versions of the Operating Procedures Manual to reflect the latest changes and improvements. We will also obtain your review and approval of the changes to ensure accuracy and ease of comprehension.

Provider Manual

RFP Reference: 2.6.3.5, p. 2-27

Vermont Medicaid provider handbooks provide all necessary information for providers to understand the regulations and policies that define the Vermont Medicaid Program and for them to correctly complete claims for adjudication and reimbursement of services provided. The manuals also include detailed descriptions of enrollment and recertification processes, facilitating continuous provider participation in the program.

Contractor Responsibilities

RFP Reference: 2.6.3.5.2, p. 2-27

We will update, maintain, and distribute provider manuals that meet the following RFP-specified contractor responsibilities.

Requirement	Comply
At a minimum, the Provider Manual must: a. Describe: • General policy and program information • The State's primary care case management program • Eligibility verification processes • Claim disposition information	Yes
Provider-specific supplements must: b. Describe: • Covered services • Payment and billing information • Provider enrollment and re-certification processes	Yes

Process for Revising or Creating

The OVHA develops the policy and regulations section of the provider handbooks. We draft the provider-specific billing instructions and general billing instructions used by all provider types for the provider handbooks and the eligibility verification system.

EDS will prepare and submit the revised provider handbooks in draft form to the OVHA for its approval at the start of the Operations Phase.

State Personnel Education Plan

RFP Reference: 2.6.3.6, p. 2-28

We recognize the critical role that state user training plays in promoting the acceptance and effective use of the VermontAIM system. Accordingly, we will provide a comprehensive State Personnel Education Plan as an integral part of our systems design, development, implementation, and operations.

The general content of our training, tailored to administrative, management, program specialist, and clerical audiences, will focus on developing job-related skills using the MMIS functions.

The State Personnel Education Plan will be quickly and easily accessed online through WebHelp. WebHelp is a Web-based application designed to run on a wide variety of platforms and browsers.

Contractor Responsibilities

RFP Reference: 2.6.3.6.2, p. 2-28

We commit to meeting the following contractor responsibilities for the State Personnel Education Plan.

Requirement	Comply
a. Identify: • Activities leading up to, and including, educating State personnel, at all levels, in the proper use and understanding of the MMIS, and associated operating and business procedures • Schedules • Location and facilities (e.g., use of screens)	Yes
b. Describe: • Education materials and methods • Plans for remedial and ongoing education • A methodology to ensure continued education during operations for new personnel or personnel changing positions (e.g., use of videotapes) • Processes and tools (e.g., email) by which the Contractor will inform system users of system changes and operating procedures, and the corresponding impact for affected personnel	Yes
c. Include at a minimum: • Claims 101 • AIM™ screens permissions and security • Business Objects and EVAH • Provider enrollment procedures • HIPAA-specific procedures	Yes

Process for Revising or Creating

We will construct a State Personnel Education Plan that meets your needs. In creating this plan, we will conduct joint walkthroughs and obtain your input and approval before creating the final version. In addition, our documentation specialists will update and maintain two complete hard copy sets of the State Personnel Education Plan throughout the contract period. Our Vermont-based team will make the necessary updates and modifications to meet current needs. In addition, we will maintain an online version of the plan.

Business Continuity and Disaster Recovery Plan

RFP Reference: 2.6.3.7, p. 2-29

The EDS Vermont Medicaid site in Williston houses a variety of operations and computer resources critical to the support of Vermont Medicaid Program. Our Business Continuity and Disaster Recovery Plan provides a detailed strategy for ensuring continuous operations. This plan covers all aspects of operations and contains our thorough preparation for different levels and types of service interruptions, including responsibilities and time frames for the recovery period. The implementation of this plan provides the following benefits to both the EDS Vermont Medicaid account and the OVHA:

- Defines objectives to be accomplished if an interruption occurs in EDS services to the OVHA
- Ensures adequate alternate processing plans
- Provides for the recovery of all information systems and continuous processing of data supported and operated by EDS

The objectives of our Business Continuity and Disaster Plan are to:

- Develop and document plans for action, direction, and control during response and recovery from disasters.
- Educate the users of our computer resources of their responsibility to retain input between system backups.
- Document the facilitation of off-site storage of backups, based upon the agreed to service levels for maximum lost data.
- Discover any existing plans for the movement of production in case the facility is impacted by disaster. This will allow us to plan for continued functional support of our support staff at the alternate production site.
- Supported applications, dates, commutations and or other devices. Product and support not associated to the VermontAIM are not within the scope of this plan.

Please refer to Vermont's Business Continuity and Disaster Recovery Plan for detailed descriptions of actions to be taken in the event of an interruption of services to the OVHA.

Contractor Responsibilities

RFP Reference: 2.6.3.7.2, p. 2-29

Our Business Continuity and Disaster Recovery Plan will meet the following RFP-specified contractor responsibility.

Requirement	Comply
Develop the Business Continuity and Disaster Recovery Plan with input from the state	Yes

Process for Revising or Creating

We will review and update the existing document once a year, or as major system or operational components change. As part of this process, we will obtain your input to ensure that we meet your current needs and requirements. In conducting the review, the site Crisis Management team will audit the documented processes and make appropriate updates.

Every two years, the corporate EDS Business Continuity Unit will audit the document to ensure compliance to EDS' business continuity standards. Action plans will be developed if deficiencies are found, and this document will be updated to reflect the corrections. In addition, we will test the plan every two years to demonstrate its reliability.

Standard Report Production

RFP Reference: 2.6.3.8, p. 2-29

Reports are generated and delivered on a regular basis: daily, weekly, monthly, quarterly, and annually. In addition, reports are available upon request and as needed. All reports are distributed to the state according to content description, schedule, format, recipient listing, and distribution channel.

The following is a list of some of the key reports that are generated:

- Missing Claims report
- Daily POS Claims reports
- Daily POS Transaction Detail reports
- Daily Activity report
- Batch Daily Reports Checks Entered
- Batch Daily Reports Checks Deposited

- Batch Weekly Report Checks Deposited
- Weekly Refund Summary report
- Monthly PMPM Cap Creation Error report
- Annual Expenditures report
- Annual Receipts and Expenditures report

Contractor Responsibilities

RFP Reference: 2.6.3.8.1

As we have done in the past 21 years of working with you, we will continue to meet each of our contractor responsibilities related to standard report production.

Requirement	Comply
Distribute all reports to the State according to each content description, schedule, format, recipient listing and distribution channel	Yes
Reference MARS and EVAH sections	Yes
Be responsive and accommodating to State reporting requirements that change over time	Yes

Process for Revising or Creating

Reports are generated and delivered as scheduled to the state according to each content description, schedule, format, recipient listing, and distribution channel.

MARS generates regularly scheduled monthly reports printed on paper or stored online for access at users' workstation. At any time during the month, users can access the MARS tables using BusinessObjects to report on previous MARS reporting periods.

The following are samples of reports that are generated:

- Claim Payment Statistics
- Financial Summary
- Expenditure Analysis
- Long-Term Care reports

For more information on MARS, please refer to the "Management and Administrative Reporting Subsystem" subsection of the "Work Plan and Schedule (Operations)" section in Section I of the proposal.

The EVAH uses BusinessObjects query software to simplify the state's needs for specialty reporting. The EVAH offers rapid and efficient access to a majority of the information captured in the MMIS database.

With EVAH, users can generate specialized data requests from their workstations with the simple point and click of their mouse without delay or the need for a formal request. There is no need to understand structured query language (SQL) or database structures. Reports can be combined with data from outside resources to provide a more comprehensive comparison of data–either in data format or graphing. All EVAH reports can be exported to a Microsoft Excel, text, comma delimited, or Dbase format to provide portability to other users and applications.

In addition to regularly generated reports, we will also provide reports to the state upon request and on an as-needed basis. We will accommodate state reporting requirements that change over time. Our approach to documentation is designed to provide you and our Vermont-based team with relevant information in a clear, succinct manner to ensure smooth, continuous operations of the Vermont Medicaid Program.

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Turnover

RFP Reference: 2.6.6, p. 2-30

In the event you select a new contractor at the end of the next contract period, we have the experience and professionalism to ensure a successful transition.

Customer reassurance is the center of our approach to turnover. We know how important it is to have the cooperation of a current contractor in achieving a smooth turnover and making the transition of the MMIS transparent to providers, beneficiaries, and OVHA users. EDS commits to producing a comprehensive turnover plan if such a need arises, and we will fully cooperate in implementing that plan as we fulfill all turnover obligations responsibly.

Before the conclusion of the contract, we will provide assistance in turning over the VermontAIM to the OVHA or its designated agent. As part of this endeavor, we will first provide an outline of our approach to turnover. Successful completion of the turnover task is a critical component of our project management and customer service approach. The pride we take in a job well done and the professional approach we apply to all tasks ensure delivery of services that will be smooth, timely, and without adverse impact to you, Vermont Medicaid providers, or beneficiaries.

We bring a wide range of experience that helps us understand the perspectives of all parties involved in turnover. Having taken over many Medicaid systems from other contractors, we know what activities are necessary for a smooth turnover. Likewise, EDS knows firsthand the impact to a state agency that experiences an ineffective turnover.

Wisconsin's Division of Health Care Financing (the Division) can attest to EDS' outstanding professional performance during a potential turnover. Wisconsin selected as Medicaid fiscal agent a contractor that was in the process of building a decision support system (DSS) for the Division. However, as the Division and the contractor negotiated the fiscal agent contract, construction of the contractor's DSS fell behind schedule. The contractor was taking 32 days to load each month's data into the data warehouse. The Wisconsin customer began having second thoughts about giving the fiscal agent contract to that other company.

The Wisconsin customer noticed that the professionalism and performance of EDS' staff had not diminished throughout this effort and determined that it was too risky to allow the other company to take over the full fiscal agent services based on the poor results of its DSS implementation.

The Wisconsin customer then asked EDS to take over the failing DSS implementation and extended our contract as their fiscal agent. EDS stabilized the DSS, reducing the data loading time from 32 days to 12 hours and has remained Wisconsin's Medicaid fiscal agent for 23 consecutive years.

The Wisconsin customer experienced our willingness to share information and remain available for assistance until they were satisfied that we met our commitments. We will bring the same commitment to you.

Our turnover approach provides a proposed guide to the orderly transfer of program operations from EDS to the OVAH or a fiscal agent successor. We recognize your concerns for a seamless transition. The turnover approach is based on the same guiding principles as other tasks of this project:

- Dedication to customer satisfaction
- Carefully developed work plan that incorporates the tasks, milestones, and deliverables needed to complete the task successfully
- Orderly transfer of components, assets, and responsibilities
- Frequent and open communication

Our objective is to provide many years of outstanding service to OVHA. However, should we be asked to turn over operations at the conclusion of this contract, you can be confident that our approach to turnover activities is planned for success.

Contractor Responsibilities

RFP Reference: 2.6.6.2, p. 2-32
2.6.6.3, p. 2-34
2.6.6.4, p. 2-34

a. Prepare the Turnover Plan at least six calendar months prior to the conclusion of the MMIS contract, or within five calendar days upon notification from the State. The Turnover Plan shall be based on all facets of turnover occurring within 90 calendar days.

We are committed to providing a comprehensive turnover plan six months prior to the conclusion of the MMIS contract, or within five calendar days upon notification from the state. The turnover plan will be based on all turnover activities taking place within 90 calendar days.

Turnover tasks proposed for a smooth and timely transition will be identified in our turnover work plan deliverable. We bring a wide range of experience that helps us understand the perspectives of all parties involved in turnover. Having taken over many Medicaid systems from other contractors, EDS knows what activities are necessary for a smooth turnover, and we will include these activities and account for the appropriate staffing levels in our comprehensive turnover plan. We will accomplish a timely transition by ensuring cooperation among the parties and by seeing that all program files, systems, and documentation are turned over to the incoming contractor.

b. Provide assistance in turning over the MMIS to the State and/or its designated agent.

As part of our commitment to fully supporting Vermont, we will provide assistance in turning over the MMIS to the state or its designated agent. Successful completion of the turnover task is a critical component of our project management and customer service approach. The pride we take in a job well done and the professional approach we apply to all tasks ensure delivery of services that will be smooth, timely, and without negative impact to all parties involved.

c. Ensure that:

- **All turnover costs, including the cost of hardware, software, and staffing, are borne by the Contractor as part of the annual fixed operations price.**

  We ensure that turnover costs will include the cost of hardware, software, and staffing, and that these costs are included in EDS' annual fixed price.

- **The MMIS is error-free to the extent acceptable to the State when turned over to the State or its designated agent.**

  EDS commits to the best of our ability that the MMIS will be error-free to the extent it is acceptable to the state when turned over to the state or its designated agent.

- **Turnover is smooth, timely, and without adverse impact on providers, beneficiaries and users.**

  We will work to provide a turnover that is smooth, timely, and without adverse impact on providers, beneficiaries, and users. Specifically, our turnover approach encompasses the following objectives:

  - An orderly, controlled transition to the OVHA
  - Uninterrupted service for providers, beneficiaries, and system users
  - Provision of continued processing and smooth operations for the OVHA
  - Meeting of obligations through the last day of the contractual responsibility
  - Retention of a positive relationship with the OVHA, the provider community, and associated state agencies

d. Prepare the Statement of Resources.

We will prepare a statement of resources for the state. Our statement of resources will be based on our actual experience and will include a detailed and comprehensive organizational chart depicting our entire operation. At minimum, the statement will identify all staff by type of activity, number, and salary and include all facilities and any other resources required to operate the VermontAIM and perform fiscal agent services.

e. Produce Deliverables.

We will produce the required deliverables in fulfillment of our responsibilities to the state. We will provide these deliverables within a time frame requested by the OVHA and documented in the Turnover Plan. In addition, we will produce each deliverable in an organized manner, according to reasonable and customary business standards. Our quality processes will serve to verify that deliverables meet your approval. Before submission, we will conduct a walkthrough of each deliverable with you to verify completeness and understanding before submitting it to you for final review.

f. As requested by the State or its designated agent:

- **Transfer all up-to-date source code, customized COTS and other applications, including, but not limited to:**
  - **All necessary data and reference files on electronic media**
  - **All production computer programs on electronic media**
  - **Job Control Language (JCL) on electronic media**
  - **Data entry software**
  - **All other documentation, including, but not limited to, user, provider, and operation manuals needed to operate and maintain the system**
  - **Procedures for updating computer programs, JCL, and other documentation**

  We agree to transfer all up-to-date source code, customized COTS and other applications, and items specified in the list above as requested by the state or its designated agent for turnover. Our turnover plan will be comprehensive and discuss our approach to the transition, staffing resources, tasks, schedule, production program and documentation update procedures during the turnover period, as well as our code, hardware, software, and licenses.

- **Begin training State personnel or designated new contractor staff in the operation of the MMIS. Such training must be completed at least two months prior to the end of the contract or any extension thereof. Training includes, but is not limited to:**
  - **Claims processing data entry**
  - **Computer operations, including cycle monitoring procedures**
  - **Controls and balancing procedures**
  - **Exception claims processing**
  - **Other manual procedures**

EDS is committed to training state personnel or designated new contractor staff in the operation of the MMIS. The training will be completed at least two months prior to the end of the contract or any extension thereof. Training will include claims processing data entry, computer operations and cycle monitoring procedures, controls and balance procedures, exception claims processing, and other manual procedures. EDS will apply the same thorough, easy-to-understand training to the state and new contractor staff during turnover as we apply throughout the duration of our contract.

- **Arrange for hardware and software removal or the transfer equipment and software leases, licenses and maintenance agreements to the State.**

  We will arrange for hardware and software removal or the transfer of equipment and software leases, licenses, and maintenance agreements to the state.

- **Provide a Turnover Results Report that documents completion and results of each step of the Turnover Plan.**

  Our Turnover Results report will document completion and results of each step of the turnover plan.

g. Provide post-turnover services, including at no charge, the services of an on-site Systems Engineer, who has worked on the Vermont MMIS at least one year, to work on-site for 90 workdays following contract termination. The proposed Systems Engineer must be approved by the State. The State will provide workspace and assign work to be done on a full-time basis to support post-turnover activity.

We will provide post-turnover services, including at no charge the services of an approved on-site systems engineer who has worked on the Vermont MMIS at least one year and who will work on-site for 90 workdays following contract termination. We agree to obtain state approval of the proposed systems engineer. It is our understanding that the state commits to providing workspace for the systems engineer and will assign the work to be done on a full-time basis in support of the post-turnover activity.

EDS knows firsthand the impact to a state agency that experiences an ineffective turnover, and we pledge our willingness to share information and remain available for assistance until the state is satisfied that we have met our commitments.

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Certification and Re-certification

RFP Reference: 2.6.7, p. 2-35

The VermontAIM meets all functional certification capabilities required by the Centers for Medicare and Medicaid Services (CMS), as described in Part 11 of the State Medicaid Manual. We will continue our efforts to ensure that Vermont continues to receive the maximum amount of federal funding for the operation of its MMIS.

> "This system is the way of the future and sets the standard for the system that will carry states well into the future."
>
> --Jim Dunnigan, CMS representative, Exit Interview for the VermontAIM certification in October 1994

In addition to the VermontAIM certification in 1995 (with retroactive approval to the first day of operations), we have prepared for and participated in five MMIS certifications within the past five years. The experience gained in those processes will be invaluable for the Department of PATH. We have experience preparing the reports and data necessary for the certification process, including the certification folders containing all required documentation, reports, and crosswalks. Our staff possesses the experience and expertise to work hand-in-hand with CMS to provide the necessary insight to secure federal certification. Our past success and commitment to the certification of the Vermont MMIS remain as we work with the state to achieve this goal.

As part of our certification or recertification activities, we will perform the following activities:

- Meet all State Medicaid Manual Part 11 documentation requirements and provide all reports and crosswalks necessary to complete certification folders
- Provide dedicated personnel who meet with OVHA staff to mutually agree on the certification procedures, system operations, and other information necessary to support OVHA staff to make presentations at the time of certification
- Provide the certification team with a walkthrough of the Vermont fiscal agent facility and operations
- Make staff available to answer questions and provide insight during the certification process

Federally Required Functions

We verify that the VermontAIM performs all functions, possesses all capabilities, and includes all data elements that CMS requires to maintain certification as described in federal certification guidelines published as of the contract start date. As the current fiscal agent, we are well-positioned to demonstrate the many facets of the VermontAIM, including all aspects necessary to operate a fully operational MMIS. We will work with the state to maintain the standards required for MMIS certification and operate the MMIS in accordance with CMS MMIS certification and recertification requirements.

Federally Required Data Elements

During the development of the Vermont MMIS, we incorporated the requirements for federal certification within the system's design. This element of our design process included all of the required data elements identified in Part 11 of the State Medicaid Manual. Both the system and user documentation for the VermontAIM contain the following elements required for certification:

- Record layouts that identify fields in all major files
- System functions and their associated files, as identified through a system diagram overall logic flow
- List of reports according to each function, including the distribution of all system-generated reports
- Example of the reports, provider handbooks, and forms processed

We are using a process control application called Autosys to ensure all the required reports and data sets are generated on time. We will preset different jobs into the calendar function of Autosys, process data, and generate reports and data sets accordingly. We will continue in our efforts to incorporate and improve this automated scheduling tool within the Vermont MMIS. The resulting analysis documents provide diagrams of logical system flow, including system inputs, outputs, and file layouts. Automated production of documentation created an environment for the initial certification review and will facilitate any recertification reviews required by CMS.

Outstanding Track Record

EDS has an outstanding track record with CMS certification reviews that our competitors cannot match. As reflected in the following graphic, all of the MMIS operations EDS has managed have consistently received certification. We expect similar results for our new accounts in Oklahoma and Pennsylvania.

EDS' MMIS Certification Track Record

Certified Medicaid Operations

State:	
Alabama	✓
Arkansas	✓
California	✓
Colorado	✓
Connecticut	✓
Delaware	✓
Florida	✓
Georgia	✓
Idaho	✓
Indiana	✓
Kansas	✓
Kentucky	✓
Louisiana	✓
Mississippi	✓
Missouri	✓
New Hampshire	✓
New Mexico	✓
North Carolina	✓
North Dakota	✓
Oregon	✓
Rhode Island	✓
Tennessee	✓
Texas	✓
Vermont	✓
Washington	✓
Wisconsin	✓
Wyoming	✓

EDS has consistently met CMS requirements for certification.

Contractor Responsibilities

RFP Reference: 2.6.7.1, p. 2-35

a. Ensure that the MMIS meets all current Federal certification and re-certification requirements throughout the contract period for the State to receive the maximum allowable Federal Financial Participation (FFP).

The current VermontAIM was implemented on November 29, 1993, and the certification process began on September 26, 1994. Cherie Bergeron and Barbara Davis were integral members of the Vermont certification team. Cherie led the effort to present all requested documentation and to perform subsystem walkthroughs with the CMS reviews.

On June 8, 1995, we received confirmation that the Vermont MMIS met all of the federal certification requirements. Ronald Preston, a CMS representative, issued Vermont's certification notification with a retroactive certification date to the start of the system on November 29, 1993.

b. Conduct takeover, operations, enhancements and modifications, and associated fiscal agent services in accordance with Federal and State laws and regulations.

Our experienced support team will monitor changes in any federal and state laws and regulations to ensure our processes meet all requirements. Our takeover, operations, enhancement and modifications, and associated fiscal agent services will comply with federal and state laws and regulations.

c. Immediately notify the State of any area identified by Contractor, for which Federal certification or re-certification requirements may not be met, or any reason for which maximum FFP would not be granted.

We will immediately notify the state of any identified area for which federal certification or recertification requirements may not be met, or any reason for which maximum FFP would not be granted.

During our more than 21 years of working together, we have continually achieved complete compliance with all federal and state requirements. By working with and drawing upon our experience from other EDS MMIS accounts, we will continue to meet new requirements or changes in an efficient and timely manner.

Medicaid Laws and Regulations

RFP Reference: 2.6.8, p. 2-35

By selecting EDS, Vermont partners with a technology leader with proven operational experience in all aspects of the Medicaid program. In the previous section we identified the CMS-certified MMIS operations EDS has managed, receiving five certifications within the past five years. Our experience comes from supporting Medicaid-related programs in 33 states during the past three decades, incorporating what we have learned into our methodology and processes, keeping current with industry demands and technology advances, and bringing thought innovation to each customer. In addition, we have supported Vermont's Medicaid Program for more than 21 years and have developed an in-depth understanding of your unique Medicaid environment.

Through this experience, we have developed a comprehensive understanding of the laws and regulations that govern the Medicaid program, nationally and locally in Vermont. In this section, we will describe the breadth and depth of this understanding.

Contractor Responsibilities

RFP Reference: 2.6.8.1, p. 2-35

To ensure that the VermontAIM complies with all appropriate Medicaid laws and regulations, EDS established the office in Williston to provide an in-state presence to meet the following requirements.

a. Maintain, on a current and ongoing basis, a comprehensive knowledge of applicable Federal and State laws and regulations, and the Vermont State Medicaid Plan.

EDS is continually evolving to meet the needs of the changing Medicaid industry. We have a strong team of industry experts representing health care and government knowledge. Lynn Lyford is a member of the Government Global Affairs group, which tracks key legislation comments and proposed rules and regulations and influences significant policy that affects our customers' business. These groups, in conjunction with our local presence, enable us to maintain on an ongoing basis a comprehensive understanding of federal and state laws and regulations as well as the Vermont State Medicaid Plan.

b. Ensure that the MMIS is sufficiently flexible to respond to changes in Federal or State laws, regulations or priorities.

The Vermont MMIS as currently implemented has been identified by both federal and local agencies as being flexible. In describing the management and administrative reporting subsystem, RFP section 2.7.9 credits us with the following: "MARS is flexible enough to meet existing and proposed changes in format and data requirements of Federal

statistical reporting without major programming or expense, and accommodate future changes to meet the unique reporting needs of Vermont's medical assistance programs."

> "The technology being employed here is the way of the future…. The flexibility that you all have with this system is what will be necessary to meet the challenges in years to come."
>
> --Jim Dunnigan,
> CMS representative,
> Certification Process for the VermontAIM, 1995

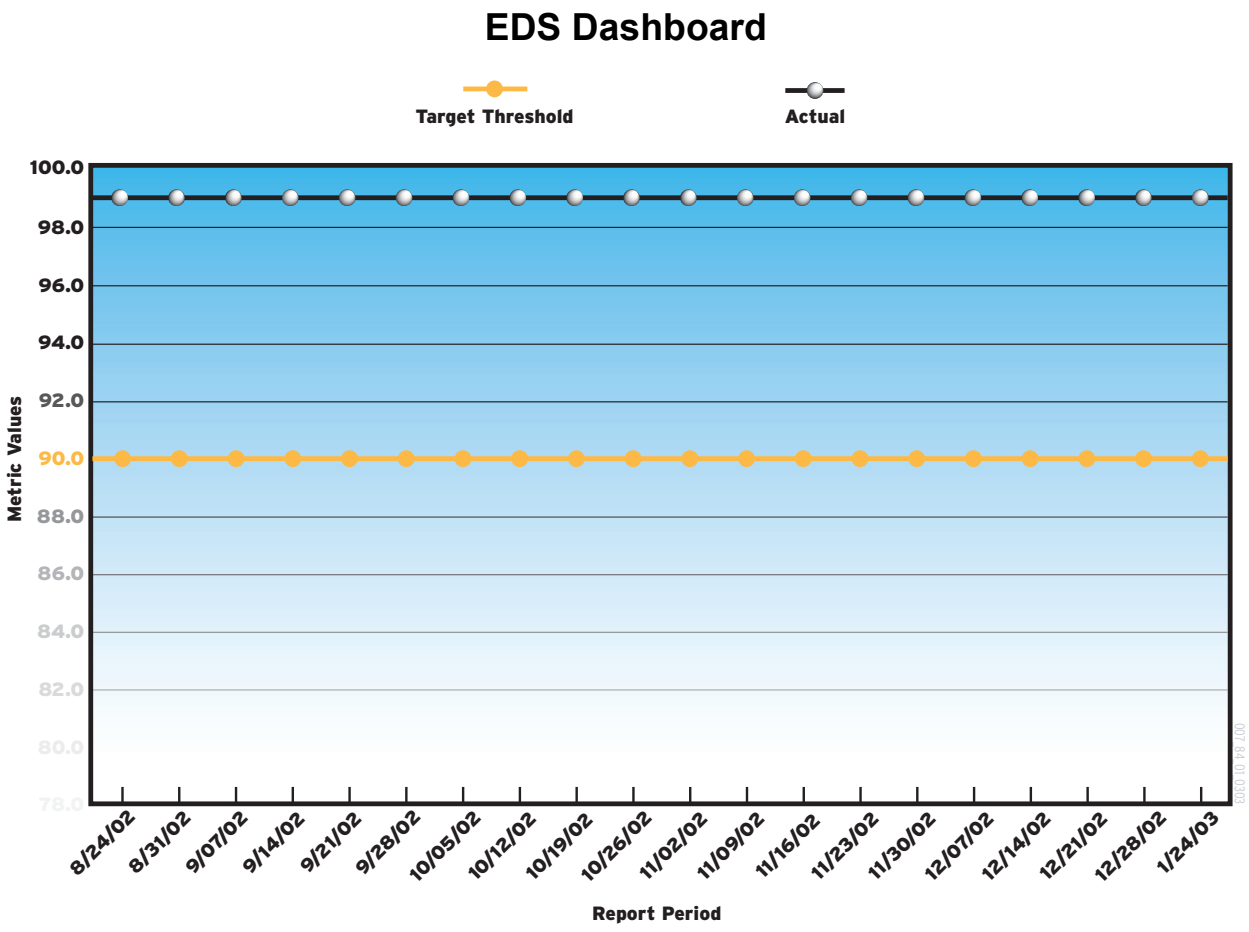
We have taken the forefront in programming to ensure the most flexible approach to meeting the OVHA's needs. As the Medicaid industry evolves and changes to meet future legislative needs, the MMIS will need to be enhanced to reflect these changes. Some needs, such as HIPAA, provide a lead-in time, while other legislative mandates may pass with retroactive time periods. VermontAIM has been programmed to allow for the greatest level of flexibility to accommodate these changing and evolving needs.

Two examples of this flexibility are evident within the claims processing subsystem. There are many edits and audits that a claim must pass to be priced and adjudicated. Different claims may process different edits, and different edits may set different results. In similar manner, there are a series of rules for the pricing of claims. Level 2 pricing has been implemented to enable the system to pay different providers at different rates for similar claims. The VermontAIM applies a series of rules for claim edit/audit and pricing processing that can be easily changed to meet your needs.

c. Correctly process and adjudicate all submitted claims, and drug transactions according to Federal and State laws and regulations, including the Vermont State Medicaid Plan.

We acknowledge how important it is to the OVHA and the provider community to depend on prompt and efficient processing and payment of submitted claims and drug transactions. We constantly monitor our processing to ensure we meet and exceed existing regulations for submitted claims and drug transactions.

One of the metrics we have implemented to track claims processing is our automated EDS Dashboard, shown in the following graphic. The Dashboard monitors claims processing timeliness, system uptime, and phone answer time against established parameters. The graph represents the percentage of claims adjudicated in relation to existing CMS regulations. While properly adjudicating 80 percent of claims is an existing industry standard set by CMS, we have set our MMIS standard to be no less than 90 percent. In Vermont, on our MMIS account, we consistently exceed this standard and perform at a level higher than 98 percent.



The percentage of Medicaid claims EDS adjudicates on time well exceeds CMS' regulations and the industry standard.

Drug transactions, while currently being processed by First Health Services, are loaded into the MMIS on a weekly basis to be included with the other adjudicated claims for the weekend financial cycle.

d. Obtain and retain at least one copy of the most current Federal and State laws, regulations, policies and manuals pertaining to Medicaid that are applicable to the Contractor's performance under this contract, and the Vermont State Medicaid Plan.

Copies of the most current federal and state laws, regulations, policies, and manuals pertaining to Medicaid are maintained on site. EDS actively stays abreast of current and pending federal and state laws, regulations, and policies pertaining to Medicaid that are, or could be, applicable to our performance under this contract. We maintain a strong presence within the Medicaid industry and will continue to grow and change with this industry to remain a good steward of Vermont's investment in Medicaid fiscal agent services.

e. Request the State's interpretation of any laws, regulations and/or policies, as needed.

Any law, regulation, or policy change at either the federal or state level that necessitates changes to the existing processing of the MMIS is subjected to the customer service request (CSR) process. The existing CSR process was established to ensure that we discuss with you all proposed changes to the system and mutually agree on the need and scope of the request. It is during this phase that we address any questions concerning the state's interpretation of the laws, regulations, and policies. Only upon mutual consent of the CSR do we initiate any changes to the system.

f. Subscribe to the Federal Register, the Commerce Clearing House and other appropriate publications to keep abreast of any Federal changes that may be affect the MMIS and Vermont's Medicaid program.

In addition to subscribing to the *Federal Register* and the *Commerce Clearing House,* EDS also participates actively in professional associations, forums, advisory groups, and task forces that examine the regulations and standards affecting Medicaid delivery. These entities include the following:

- Accredited Standards Committee X12N
- Accredited Standards Committee Health Level 7
- Association for Electronic Health Care Transactions (AFEHCT)
- CMS Private Sector-Technology Group (PS-TG)
- National Council for Prescription Drug Programs (NCPDP)
- Workgroup for Electronic Data Interchange (EDI) or (WEDI)
- National Uniform Code Committee (NUCC)
- National Uniform Billing Committee (NUBC)
- National Medicaid EDI HIPAA Work Group (NMEH)
- Center for Digital Government

g. Be a proactive resource for the State in management, design and evaluation of the MMIS and the Medicaid program.

One of the best resources for the state in the management, design, and evaluation of the MMIS and the Medicaid program is the Vermont Health Access Team (VHAT). VHAT meets monthly to evaluate the legislative system. We are an active participant in the VHAT, with Systems Manager Cherie Bergeron serving as the EDS representative on the team.

HIPAA Translator Services

RFP Reference: 2.6.9, p. 2-36

Using EDS' exclusive, proven HIPAA review tool to facilitate and organize the major tasks, the Department of PATH and EDS conducted HIPAA operational and technical assessments, which led to the selection of translator services as the most cost-effective and efficient method of HIPAA remediation.

The translator solution currently under development and scheduled for implementation prior to October 16, 2003, uses the Sybase HIPAA EDI suite of tools. The suite includes compliance mapping capabilities for all the transactions mandated under the transaction and code set rules, with the exception of the NCPDP standard. The NCPDP standard transactions will be processed through the First Health systems and do not require translation through the regional translator system.

Furthermore, by using EDS' multistate joint purchase relationship to implement HIPAA transaction and code sets rules, Vermont will be able to reduce its total HIPAA implementation cost by as much as $3 million dollars. Through EDS' exclusive Multi-State HIPAA Remediation Project, the Department of PATH is able to take advantage of regionalized support and share the cost of hardware, software, and experienced personnel with three other states: Rhode Island, New Hampshire, and Connecticut. New Hampshire, Rhode Island, and Vermont will share system programming modifications, saving millions of dollars in federal funds and saving each state hundreds of thousands of dollars in state matching funds. Connecticut, New Hampshire, Rhode Island, and Vermont will share translator services.

The HIPAA translator solution currently used by Vermont was designed to simplify the implementation and ongoing maintenance of HIPAA transaction requirements. Under this solution, the translator and the MMIS work in concert to send and receive HIPAA standard transactions. EDS is the only vendor that has experience implementing the translator solution and the VermontAIM interface. We are also the industry leader in HIPAA compliance, as demonstrated by the fact that we are the first fiscal agent to enable the first state Medicaid system, the Delaware MMIS, to become fully HIPAA compliant.

Contractor Responsibilities

RFP Reference: 2.6.9.2, p. 2-37

Under the following requirements, we describe our approach to meeting the contractor responsibilities for the HIPAA translator services in the Operations Phase of this contract.

a. Provide ongoing Translator interfaces without disruption.

As the vendor responsible for implementing the translator solution and VermontAIM interfaces, we are thoroughly familiar with the system design and operational

requirements. In addition, we are in the unique position of having staff familiar with not only the specific technologies used, but also with the applications customized to support the interfaces. This experience allows us to provide ongoing translator interfaces free from disruption.

Our firsthand knowledge and experience will minimize the potential for error or disruption that could be introduced by new staff less familiar with the process. Our in-depth understanding will also aid in diagnosing and correcting any potential disruption to services. We have the advantage of providing an MMIS interface solution that is technically equivalent in both the New Hampshire and Rhode Island MMIS AIM systems, which enhances our ability to identify common issues across states for the benefit of all.

EDS uniquely understands the key components that must work together to continue to deliver translator interfaces without disruption. The following table summarizes the key components of the VermontAIM Translator Services Project and the contractor responsibilities necessary to ensure the continued operation of translator services.

VermontAIM Translator Services Components

Component	Component Description	MMIS Contractor Maintenance, Operations, and Enhancements/Modifications Responsibilities
1. Translator Platform Infrastructure	Hardware, operating system software, messaging software, and database software required to support the translator	Coordination with translator team required to manage ongoing translator platform infrastructure maintenance
2. Telecommunications Infrastructure	Primary and backup telecommunications capability for providers to connect to the translator and for the MMIS and translator interface	Coordination with translator team required to manage ongoing translator telecommunications maintenance
3. Customized Translator Software	Sybase translator software, HIPAA syntax mapping by transaction, and customized translation maps that define the rules used to translate HIPAA data into a simplified data set designed to meet the Department of PATH's business and operational requirements	Customization of translator software must be led and managed by the MMIS contractor and coordinated with the translator team. This includes the monitoring and maintenance of HIPAA standard maps as well as the definition, design, construction, and testing of customized translator maps required to meet the Department of PATH's evolving business and policy requirements

Component	Component Description	MMIS Contractor Maintenance, Operations, and Enhancements/Modifications Responsibilities
4. Translator and Provider Interface	Web-based provider portal for file submission and responses	Maintenance of the provider trading partner agreements used to manage the Web portal, in addition to the overall operations and maintenance of the portal, will require coordination and cooperation across the MMIS contractor provider team, MMIS contractor systems team, and translator team
5. Translator and MMIS Interface	FTP-based file transfer solution based on predefined operations events with built-in quality control activities on both the MMIS and translator solutions	Ongoing operations, maintenance, and modifications to the translator and MMIS interface must be completed collaboratively with regular coordination and support across the MMIS and translator teams

b. Fulfill programming, analytical and planning roles equal to the one currently held by the EDS Vermont account, including systems development and maintenance.

Our commitment to Vermont is to provide the same level of experienced personnel currently dedicated to the Vermont HIPAA remediation until its successful completion.

The translator solution is closely integrated with the MMIS. All MMIS processes governed by HIPAA transactions standards, including claims load, financial remittance advices, claims status inquiry and response, and eligibility inquiry and response, must be fully synchronized at all times. Loading an additional claims data element necessary to meet new policy objectives requires corresponding changes to the HIPAA maps used in the translator to produce the simplified file layout sent to the MMIS. This MMIS claims load and database structure must be designed to accept the modified translator output format and store the data appropriately. Once loaded to the database, the MMIS processes must be modified to meet the new business requirement.

Each of these tasks requires specialized technical skills, industry knowledge, and familiarity with the Department of PATH's existing system and policy design. Because EDS made the investment required to build these skill sets, we now bring the advantage of a team that has already acquired the skills necessary to complete these tasks.

We also understand the complexity of these tasks, having recently acclimated staff to the Sybase translator tool, and having designed and constructed the translation maps, new claims load, and financial remittance processes developed to integrate HIPAA requirements and Department of PATH policy.

We bring all of this experience and knowledge to continue fulfilling the programming, analytical, and planning roles currently held.

c. Provide:

- **Staff knowledgeable in translator operations for ongoing operations and maintenance (i.e. System Administrators to maintain the platform; Systems Engineers to maintain the interfaces and application; and Operations staff to monitor the system and process system backups) to work on regional translator team.**

EDS has more than 60 team members on staff with system engineering or administration experience specific to the Vermont MMIS operations and HIPAA solution. Our staff has demonstrated that it is knowledgeable in translator operations for ongoing operations and maintenance.

In addition to our experience with you, EDS has supported more than 20 other customers on HIPAA engagements, including five Blue Cross and Blue Shield organizations, 18 state Medicaid agencies, the Centers for Medicare and Medicaid Services, and the Department of Defense Health Affairs.

In more than 10 MMIS systems across the nation, we also support solutions using the Sybase HIPAA translator product selected by the Department of PATH, including Vermont, New Hampshire, Rhode Island, Connecticut, North Carolina, Oklahoma, Kansas, Tennessee, Delaware, Idaho, and Alabama. Combining our experience, EDS brings a tremendous depth of knowledge specific to the Vermont MMIS, HIPAA, the Sybase translator product used in Vermont, and the health care industry.

The following table summarizes the EDS staff capable of performing the tasks defined in RFP requirement 2.6.9. Beyond the HIPAA experience itemized in the table, most of the team members listed have between five and 10 years of experience working with the technology used to support the Vermont MMIS.

EDS Translator Operations Staff

Name	Title	Skill Set	Years of HIPAA Experience
Shawn McFadden	Project Manager/Systems Administrator	Translator solution architecture, design, and implementation	3
Michael Cabral	Business Services—Connecticut Member, Translator Team	X12N committee member, EDI specialist, Sybase, and Vermont-specific data map design, construction, and maintenance	5
Mike Smith	Web Development Specialist	Vermont Web-based provider portal design and construction, and HIPAA MMIS assessment and design for Vermont	3
Mike Davis	Systems Administrator	MMIS platform, interface and operations support	2
Cindy Littlefield	Systems Engineer	General HIPAA subject-matter expert, as well as translator mapping rule and MMIS integration specialist	3
Chrissie Racicot	Systems Engineer	General HIPAA subject-matter expert, as well as translator mapping rule and MMIS integration specialist	3
Chip Mark	Systems Administrator	Translator platform infrastructure, file transfer management, IBM MQ Series, and operational monitoring	2
David Drechsler	Software Engineer—Member Translator, Platform Team	Translator platform and interface design and construction experience	1
Rich Messier	Systems Administrator—Translator Team	UNIX operating system and systems application support	1
Nathaniel Ohler	Software Engineer—Translator Team	Translator platform infrastructure, IBM MQ Series	1
Jeff Kowalik	Information Specialist—Translator Mapping Team	Sybase and Vermont-specific data map design, construction, and maintenance	1+

Name	Title	Skill Set	Years of HIPAA Experience
Neil Brodeur	Information Specialist—Translator Mapping Team and Vermont Operations Support	Sybase and Vermont-specific data map design, construction, and maintenance	1+
Peter Mwasaru	Information Specialist—Translator Mapping Team	Sybase and Vermont-specific data map design, construction, and maintenance	1+
Greg Carr	Information Specialist—Translator Mapping Team	Sybase and Vermont-specific data map design, construction, and maintenance, and integration of the HIPAA remittance requirements in the Vermont MMIS	1+
HIPAA Implementation Staff—Non-Translator Specific	Team of approximately 40 AIM batch processing specialists	AIM process modifications to support HIPAA, including claims and financial modifications	More than 60 collective years of experience with Vermont requirements and HIPAA

- **The State with perpetual functionality through translator access and services through the duration of the contract with an annual service increase no greater than 10%.**

EDS will provide the state with perpetual functionality through translator access and services through the duration of the contract with an annual service increase that will be no greater than 10 percent.

Privacy, Security, Confidentiality

RFP Reference: 2.6.10, p. 2-38

The VermontAIM will provide security from anticipated threats or hazards to its data and will restrict the availability of data to appropriate staff and other designated individuals and organizations using standardized system applications and data security capabilities. When using and managing confidential recipient information, we will follow the specified HIPAA rules and obligations and any other rules and obligations required by the Department of PATH, including those specified in the RFP.

Contractor Responsibilities

RFP Reference: 2.6.10.2, p. 2-38

a. Ensure that the MMIS:

- **Operates according to all Federal and State privacy, security and confidentiality regulations, including all applicable and duly promulgated provisions of the HIPAA.**

The VermontAIM will comply with all technical, administrative, and physical security requirements specified in the HIPAA-proposed security rule and will incorporate all necessary features to protect the confidentiality, availability, and integrity of health information, in accordance with the HIPAA privacy rule and the security rule. Although some rules have yet to be finalized, we will modify specific tasks as necessary to ensure HIPAA-compliant mechanisms are in place.

We will assign user- and role-based security to ensure we adhere to all information protection policies developed in accordance with HIPAA, including policies related to the "minimum necessary" standards and for specific applications and data as well as access restrictions to protected and confidential information. When using and managing confidential recipient information, EDS will follow the specified and duly promoted HIPAA rules and obligations. Furthermore, we will verify that the VermontAIM development and operations are in accordance with both state and federal regulations and guidelines related to security, privacy, confidentiality, and auditing.

- **Facilitates auditing of individual claims, and provides adequate audit trails, including audit trails for conversion programs. Where override codes are permitted, the use of such codes must be reported. Changes to prices, provider and recipient data, and the use of override codes must be highly controlled, and produce appropriate audit trails and reports.**

We will carefully control changes to prices, reference files, recipient eligibility, third-party liability (TPL), provider file data, and financial transactions. The VermontAIM will maintain the appropriate audit trails, including, at a minimum, unique logon ID (or batch update identifier), date, and time of the change. We will report to the OVHA all completed or rejected updates to system files in a timely and approved manner.

Audit and Control Requirements

Ensuring the integrity of data is absolutely critical for any data processing environment. Only authorized employees are allowed to update or change MMIS data, which is critical to preventing fraud and minimizing health care benefit dollars. We use methods such as table-driven edits and audits that minimize the time required for changes and maximize responsiveness to the Department of PATH's needs. We have also developed system controls that are effective in preventing errors or unauthorized modifications to programs and information, recognizing when an improper action may have taken place, and ensuring that problems are promptly identified and correctly resolved. We consider audit and control features to be an integral part of the overall architecture of the system.

These system controls include systematic and manual procedures for processing paperwork. For example, each document control/input receipt is assigned a control number used to track each transaction as it processes through the system. This control number can also be used to refer a system transaction back to the original document. By assigning a control number, EDS allows management to assess the performance of the automated and manual system processes.

We have extensive experience in data access and control. Through our experience with many types of security measures, we have adopted rigorous corporate polices to which we strictly adhere. All procedures for managing sensitive information and pricing data and for maintaining the physical security of the system are thoroughly reviewed by EDS' internal corporate auditors. Identified discrepancies are reported and corrected.

We will work with you to ensure we have the controls that meet the specific needs of the Vermont Medicaid Program.

Preventive Controls

Preventive controls are designed to prevent errors and unauthorized events from occurring. They are based on the control functions present within the system and include workstation and application security. Examples of the preventive controls we use are the check logs and reports for processing checks and inventory reports. We use these logs and reports to make certain that we enter all claims received into the system and track them to completion.

We assign a unique network address to each workstation on the system as another important preventive control to restrict physical access to the Vermont MMIS. Restricted access is maintained within network routers secured behind firewalls. EDS only allows known network addresses to access to the VermontAIM. The security system logs and reports unauthorized access attempts.

We also apply preventive controls to application security by issuing a logon ID and password to each user. The logon ID is the key identified for the application and function restrictions inherent in the application security features of the Vermont MMIS.

The LAN security function validates a user's logon ID and allows access only to authorized users. After we have granted the user access to the LAN, the user has access to only those applications that he or she is authorized to use.

Detective Controls

We use the inherent controls in the VermontAIM to identify errors and report unauthorized transactions that have occurred in the system. The system identifies and reports the source of any successful and unsuccessful attempts to update the system tables.

We also use the security features built into the Sun Solaris operating system (NIS security databases) as well as the LAN security software to detect unauthorized use of the MMIS.

Corrective Controls

EDS maintains the controls needed to correct any problem identified by the detective controls. Workstation IDs, logon IDs, and passwords in the Vermont MMIS applications and architecture help prevent unauthorized application access or access to unauthorized functions.

Should a user attempt to access unauthorized applications or perform unauthorized functions, the system logs the attempts. The VermontAIM generates reports that list these attempts—noting user ID, workstation ID, the application that was attempting to be accessed, date, and time. The systems administrator regularly reviews these reports for unauthorized access attempts. The systems administrator works with the managers to determine the reason for the unauthorized attempt and takes proper measures to confirm that the user is aware of his or her limitations within the system and to prevent a subsequent attempt. EDS will work with the Department of PATH to actively apply corrections to any access problems identified within the MMIS.

Audit Trails

EDS' operating procedures enable you to track data from source documents through the processing stages to final disposition within the system. Combining the use of required control numbers with the inherent audit and control features of the MMIS, these audit trails provide the ability to trace data from the final place of recording to the source document. The audit trails are supported by the listings, transaction reports, update reports, transaction logs, and error logs that the MMIS produces.

Auditing of individual claims occurs through the use of the inherent audit trails in the VermontAIM, including all edits and audits encountered and how they are resolved. The processes are tracked by individual claim using control numbers that we assign to incoming documents. Should any future conversion programs be needed for any modifications, we will maintain exact logs and documentation of the changes to master table data as a part of the modification project.

We will create and maintain an audit trail of all approved override transactions and the identification of unauthorized overrides by logon, date, and time. If the claim fails any edits or audits during processing and these edits and audits are authorized as overrides, the written approval will authorize the resolutions clerk to override the edits, audits, or both. Additionally, the edit disposition manuals document the use of other types of overrides. The existing manuals contain this documentation, which we will maintain and submit for state approval.

We will provide you with reports of all updates to tables, files, and all rejected update transactions. We will also make sure that each record contains the date of a change and the identification of the source of the change. In addition, we will maintain online windows and reports that show file data and display the data and the source of the last change.

Overrides of Edits and Audits

We will permit only authorized users who have prior written approval from the state to override edits and audits. The written approval, signed by an authorized individual at the state, must accompany each request for override. Only authorized personnel may override edits and audits. Using the VermontAIM capability to restrict functions to a limited number of users, we will maintain the limits that control edit and audit override authorization to provide additional control.

b. Provide:

- **Physical site and data security sufficient to safeguard the operation and integrity of the MMIS.**

Through standardized system applications and data security capabilities, the VermontAIM will provide security from anticipated threats or hazards to its data and will restrict the availability of data to appropriate staff and other designated individuals and organizations. EDS will provide a secure environment for both online and batch access to OVHA data through the use of fully implemented and documented security software.

We will apply our security measures to all system functions, staffing, and on- and off-site facilities. We protect these resources by embedding proven security practices throughout all business processes. EDS has site-specific security measures to limit access to secure areas through the use of a card key access system that also records and reports all access attempts. We will continue to update these measures as appropriate. Our approach to physical security focuses on restricting access and safeguarding processor sites. EDS restricts access through employee and visitor security procedures for keys, card keys, and combination locks. EDS safeguards processor sites with extensive disaster prevention measures for hardware, MMIS files, programs, and system software at state sites, off-site processing sites, and EDS' backup site. Our security measures prevent disasters caused by electrical power failures by using surge protectors, uninterruptible power supply (UPS) equipment, and staff training on emergency procedures. Fire protection equipment and procedures assure uninterrupted operations in the event of a fire. In addition, our processing facilities will meet the following requirements.

EDS will distribute three types of badges for the facility: employee, state, and visitor badges. EDS will provide current EDS employees and approved state staff with a magnetic card key that allows access to the security system, which they need to unlock entrances. The system includes an individual profile for each user that specifies the hours during which the user's badge is operable.

Access to the computer equipment room will only be allowed through secured doors, and there will not be any external doors or windows.

- **Business Continuity and Disaster Recovery Plan procedure and documentation updates.**

A Business Continuity and Disaster Recovery Plan is in place should an event occur that brings our site down. This document will be reviewed and updated once a year, or as major system or operational components change. As part of this review, the site crisis management team will audit the documented processes and make appropriate updates.

Every two years, the corporate EDS business continuity unit will audit the document to ensure compliance to EDS' business continuity standards. We will develop action plans if deficiencies are found, and we will update this document to reflect the corrections. In addition, we will test the plan every two years to demonstrate the reliability of the plan.

c. Maintain a security protocol that only allows authorized inquiry, access and update capabilities to designated personnel. Security must be imposed at various levels as deemed necessary by PATH (e.g. operator, screen or data element). The State must approve and designate personnel access to MMIS data.

The VermontAIM will protect against unauthorized access according to OVHA and federal guidelines. EDS will create, maintain, add, change, delete, and modify all user logon accounts and profiles, and the system will require users to reset passwords. We also will maintain security settings for all supplied systems and programs provided to the state and will develop a procedure that provides access to any systems functions for individuals authorized by the state. After the state gives authorization for an individual, we will maintain that individual's access.

d. Produce audit trail reports for all batch and online update transactions. Online audit trail reports include user ID, date, time, and before and after images of the record or field updated.

We supply reports that show an audit trail for all batch and online update transactions. These reports provide the user ID, date, time, and before and after images of the record or field updated. The audit trail reports reside in our IBM Content Manager OnDemand storage system.

Statement on Auditing Standards 70 Report

RFP Reference: 2.6.11, p. 2-39

Recognizing the immense responsibility placed upon the state to spend money wisely and the level of trust instilled upon you by the citizens of Vermont, both the Auditor's Office and the Department of PATH must be vigilant in ensuring that all state and federal monies are expended wisely and appropriately.

A major audit process of the State Auditor's Office is the Single Audit of all programs receiving federal funds. The Single Audit is performed both by the State Auditor's Office and by contracted independent public accounting firms. The Single Audit reviews the $700 million Vermont receives annually from the federal government to ensure that it is spent in compliance with all applicable laws and regulations. The audit also monitors internal controls over federal monies, including program effectiveness and efficiency.

EDS shares your concerns for spending money wisely and appropriately, and we have willingly undergone the Statement of Auditing Standards No. 70 (SAS 70) audits, the Single State Audits, the Office of Inspector General (OIG) audits, and the CMS audits. In addition, we undergo periodic EDS internal corporate audits designed to identify potential areas of weakness or gaps in our control processes. We have consistently passed the corporate audits, the state audits, and the independent audits and will continue to adhere to documented control procedures. This track record of successful audit reviews ensures you that we have the right controls in place, we adhere to these controls, and we understand the level of trust placed upon us in safeguarding your program expenditures.

In the remainder of this section, we respond to each of the contractor responsibilities defined in the RFP for the SAS 70 Report.

Contractor Responsibilities

RFP Reference: 2.6.11.2, p. 2-40

a. Provide the State with an audit of claims payment process controls, conducted by a third party, annually.

Due to the substantial amount of federal and state program expenditures in the Vermont Medicaid program, it is imperative that the state has full confidence in the system and operational procedures of the MMIS. We will provide you with an annual independent, third-party audit of our claims payment process controls to ensure that these funds are being expended in a proper and appropriate manner. To facilitate this requirement, we will work with our independent auditor, Ernst & Young LLP, to present you with an audit selection criteria list so that you can select control objectives to be used in our annual audit.

Following are some examples of the claims payment process control audit criteria that have been reviewed in the past:

- Funds are used only for Medicaid benefit payments, and appropriations for Medicaid beneficiaries covered by Medicare Part B are appropriate and authorized.
- Case management services are provided to eligible Medicaid beneficiaries, and expenditures are authorized and appropriately documented.
- Third-party medical services are identified, and third-party reimbursements are appropriately obtained and documented.
- Canceled, uncashed checks and overpayments are credited timely, accurately, and completely.
- Drug rebate data is produced timely, completely, and accurately and is reviewed, and manufacturer rebates are monitored.
- Medicaid beneficiaries are appropriately eligible, identified, and maintained in the system.
- Appropriate procedures have been implemented for safeguarding against unnecessary utilization, and fraud cases are identified.

We will work with you to finalize the claims payment processing controls that you wish to have reviewed and ensure that the independent audit firm adheres to the criteria selected for the annual audit.

b. Prioritize audit requirements and provide the State with a cafeteria-style menu of audit choices with associated costs.

In 2002, during a State Single Audit, the Attorney General's office recommended that the state implement a full SAS 70 Level II audit, even though the state was facing severe budgetary constraints. We worked with you to set out a long-term contract review vision, in which we offered a cafeteria-style menu of audit components. You then ranked these components by priority, indicating which were most beneficial to assure security for the program participants, the department, and the taxpayers. CMS appeared willing to go along with your suggestions for a timed, or stepped, implementation of the SAS 70 audit plan. We will continue to provide you with this option for selecting the audit criteria you wish to have us concentrate on during the independent audit process. We propose to continue our relationship with Ernst & Young because its representatives have been extremely cooperative and responsive to your needs in the past.

The following table depicts the cafeteria-style audit criteria approach that we will continue to use.

Cafeteria-Style Audit Criteria Approach

Time Frame	Audit Criteria
Spring 2002	A. Physical security of ADP resources—**COMPLETE** B. Equipment security to protect from theft and unauthorized use—**COMPLETE** C. Software and data security—**COMPLETE**
Spring 2003	D. Telecommunications security—**IN PROCESS** E. Personnel security—**IN PROCESS** F. Contingency plans for interruption of service—**IN PROCESS**
Spring 2004	G. Emergency preparedness H. Designation of security manager

This collaborative approach will meet the state's desire for control over the auditing control objectives while also meeting the stated requirement to review all key contingencies during a five-year timetable. We will provide you with the audit choices and their associated costs so that you may select the audit criteria for the following year.

c. Facilitate the SAS 70 and audit service systematically with a long-term plan.

EDS will continue to facilitate the SAS 70 and audit service with a long-term plan as described above. We will sit down with the state at the beginning of each state fiscal year to determine the criteria you wish to audit during the following state fiscal year and work with Ernst & Young to accommodate your audit selection criteria. This approach will meet your desire for a long-term audit plan, a plan that we have fully supported in the past and will continue to support during the new contract period.

d. Provide audit expertise, guidance and services according to Federal and State requirements.

We understand that if EDS fails an audit, PATH also fails. That is why, when you request our assistance during a state audit, we will provide you with our most knowledgeable claims experts to work with the auditors on their requests for information and documentation. In all of the audits that the MMIS and the state Medicaid program have undergone over the years, we have provided our claims experts to the audit team to guarantee no processing or pricing policy is overlooked.

A typical example is the most recent KPMG Single State audit performed in February 2002. This audit required a random sampling of 400 claims processed during the previous year. Upon their initial review, KPMG identified 60 claims that necessitated further review because they appeared to have been incorrectly processed. Mary Lefebvre, a 12-year EDS veteran employee who is very knowledgeable in Medicaid claims pricing, reviewed each of the claims with the auditors and was able to help them to understand the intricate payment mechanisms that PATH has in place. **The auditor was able to document that the MMIS processed these claims at a 99.9 percent accuracy rate, thus exceeding the standard 99 percent accuracy rate requirement.** This is the type of support and assistance we will continue to provide the state as we work in partnership to ensure the Vermont Medicaid program complies with the audit requirements—whether they are SAS 70, Single State, independent, or internal state audits.

e. Provide audit findings to the State.

We will continue to provide you with the formal SAS 70 audit reports as we have in years past. The most recent SAS 70 Level II audit is an excellent example of the collaborative reporting mechanism we have in place. Annually, we ensure that the audit findings are presented in a formal report. In addition, we asked James Merrill, Ernst & Young auditing principal, to travel to Vermont to provide PATH with a full review of the Draft SAS 70 so that you could make suggestions for changes in the report format. The Vermont Medicaid Report on Controls Placed in Operation and Tests of Operating Effectiveness audit performed by Ernst & Young in 2002 incorporated the state's suggested changes.

A key change that Paul Wallace-Brodeur requested was the addition of a column stating that there was not an audit finding if there was not one. This suggestion was incorporated before the final audit was presented.

The following table documents the results of the 2002 SAS 70 Level II audit of General Computer Controls.

Results of General Computer Controls Audit

Category of Audit	Findings
Application development, maintenance and documentation, and systems software maintenance	No relevant exceptions noted
Access to data files and programs	No relevant exceptions noted
Access to computer facilities	No relevant exceptions noted
Operational and procedural controls	No relevant exceptions noted
Output controls	No relevant exceptions noted

f. Comply with audit findings as directed by the State.

We will continue to comply with the audit findings as directed by the state.

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Accounting Requirements

RFP Reference: 2.6.12, p. 2-41

As the existing Medicaid contractor for the state of Vermont, we are familiar with your program requirements and financial reporting needs. We have the resources and tools available to properly track and report program revenues and expenditures. Although many of the accounting requirements of this RFP are new to the Vermont contract, our financial reporting experience gained from handling other state Medicaid contracts enables us to leverage our knowledge and capabilities and provide you with the necessary accounting functions. In this section, we will demonstrate our ability to accurately and effectively account for your program funds.

Contractor Responsibilities

RFP Reference: 2.6.12.1, p. 2-41

Under each of the following requirements, we discuss our approach to meeting our responsibilities for accounting requirements.

a. Maintain books, records, documents, and other evidence pertaining to the revenue, costs and expenses of the contract in such detail as to properly reflect all revenues, all costs (direct and apportioned), and other expenses of whatever nature is relative to performance of contractual duties. The accounting system must maintain comprehensive financial records, and correspondence between the parties of this contract. Further, accounting records specific to this contract shall be maintained separate and apart from other corporate accounting records.

We will maintain books, records, documents, and other evidence pertaining to the revenue, costs, and expenses of the contract in such detail as to properly reflect all revenues, all direct and apportioned costs, and other expenses of whatever nature is relative to performance of contractual duties.

EDS' general ledger system enables the detailed and proper recording of all financial transactions required under the terms of this contract. A hierarchy of unique responsibility centers is assigned to separate all financial activity related to the Vermont account from other corporate accounting records. Account numbers categorize revenues or costs by expense type within each responsibility center, and expenditures are tracked according to a unit or project. This structure provides the ability to analyze direct and apportioned expenses for each operational area within the Vermont organization. Additionally, within the Vermont contract, costs for selected activities or projects can be further separated from other activities. Each project that requires separate tracking can be assigned a separate responsibility center. Unique responsibility centers allow the different contractual areas and duties of our contract to track revenues and expenses. This approach provides a documented audit trail for the state to monitor pertinent revenue, costs, and expenses related to this contract.

Our correspondence tracking system, S-Log, will document and archive all financial and operational contract correspondence. Supplemental electronic mail folders maintain archived e-mail correspondence. Whether through hard copy documents or archived e-mail, the state can be assured of appropriate retention and availability of contract correspondence.

b. Adhere to accounting procedures and practices that:

- **Conform to generally acceptable accounting principles.**
- **Meet Federal and State regulations, policy, and procedures in a format that is acceptable to Federal and State entities.**
- **Reflect financials in a manner readily ascertainable by non-financial personnel.**
- **Prepare a:**
  - **Monthly reconciliation of billed charges to expenses incurred.**
  - **Cost Allocation Plan to document and update costs beginning the first day of operations.**

EDS maintains financial books and records in accordance with Generally Accepted Accounting Principles (GAAP). Our records are regularly reviewed by both internal and external auditors. Our leadership and auditing staff ensure adherence to GAAP principles and established accounting policies and procedures. Additionally, our reporting meets federal and state regulations, policy, and procedures in a format acceptable to federal and state entities. Furthermore, EDS maintains a Government Liaison & Compliance organization to assist with the interpretation of and compliance with government audit standards.

EDS' financial records are reported in a straightforward and concise manner, readily ascertainable by nonfinancial personnel. If necessary, we will provide assistance in interpreting these records. We will also work with you to mutually define the ongoing processes and reporting formats to ensure compliance with the monthly reconciliation of billed charges to expenses incurred.

Additionally, we will work with the state to define the format of the required Cost Allocation Plan. EDS will prepare a draft plan prior to the first day of operations. This approach will enable you to verify the appropriate allocation of costs to program responsibility centers. Through our work with other state Medicaid programs, we have the knowledge and experience to thoroughly document and provide necessary reporting. Our structured approach, in combination with a proven accounting system, will allow us to accurately and appropriately allocate costs to designated projects.

c. Maintain, document, and submit takeover, operations, and enhancement and modification cost data according to Federal and State regulations, including the State Medicaid Manual. Documentation shall support and differentiate between contract takeover, operations, enhancement and modification costs for MMIS and non-MMIS with applicable FFP matching rates.

We realize that properly categorizing components for federal financial participation (FFP) reporting is key to maximizing the availability of federal matching dollars. As such, our focus on accuracy and controls is unwavering. The state can be fully confident in EDS' ability and commitment to ensuring appropriate billing of contract funds. We will submit invoices with appropriate documentation and differentiate them according to contract takeover, operations, enhancement and modification costs for MMIS and non-MMIS activities. In addition, we will maintain, document, and submit all cost data in accordance with federal and state regulations, including the State Medicaid Manual. Applicable FFP matching rates will be included in our documentation.

d. Specify the allow-ability of direct and indirect costs according to Federal regulations for work to be performed on an hourly reimbursement rate or cost reimbursement basis.

Federal regulations provide guidelines for determining allowable and unallowable direct and indirect costs. EDS will work with appropriate auditing staff to ensure accurate reporting and the correct allocation of designated costs. This methodology will be used for work performed on an hourly reimbursed rate or cost reimbursement basis. We will work with you to finalize the state's reporting and documentation requirements.

e. Report all suspected provider fraud and abuse to the State.

With our years of experience in handling Vermont Medicaid claims and our familiarity with your billing requirements, we are able to identify suspected fraudulent claim billings and refer them to the Medicaid Fraud Unit at the Attorney General's office. In fact, we have a representative on the Medicaid Fraud Committee (MFC), Judy Isham, whose responsibility it is to bring these suspected fraudulent billings to the committee's meetings.

In one instance, our reporting specialist, Louise Brooks, identified a suspicious billing anomaly in the course of her daily work. When presented to the MFC, it was determined that the provider was upcoding his claims inadvertently as the result of implementing a new billing system. The provider agreed to reimburse the state $350,000 for the inaccurate billings. While this upcoding was not noticeable enough to set any alarms or red flags in the auditing processes in the system, our experienced Medicaid personnel were still able to identify these types of errors when reviewing Medicaid billings, which results in cost-savings to the program.

f. Be responsive and accommodating to State accounting requirements.

As our history demonstrates, EDS possesses the knowledge and experience required to successfully meet state accounting requirements. We will continue in our efforts to work with the state in a responsive and accommodating manner. Furthermore, we will provide staff to support the state's accounting requirements to ensure that all requests are processed on a timely basis. By combining the knowledge of our Vermont-based team with our corporate financial resources, we are able to offer you an all-encompassing approach to accurate financial management and oversight of program funds.

Records Retention

RFP Reference: 2.6.13, p. 2-42

EDS understands the importance of document tracking and retention as well as the ongoing need to access all documents as efficiently as possible. We also understand the care required to store paper documents for extended periods of time. We currently microfilm all paper claims, adjustments, and attachments, batching each claim type separately. To address the future needs of the state of Vermont, we propose a new imaging process and solution using the latest technology. The imaging solution, combined with our current IBM Content Manager OnDemand solution, provides a complete image document management system that operates in a client/server network configuration over local and wide area networks.

Our combined imaging and OnDemand solution will provide you with instant access to documents. We will continue to provide a facility for proper storage of any necessary paper documentation for extended periods of time.

Current Procedures for Paper Claims

We assign an internal control number (ICN) for tracking claims and adjustment requests. We microfilm these documents, which are stored and can be accessed at a later date. For nonstandard form paper documents, such as provider correspondence, we will use our imaging software to create and review the images and to manually enter and create the data indices necessary for easy access and retrieval using the OnDemand solution.

Currently, we use the VermontAIM to create production reports electronically. We create and store electronic reports on the image server using a reporting template that allows for later retrieval using the IBM OnDemand solution.

Paper documents are stored in an off-site storage facility. The storage facility provides a climate-controlled environment to combat the natural aging and disintegration of paper documents. The facility also provides monitoring and security, including intrusion and motion detection monitoring, as well as fire detection and suppression. Requests to retrieve documents from the facility are limited to an approved and limited number of EDS personnel.

The following table lists document types and the amount of time that we retain each document based on RFP requirements.

Current Document Retention

Document Type	Retention
Provider correspondence and applications	Paper copy for length of contract, plus six years
Claims and attachments	Paper copy for six months, plus six years
Appeal documents and related correspondence	Paper copy for length of contract, plus six years
Customer service unit correspondence	Paper copy for length of contract, plus six years
Policies and policy clarifications	Image/electronic copy for length of contract, plus six years
MMIS production reports	Image/electronic copy for length of contract, plus six years

Scanning Solution Overview

We will implement new technology that will improve the work flows of everyone who must access copies of claims for research or other purposes. We will replace the microfilm machine we currently use to make electronic copies of claims with a Kodak scanner that will create digitized copies of the claims that can be viewed from a desktop PC.

The ability to view claims from the desktop will radically improve the work of any unit at the state or EDS that requires claims copies. Personnel will retrieve claim images from their desktops, eliminating the time required to send us a research request and the time needed to retrieve the paper or microfilm copy.

Scanning Solution

We will implement scanning technology to replace the current microfilm process. With the scanning technology, input documents such as claims, provider communications, provider enrollment recertification documentation, refund checks, drug rebate, and TPL checks will be scanned and assigned a document number. Once scanned, the electronic image of the document will be stored and will be accessible electronically through a Web browser just like the OnDemand report data. We will use the images for three main functions: data entry, resolution processing, and claims research. This technology will eliminate the time-intensive chore of tracking down film rolls, will allow more than one person to view scanned images at a time, and may reduce the need for retaining hard copies.

The following table lists document types and the length of time we will retain each scanned image.

Scanned Image Document Retention

Document Type	Retention
Provider correspondence and applications	Scanned images for length of contract, plus six years
Claims and attachments	Scanned images for six months, plus six years
Appeal documents and related correspondence	Scanned images for length of contract, plus six years
Customer service unit correspondence	Scanned images for length of contract, plus six years
Policies and policy clarifications	Scanned images copy for length of contract, plus six years
MMIS production reports	Scanned images copy for length of contract, plus six years

Document Disposal

We are committed to maintaining the privacy of the citizens of Vermont and to protecting the data entrusted to us as your fiscal agent. We contract with a licensed document disposal company, SecureShred, who shreds all documents on-site at the account and disposes of them according to state and federal laws and regulations.

Contractor Responsibilities

RFP Reference: 2.6.13.1, p. 2-42

Accounting procedures, policies, records and related documents (e.g., 1099s) must be:

a. Retained during the contract period, and for six years thereafter, unless the State specifies in writing a shorter period of time. Records and supporting documentation under audit or involved in litigation must be kept for one year following the conclusion of the litigation or audit if the litigation or audit has not terminated within the six-year post contract period. ***The provisions of this section must be incorporated into any subcontract of $100,000.00 or more.***

These records must include all financial and programmatic records, supporting documents, statistics, and other recipient records for a period of three years from the last date of decision, in accordance with 45 CFR 74.164.

EDS retains all accounting procedures, policies, records, and related documents for the contract period, and for six years thereafter, unless directed in writing by the state to retain the information or documents for a shorter time period. We keep records and supporting documentation under audit or involved in litigation for a minimum of one year following the conclusion of the litigation or audit period. Furthermore, we will incorporate the provisions of this section into any subcontract that is valued at $100,000.00 or more.

We will comply with the specifications of this requirement, including the types of records and supporting documentation, statistics, and other recipient records for a period of three years from the last date of decision.

b. Accessible to Federal and State representatives for review, inspection, evaluation, audit, and reproduction at reasonable times during the contract period, and for six years following the end of the Federal Fiscal Year (FFY) during which the contract is terminated or State and Federal audits have been completed, whichever is later, unless the Department of PATH specifies in writing a shorter period of time. During the contract period, access to these items must be provided at the Contractor's Vermont location. During the six-year post-contract period, delivery of and access to the listed items must be at no cost to Department of PATH.

We will provide access to, and deliver at no additional cost, the accounting procedures, policies, records, and related documents for review, inspection, evaluation, audit, and reproduction to federal and state representatives upon request at reasonable times during the contract. Unless otherwise specified by the Department of PATH, EDS will continue to make available this information for six years following the end of the federal fiscal year (FFY) during which the contract is terminated, or until state and federal audits have been completed, whichever is later. We will provide access to these items at our EDS location in Williston, Vermont.

c. Available to the State within 10 workdays of receiving a written request for specified records. If such original documentation is not made available as requested, the Contractor agrees to provide transportation, lodging, and subsistence at no cost, for Federal and/or State representatives to carry out their audit function at the principal offices of the Contractor or other location of such records.

Upon receipt of a written request for specified records, we will supply copies of documents to state and or federal representatives within 10 business days. In the unlikely event we should fail to comply with the written request for documentation, we agree to provide—at no cost—transportation, lodging, and subsistence to the federal and state representatives while they complete their audit function at our principal office in Williston, Vermont, or other location of such records.

d. Turned over to the State or its designated agent at the conclusion of this contract, including, but not limited to:

- **All original adjudicated paper claims received (must be retained for a minimum of 180 calendar days, then transferred to microfilm or CD and retained as specified above).**
- **All electronic media claims and related records received.**
- **All claims and drug transactions processes.**
- **All other pertinent books, documents, papers and records involving transactions related to the contract.**
- **All original canceled checks and EFT documentation must be retained within the State of Vermont as specified above, from the date of issuance.**
- **Databases built and programmatic documents.**
- **Adjudication decisions made by the MMIS.**

At the conclusion of this contract, EDS agrees to turn over to the state or its designated agent, the required documents specified above. We incorporate this transfer of documents as part of our detailed turnover plan, which we will submit to the state for review and approval in a timely manner prior to the actual turnover.

e. Be responsive and accommodating to State record retention requirements.

EDS will continue to be responsive to the needs of the state and accommodate your requests for record retention.

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Contractor Staff Requirements

RFP Reference: 2.6.14, p. 2-43

The staffing plan described in our response to section 3.2.2.8, "Project Organization and Staffing," for both the Operations and Enhancements/Modifications phases is our best response to the staff requirements identified in 2.6.14. Those staffing plans show that EDS already has:

- Experienced leaders in management positions: Client Delivery Executive Barbara Davis, Systems Manager Cherie Bergeron, and Program Services Manager Valerie Lewis
- Staffing structure that has developed over the years to provide the right level of support (that is, the correct numbers and the appropriate skill sets) for our contract responsibilities
- Existing staff (as identified in requirement "i" under the Contractor Responsibilities in this section) in required positions and locations

As Vermont knows, the quality of the staff is a distinguishing feature of our proposal. The staff we are bidding brings a total of 410 years of Vermont experience, knowledge, and dedication.

EDS will continue to staff the contract with the existing experienced, long-term employees. We desire to retain our experienced staff because the company has invested years of development and training to enhance their skills. In addition, our employees are vested in the company retirement plan, possess strong loyalty, and maintain a desire to continue to live in Vermont while growing their careers with EDS.

In the remainder of our response to section 2.6.14.2, we will indicate our compliance with this RFP subsection's requirements for contractor staffing. For the actual staffing plans and resumes, please refer to our responses to section 3.2.2.8, "Project Organization and Staffing," in Sections I and J of our proposal for both the Operations Scope of Work and the Enhancements/Modifications Scope of Work.

Contractor Responsibilities

RFP Reference: 2.6.14.2, p. 2-44

a. Comply with staffing commitments made in Contractor's proposal, or in a subsequent State-approved staffing plan.

We will comply with the commitments made in the staffing sections of our proposal: "Contractor Staff Requirements" and "Project Organization and Staffing". Our compliance extends to subsequent state-approved staffing plans.

The staffing plans that appear in our response to section 3.2.2.8, "Project Organization and Staffing" (in both the Operations and Enhancements/Modifications narratives) describe our commitment to Vermont. Our organization charts, resumes, and staff loading charts depict our firm commitment to present the best people and the right numbers of people in an organization that has evolved to meet all contractual requirements.

b. Warrant that all staff assigned to the performance of this contract are:

- **Employees of the Contractor (or specified subcontractor).**
- **Fully qualified to perform the work required herein.**

All EDS employees currently assigned to the Vermont Medicaid contract are employees of EDS or of a specified subcontractor and are fully qualified to perform the work required by the contract. EDS warrants that all new staff joining the project team will be employees of EDS or of a specified subcontractor and that they will be fully qualified to perform the work required in the contract.

The provisions of section 2.6.14.2(b) must be incorporated into any subcontract.

We will incorporate the provisions of section 2.6.14.2(b) into any subcontract.

c. Provide the State with a resumé of any of its staff or subcontractor's staff assigned to or proposed-to-be-assigned to this contract, upon request.

EDS will provide the state with resumes for our staff and subcontractor staff who are assigned to this contract. Please refer to our response to section 3.2.2.8, "Project Organization and Staffing," for resumes of the proposed leadership team for the Operations and Enhancements/Modifications scope of work.

d. Fill vacant positions with staff of equal ability and qualifications within 30 calendar days of initial vacancy.

EDS will fill vacant positions with staff of equal ability and qualifications within 30 calendar days of the initial vacancy. Each Medicaid contract that EDS manages has a detailed succession plan to identify the pool of qualified candidates who can assume positions of new or greater responsibility. By fostering in-house talent through ongoing training and increased responsibility, we are prepared to fill vacancies with employees trained and mentored by our experienced leadership team.

Should we need to hire additional staff, we are also fully prepared to seek and select new, qualified employees. We will look locally for qualified candidates, as well as using succession planning and development activities in our existing Medicaid contracts to staff the project. We have personnel in numerous states, and we are continually developing personnel with the right mix of Medicaid experience, general health care experience, technical and leadership experience, and specific AIM system experience, to staff new opportunities, or to take on additional responsibilities. If a qualified EDS employee is identified as the best person for a position and needs to relocate to Vermont, Client Delivery Executive Barbara Davis can initiate this process. Providing you with the best candidates to do the job is a top priority for EDS. The personnel proposed to support the VermontAIM reflect this commitment to the state.

We use the following resources to locate and identify the most qualified candidates for the Vermont MMIS contract:

- Succession planning at EDS' existing Medicaid contracts
- EDS' internal online job posting system, available to all employees worldwide
- EDS' corporate recruiters who continually review resumes of qualified candidates
- Advertising in local publications and the Internet
- Participating in job fairs
- Vermont EDS employee referrals

We are confident in our ability to maintain a team that is fully prepared to assume responsibility for the Takeover, Operations, and Enhancements/Modifications Phases of this contract.

e. Confirm all management and key staff commitments to this contract for the entire contract term unless the State exercises its option to have a staff person removed.

EDS confirms all management and key staff commitments to this contract for the entire contract term unless the state exercises its option to have a staff person removed.

f. Notify the State immediately upon notification that a management or key staff positions may be vacant.

EDS will notify the state immediately upon notification that a management or key staff position may be vacant.

g. Obtain prior written approval from the State for:

- **Staff assigned to this contract.**
- **Staff changes, including permanent or temporary changes to or deletions from Contractor's management, and key staff if the change is within the Contractor's control.**
- **Diversion of management and key staff to other Contractor duties, either internal or external to the Vermont account.**
- **Job descriptions.**
- **Definition of positions that qualify as "key staff".**
- **Organizational structure or re-structuring as determined by business needs.**

EDS will obtain the state's written approval before performing any of the actions described in the previous six bullet points.

h. Maintain a staffing structure, of sufficient background, expertise, training, size, scope, and authority to perform Contractor Responsibilities to the satisfaction of the State.

EDS' staffing structure will be of sufficient background, expertise, training, size, scope, and authority to perform contractor responsibilities to the state's satisfaction. Please refer to our response to section 3.2.2.8, "Project Organization and Staffing," for a description (including organization charts) of the staffing structure for the next operational contract period and the Enhancements/Modifications scope of work.

i. Retain Existing Staff:

The following positions are mandatory throughout the length of the contract and any contract extensions. The EDS staff currently employed in these positions with existing job descriptions shall be retained by the new Contractor. ***The salary and benefit costs associated with these positions are fixed throughout the contract term and already accounted for in the Total Price Proposal Worksheet.***

- **School-based Health Program Field Representative – 4 FTEs (as utilized)**
- **School-based Health Program Lead – 1 FTE (as utilized)**
- **OVHA/TPL Cash Coordinator – 1 FTE**
- **Physical Therapist – 1 FTE**
- **Self-Managed Nursing Coordinator – .5 FTE**

The OVHA/TPL Cash Coordinator and Physical Therapist are located at the State of Vermont Office Complex in Waterbury and do not require equipment under this RFP. However, the School-based Health Program Field Representatives and Lead will require workspace and all necessary equipment.

EDS will continue to comply with the staffing and location requirements identified in bullet point (i). The following table identifies the unit supported by these positions.

Staffing and Location Requirements

Position name	Organizational unit where the position reports
School-based Health Program Field Representative	Program Services
School-based Health Program Lead	Program Services
OVHA/TPL Cash Coordinator	OVHA's TPL Unit
Physical Therapist	OVHA Clinical Support Unit
Self-Managed Nursing Coordinator	Program Services

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System Reliability

RFP Reference: 2.6.15, p. 2-45

Protecting Vermont's Medicaid Program information is a fundamental goal for both the OVHA and EDS. Avoiding potential disasters while building data processing reliability begins with comprehensive planning. Recognizing this fact, EDS' system reliability controls are among the most stringent in the Medicaid fiscal agent industry. Having safeguarded the operation and integrity of Medicaid data, Medicare data, national security data, and financial services data for more than 30 years, we are highly skilled at applying advanced and appropriate security technologies, systems access restrictions, and security procedures that fully address your concerns about system availability, data restoration, and disaster preparedness.

We demonstrated our disaster recovery capability by restoring the MMIS at our recovery site and performing critical functions during the first quarter of 2002. The disaster recovery exercise was extremely successful. We are confident in our ability to restore the Vermont MMIS in the event of a disaster.

In addition, our disaster recovery plan covers physical plant security, data security, and disaster prevention and recovery procedures. EDS recognizes the significance of effective backup and recovery procedures to quickly restart operations and reconstruct the system and affected data in the event of an unexpected interruption in the delivery of MMIS services. During the Implementation Phase, we will update the disaster recovery plan that incorporates procedures to follow for backup and recovery situations, including the following examples:

- A major disaster in which the central computer installation and resident software are destroyed or damaged
- A problem that is system- or application-dependent, resulting from network failure, software error, or operational errors where one or several days' processing is invalid, making data on the master tables also invalid
- System downtime caused by the failure of one or more components of the MMIS application software

Our approach to maximizing system availability includes the following features:

- Scheduling routine preventive maintenance activities to occur during nonworking hours
- Maintaining access to corporate resources for replacement servers, monitors, terminals, and controllers should the equipment fail
- Maintaining service agreements with our major vendors, such as Sun, which enables us to receive rapid on-site service should one of our pieces of equipment fail
- Rerouting network communications as needed to bypass component failures

Localized, preventive activities allow us to avoid most potential disasters and establish up-front corrective action plans to minimize or correct problems before operational capacity is lost.

EDS meets the RFP requirements for backup and recovery by following stringent disaster prevention practices and developing and strictly adhering to the proven disaster recovery plan. EDS establishes disaster prevention procedures for on-site processing, such as daily backups of server data that we will rotate off-site every business day. Standard backup procedures require keeping copies of software with the backup files at a secure off-site disaster recovery location.

The disaster recovery plan details steps we will take to prevent a disaster, and in the unavoidable event of a disaster, the steps we will take to respond. These steps include actions required to protect the system against hardware, software, and human error. Both state and EDS staff will use the plan to periodically review the disaster recovery processes for the VermontAIM and to validate that all prudent and reasonable steps for disaster prevention and response are current and documented. The disaster recovery plan will be available for review by state and federal officials at any time.

EDS' disaster recovery plan addresses all of the areas defined in the RFP and includes the following:

- Description of checkpoint/restart capabilities
- Retention timeframes and storage media of backup files and software
- Hardware backup plans for the main processor
- Hardware backup for data entry equipment
- Backup for telecommunications links and networks
- List of key personnel to be contacted, including telephone numbers
- List of hardware and software components and vendor contact names and telephone numbers for recovery purposes
- System network diagram and hardware diagrams
- Description of continued processing plans for OVHA transactions, such as claims, eligibility, and provider file, in the event of the loss of primary OVHA or EDS processing site; includes interim support for the OVHA online component of the MMIS and required time frames for accomplishing planned recovery
- Backup procedures and support to accommodate loss of online communication between the OVHA's and EDS' processing site

- Detailed file backup plan and procedures, including the off-site storage of crucial transaction and master tables; plan and procedures that include a detailed schedule for backing up critical files and their rotation to an off-site storage facility. (The off-site storage facility will provide for comparable security of the stored data, including fire, sabotage, and environmental considerations.)
- Maintenance of current systems documentation and source program libraries at an off-site location

For more information on our backup and disaster recovery capabilities, please refer to our response to bullet (f), Approach to System Security, Backup, and Disaster Preparedness, in the "Work Plan and Schedule (Operations)" subsection of Section I: "Operations Narrative."

Contractor Responsibilities

RFP Reference: 2.6.15.2, p. 2-46

The Contractor shall maintain and update two complete hardcopy sets of the Business Continuity and Disaster Recovery Plan throughout the contract period, one for the State and one for the Contractor. The Business Continuity and Disaster Recovery Plan shall be continuously updated from the preliminary version as described in RFP section 2.6.3.8 to remain current, and shall include details pertinent to the following Contractor Responsibilities.

We have already developed a Business Continuity and Disaster Recovery Plan that will quickly restart operations and reconstruct the system and affected data in the event of an unexpected interruption in the delivery of MMIS services. We will ensure that this plan is continuously updated from the preliminary version, and we will maintain and update two complete hard copy sets of the plan throughout the contract period.

We have established the system security portions of a Security Plan and a Contingency Plan to instruct the Department of PATH in responding to a system emergency or the unavailability of the system. Our work plan contains details about our proven and thorough business continuity planning process and how it applies for you.

a. Establish and maintain:

- **Complete daily backups that are adequate and securely stored in an approved off-site location, for all software and operating programs; data, files, and system, operations, and user documentation (in electronic and hardcopy).**
- **A complete weekly backup that is adequate and securely stored in an approved off-site location, for all software and operating programs; data, files, and system, operations, and user documentation (in electronic and hardcopy).**
- **Complete backups that support the restoration and recovery of lost or corrupted data or software within two calendar days.**

EDS has assigned a secure disaster recovery area (DRA) for all VermontAIM backup files, programs, system software, and documentation in case of loss of primary data through an unforeseen disaster. The primary off-site location selected to process MMIS data in a disaster is in Plano, Texas. EDS maintains all necessary hardware, software, and network infrastructure to restore operations of the Vermont MMIS as quickly as possible in the event of disaster.

We will take full daily and weekly backups for all software and operating programs, data, files, and the database, and we will take these backups off-site every business day. The environment in the recovery area is climate controlled to protect the integrity of the data, and all media are periodically checked for readability.

Restoration of lost data currently takes no more than two days (much less depending on the size and complexity of what needs to be recovered) for data that must be recovered from off-site backups.

b. Maintain or otherwise arrange for an alternative site for use in the event of a catastrophic or other serious disaster event. This site must provide for complete restoration of normal operations, as well as other system and services deemed necessary by the State.

The primary off-site location selected to process MMIS data in a disaster situation is at EDS corporate headquarters in Plano, Texas. EDS maintains all of the necessary hardware, software, and network infrastructure to completely restore normal operations of the Vermont MMIS, as well as other systems and services deemed necessary by the state, as quickly as possible in the event of disaster. EDS periodically performs recovery testing and full recovery.

c. Specify the respective time frames deemed reasonably necessary for complete recovery. The recovery period shall not exceed two calendar days for critical functions (i.e., claims processing and paying providers). The recovery period for all MMIS functions shall not exceed 30 calendar days.

If disaster strikes, we are ready. Our business recovery procedures provide guidelines for restoring service at any site that supports the VermontAIM. EDS' recovery procedures prepare our personnel to replace sites, equipment, networks, and documentation as rapidly as possible. Our recovery period will not exceed two calendar days for critical functions such as claims processing and paying providers, and the recovery period for all MMIS functions will not exceed 30 calendar days. The EDS leadership team verifies that the plan meets requirements for federal certification, EDS' corporate standards, and requirements for routine error recovery and disaster recovery procedures and plans.

The Business Continuity and Disaster Recovery Plan identifies all individuals and their responsibilities in terms of specific recovery actions and their time frames. These individuals identify files, libraries, system software, and critical data sets. They also establish a schedule for duplication to restore VermontAIM data up to the date of physical loss at the data center or at EDS' Vermont fiscal agent facility. The Business Continuity and Disaster Recovery Plan also includes names of individuals responsible for executing the recovery and formatted instructions for recovery procedures.

The plan also considers the data center resources necessary to recover data and continue processing. Such resources include server sizing, total tapes, total disk space, and total execution time necessary to recover data and process Medicaid claims. This consideration enables our data center staff to accurately assess the VermontAIM resource requirements in the event of a disaster and to arrange for recovery and continued processing at the backup data center.

Data Center Disaster Recovery Procedures

The data centers are also prepared to quickly recover from disasters. The following exhibit, Data Center Disaster Recovery Procedures, presents the high-level procedures that EDS will follow should a data center disaster occur, and the approximate schedule for carrying out each activity.

Data Processing Center Disaster Recovery Procedures

Action	Responsible Personnel	Time Frame
Assess scope of the disaster, damage, work required, time frames	DRA manager and DRA representative from each operations group	Day 1
Review damage assessment, decide on recovery strategy, notify backup data center if necessary, notify all data center accounts, contract for equipment and supplies	Data center manager, computer operations, software services, planning, data security, and network services managers	Day 1
Inform Vermont MMIS Client Delivery Executive Barbara Davis of disaster and estimated time for service restoration for data center or alternate data center	DRA manager and DRA representative from each operations group	Day 1

Action	Responsible Personnel	Time Frame
If Information Processing Center is destroyed:		
Dispatch operations and systems personnel to alternate data center	Resource management manager	Day 1
Transport VermontAIM backup tapes from DRA site to alternate data center	Direct access storage device (DASD) management technician	Day 1
Contact vendors for equipment and supplies	Hardware planning manager	Day 1
Contact telephone company for additional lines	Network operations manager	Day 1 and 2
Install source code, object code, and scripts for VermontAIM and other applications	System administrators, software engineers	Day 1 and 2
Restore VermontAIM and other application tape libraries; reload databases and files; update production management, tape management, and security system	Direct access storage device (DASD) technicians, database administrators, system administrators	Day 1 and 2
Modify network software at alternate site as required for VermontAIM and other applications; bring up lines	Network software specialists, programmers	Day 2
Bring up production cycles in priority sequence	Scheduling and production control technicians	Day 2

The Business Continuity and Disaster Recovery Plan specifies the responsibilities of EDS and the state in case of an interruption in service delivery. Additionally, it satisfies all requirements for federal certification. We will maintain the plan throughout the term of the contract.

d. Implement all steps necessary to fully recover the data and/or system from the effects of a disaster and to reasonably minimize the recovery period.

We will implement all steps necessary to fully recover the data and system from the effects of a disaster and to reasonably minimize the recovery period. Prompt and accurate damage assessment is essential to a complete recovery in the event of a disaster. EDS defines three levels of disasters.

Level One Disaster—Disrupts processing for less than 24 hours. Prompt assessment by experienced technical staff establishes the tasks necessary to return to normal operations, ensuring service can be restored within 24 hours.

Level Two Disaster—Disrupts processing for 24 to 72 hours. Again, proper assessment is critical and allows management to allocate the necessary resources to restore normal operations.

Level Three Disaster—Disrupts processing for more than 72 hours. A Level Three disaster is the result of a catastrophic event and causes all processing activities to be relocated through the use of backup facilities. Once the disaster has been assessed as Level Three, key personnel identify the materials needed to recover from the disaster, place an order to have them retrieved from the off-site storage site, and ship the data to the backup facility where restoration can begin.

As a result, in the event of a disaster, all databases and activity files necessary for restoring service are identified. We also establish a duplication schedule with the DRA.

In the event of a disaster at EDS' Vermont fiscal agent site, we can resume the image and entry function by transferring it to another site. Vermont-specific image and entry functions are maintained on disk and can be quickly shipped to another EDS Medicaid project site. Normal production rates are maintained with overtime and additional shifts at these alternate sites.

We further promote a timely return to accurate processing by temporarily transferring necessary data entry personnel to an alternate site. Claims adjudication and other manual functions will be performed at the temporary processing site in Pennsylvania or may be performed at another EDS facility in the region, such as New Hampshire.

In the event of a telecommunications failure, data entry equipment features allow data to be stored on disk until service can be restored. Server backup processes are used to back up data. These backup files are created daily, allowing files to be restored to their most current version in the event of processing difficulties. This ability to restore files on a daily basis reduces the chance that data will require re-entry.

The following table presents an overview for the plan we will follow in the event of a disaster at the EDS Vermont fiscal agent site. The plan is designed to recover full operational capability for the VermontAIM.

Key Elements of Project-Site Service Interruption Recovery Plan

Task	Description
Provide Disaster Recovery Management	EDS provides management and controls the disaster recovery process at the local facility and processing center. The management team monitors the disaster recovery process to completely and accurately recover data files according to the specified time frames.
Notify Disaster Recovery Team	The EDS management team notifies appropriate managers, programmers, and disaster recovery specialists that a disaster has occurred. Disaster recovery specialists address recovery for facilities, communications, and telecommunications.
Notify the Department of PATH of Disaster	EDS' management team notifies the Department of PATH that a disaster has occurred and continues to keep the Department of PATH informed throughout the recovery process. The management team describes the disaster, the steps being taken to resume operations, and the impact on the provider community.
Assess Scope of Disaster	Our managers and programmers carefully evaluate the extent of the disaster and begin planning for recovery of operations. We assess the scope of the disaster, rating it as a Level One, Level Two, or Level Three disaster.
Business Continuity and Disaster Recovery Plan	Our managers and programmers review the Business Continuity and Disaster Recovery Plan and use it to guide the recovery process. Managers assign specific personnel to the tasks detailed in the plan to provide for the complete and accurate recovery of VermontAIM operations.
Estimate Recovery Time	Our managers estimate the time required to recover VermontAIM operations. This estimate depends on the scope of the disaster and the tasks required for recovery. We inform the Department of PATH of the scope of the disaster and the time required for recovery.
Provide Temporary Image and Entry	We provide temporary processing, as well as entry of claims and file update transactions, at our assigned backup facility. This temporary arrangement allows EDS to continue the imaging and entry of claims while recovering the local facility.
Locate Alternate Facility	The management team identifies and secures a temporary backup facility. We maintain project management at this temporary facility until the existing facility can be repaired.

Task	Description
Order Equipment	The EDS management team orders the necessary equipment from our hardware planning group to resume operations at the temporary facility. The hardware planning group controls the ordering and delivery of equipment from hardware and equipment vendors. In an emergency situation, EDS can obtain equipment in short periods of time, as our contracts with equipment suppliers include provisions for disaster-level reaction.
Establish WATS and Local Lines	EDS contacts the telephone company to install wide-area telephone service (WATS) lines and local telephone lines at the temporary facility. These lines allow the continuance of provider relation services and telecommunications at the temporary facility.
Relocate and Install Equipment	Our hardware planning group receives and installs equipment at the temporary facility. Equipment—from office furniture to computer processing equipment—is installed to make the temporary facility totally operable. We relocate our various groups to the temporary facility.
Mail Room	We install mail room equipment and organize the mail room in preparation for claims receipts. Once the mail room is set up, we can process all mail and claim receipts at the temporary facility.
Operations	We install all data processing equipment necessary for operations at the temporary facility. Data processing equipment includes printers, a minicomputer, disk packs, tape drives, and terminals for data entry and online access.
Systems	We relocate all systems personnel to the temporary facility. The systems personnel can then maintain MMIS operations from the temporary facility.
Claims Processing	We relocate all claims processing personnel to the temporary facility. Claims processing personnel include all data entry, mail room, and adjudication personnel. The relocation of these personnel allows claims entry and processing to be performed at the temporary facility.
Provider Relations	We relocate all provider relations personnel to the temporary facility. Provider relations personnel resume services to Vermont provider inquiries.
Begin Operations	The disaster recovery process is complete at this point; EDS performs all VermontAIM functions at the temporary facility.

Our comprehensive disaster prevention and recovery approach ensures that all reasonable measures will be taken to continue VermontAIM processing in the event of a disaster at the local processing center. Within 48 hours of a disaster, our commitment is to have processing restored in a backup data center.

e. Demonstrate:

- **Full disaster recovery capability no less than every two calendar years at which time full documentation of system testing and functioning must be provided to the State.**
- **Readiness and obtain State approval prior to returning to primary telecommunications network.**
- **Functions (i.e., claims processing and paying providers). The recovery period for all MMIS functions shall not exceed 30 calendar days.**

EDS periodically performs recovery testing and full recovery. We will demonstrate this full disaster recovery period no less than every two calendar years, at which time we will provide full documentation of system testing and functioning to the state.

We will also demonstrate readiness and obtain state approval prior to returning to our primary telecommunications network. Our comprehensive Business Continuity and Disaster Recovery Plan enables us to achieve a recovery period that will not exceed 30 calendar days.

We demonstrated our disaster recovery capability by restoring the MMIS at our recovery site and performing critical functions in the first quarter of 2002. The disaster recovery exercise was extremely successful. We are confident in our ability to restore the Vermont MMIS and perform critical processes within two days of a declared disaster.

EDS' unique position in the marketplace enables us to provide superior backup and recovery solutions. We have the computing resources and available personnel to respond quickly. We develop custom contingency plans for each component of the MMIS with the approval and guidelines of the OVHA. EDS has a reputation for responding to customer needs in unusual circumstances and an outstanding record of providing uninterrupted service in the MMIS market.

f. Provide:

- **Network telecommunications with backup capability.**
- **The State with the capability of performing unscheduled testing of backup telecommunications.**

Avoiding potential disasters while building data processing reliability begins with comprehensive planning. Our resulting configuration for on-site processing, off-site processing, and backup facilities emphasizes advanced communications linkages, data centers, and reliable, alternative processing contingencies.

EDSNET, one of the world's largest private telecommunications networks, links EDS data centers, service delivery centers, and customer locations in 42 countries. EDSNET consolidates communications lines among computer centers, connecting customers to a fully integrated network. EDSNET provides backup capabilities for rerouting data in the event one part of the network fails.

We will also provide the state with the capability of performing unscheduled testing of backup telecommunications.

g. Convert to backup telecommunications if the primary telecommunications becomes unavailable.

If the MMIS becomes unavailable during the contract period, the State may require the Contractor to convert to the backup site. In this event, the Contractor will not be allowed to return to the original site without State approval. State approval will depend upon the Contractor's ability to demonstrate that the original site is again fully operational and that all terminals are available.

Our detailed Business Continuity and Disaster Recovery Plan identifies all databases, files, data sets, scripts, and prerequisites, including a conversion to backup telecommunications should primary telecommunications become unavailable. Our plan includes all elements necessary to conduct business after a worst case scenario that results from operator error, system failure, or a disastrous event at our data center or at the Vermont fiscal agent facility.

Our backup telecommunications plan includes use of our private nationwide network, EDSNET, for network connectivity. For local phone service, EDS contacts the telephone company to install wide-area telephone service (WATS) lines and local telephone lines at the temporary facility. These lines allow the continuance of provider relation services and telecommunications at the temporary facility.

In the event that a disaster causes us to relocate operations to a temporary facility as called for in the Business Continuity and Disaster Recovery Plan, we will not return to the original site without obtaining state approval and without first demonstrating that the original site is fully operational and all terminals are available. Our comprehensive approach to disaster recovery assures that we will take all reasonable measures to provide continuous service at the same level of quality and efficiency in times of distress that you have come to expect of us during the past 21 years.

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Customer Service Requests

RFP Reference: 2.6.16, p. 2-47

We are excited to work with you to meet the requests and mandates to maintain and modify the current MMIS. As we have demonstrated over the past 21 years, we adhere to processes that enable us to perform maintenance and modifications activities effectively and efficiently. We describe these processes in this section, including our approach to managing written customer service requests (CSRs) and project work flow, conducting weekly status meetings, and maintaining status documentation.

We use an automated system process called the Tracking Log (TLOG) system for managing maintenance and modification CSRs. This system stores information about CSRs and associated tasks in addition to tracking status, assignment information, milestones, and text notes. The system has the ability to categorize the work, prioritize the work inventory, and record and report on the number of hours expended on any task, CSR, or other definable event, such as vacation or education. The TLOG system provides a central repository for CSR definitions, storage, assignment, tracking, and reports.

During the Enhancements/Modifications Phase, we will work with you to tailor our process to meet your requirements. Whether a project or situation is a maintenance or modification issue, whether you or we have proposed the change, or whether the project results in minor or major changes, the CSR process provides a clear path to facilitate the outcome desired.

The following graphic illustrates the CSR process flow.

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We have shared several successes during the past contract years in a joint effort to improve the MMIS. The PC*Plus* project owes its success to our cooperative effort with you to match Medicaid beneficiaries to a primary care physician, thus creating a primary care case management program. There were 32 CSRs created and successfully completed to bring this program into existence. **For our dedication and results, the OVHA presented us with The Quality of Service Award for the PC*Plus* program in June of 2000.** Furthermore, we shared in the implementation of the Cash Controls project that implemented 12 windows and 13 reports within the MMIS and automated several processes that had been previously performed manually. This project helped to streamline the process and improve the time required to perform cash transactions and generate reports.

Contractor Responsibilities

RFP Reference: 2.6.16.2, p. 2-48

a. Provide the State with 5,000 CSR hours per year.

For each year of operations, we will allocate the granted hours for the on-site and off-site groups to perform system modifications. During this past year, EDS allocated 6,217 CSR hours. We will report all charges monthly by individual against the granted hours. We will seek your direction in the distribution of these modification hours in addition to your approval of all charges of hours against the annual total.

Our staff also performs all regular systems maintenance. The granted hour allocation used for modifications does not include the time that we spend in system maintenance. We provide our technical staff with the ongoing technical training needed to refresh skills and focus on learning updated technologies and capabilities. As the state requires new technologies and skills, we are prepared to provide a team that has up-to-date technical skills.

On a monthly basis, we provide a report that specifies hours allocated to CSRs worked during the past month as well as the remainder of hours for the current fiscal year.

b. Identify proposed system and process enhancements as CSRs or Plogs.

The PC*Plus* and the Cash Controls projects demonstrate changes to the system that have improved how you and we conduct business. Plogs have been employed to change or modify a process or function of a window. An example of such an improvement can be seen in the changes made to the REGV window that allowed Dick Higgins at the OVHA to use the Peek and Jump options to move from the REEL window to the REGV window to view dental vouchers. This Plog now saves Mr. Higgins time in obtaining voucher information on a beneficiary.

Recommendations for improving a process may come out of a flow diagram that is created by the Quality Improvement Process (QIP) team. Since many operations within EDS consist of a series of steps taken to perform a job or task, the QIP team finds efficiencies in these routines by making changes in staffing, allocation of time and resources, and enhancements to the system. Streamlining the process may save steps, staffing requirements, resources, and time to generate significant savings and a more efficient staff.

Implementing such changes or enhancements begins with the creation of a CSR. Examples of such CSRs have occurred with the bank reconciliation process and the drug rebate process. We now have better controls on cash management, and the bank file is sent electronically to the bank reconciliation process. Likewise, the CSR process has enabled us to automate drug rebate jobs and reduce the time to print and mail out manufacturer invoices.

c. Propose system and process enhancements when it is determined to increase efficiency and/or streamline operations.

During the past 21 years, we have implemented MMIS changes that have improved the way we work. In 1999, to better support you, we completed Vermont Platform Upgrade project (PUP), an upgrade project that improved the disk space, added new servers that increased processing capacity and speed of operations, and included many other enhancements to increase efficiency. The PC*Plus,* Cash Control, and HIPAA projects are only a few of the projects that have been jointly implemented to better support our mutual goals and objectives.

We have developed a process for entering and tracking CSRs from inception to implementation. The process begins with the introduction of a modification or enhancement in the form of a request from the state. The request is entered into a template and saved to a folder for review. All CSRs undergo a review and estimate of effort required. When the necessary approvals are obtained and the changes are prioritized, we implement and thoroughly test the requested changes to prevent any adverse impact. For all CSRs, we carefully monitor and document expected results and actual results and communicate efficiently and openly with you. Upon confirmation of satisfactory results in the model office environment, we implement the actual changes in the production environment and realize the expected improvement in efficiency.

d. Track and report progress on CSRs to the State with:

- **Weekly Progress Reports as to the current status of system changes.**

On Monday of each week, the CSR/Plogs Moved to Production report is created and routed to individuals at the state and EDS who need to know when CSRs are ready to be implemented in the production environment. The reports acknowledge CSR/Plogs moved to Production in CHAMP and note the move in the TLOG system, informing the state and us of any impending changes or enhancements to be implemented.

- **Monthly Summary Report with lists of all completed and outstanding CSRs with estimated personnel hours to complete them, by status and priority.**

In conjunction with the weekly CSR/Plogs Moved to Production report, an SQL query is run to capture data that is formatted to generate a monthly Excel report, which displays all CSRs in every status, with the exception of cancelled CSRs. The report includes columns with the CSR sorted by subsystem and ID, title hours worked, and status. A cover sheet accompanying the Excel spreadsheet displays the state-approved hours from 1994 to the present as well as the accumulated used hours. The most current years' listing specifies the approved hours for comparison against the used hours, thus displaying the remaining hours for the fiscal year. We review this report with you monthly during the fiscal agent meeting.

e. Retain each CSR for documentation and analytical purposes.

The initial documents, which consist of the CSR request form, supporting documentation, screen prints, and signed cover letter are filed in a "To do" drawer, by subsystem, for access by the systems engineer and the tester. The system manager e-mails a monthly updated Systems Engineer Priority List of CSRs sorted by systems engineer, with the associated project, if applicable, and estimated hours. This Systems Engineer Priority List report only contains pending CSRs. Upon completion of a CSR, the appropriate documents are stored in another file drawer labeled "Completed," again sorted by subsystem. When CSRs are more than a year old, we send them to the mailroom to be archived on microfiche. Under the new contract, we will implement a scanning solution to capture and store the CSRs electronically. This solution will allow for easier access to and retrieval of CSRs.

f. Be responsive to all CSRs from the State.

Within 10 business days, we will respond to all CSRs we receive from the state. This response includes an acknowledgment of the request, your priority assignment, a preliminary assessment of the effort required to make the change, and the assigned entry ID or control number from the TLOG system.

g. Acknowledge all State-initiated CSRs by providing a written response within 10 workdays of receipt of the CSR, with a clear and complete:

- **Understanding of the CSR.**

Each CSR request is written and entered in to a CSR/Plog Request template and stored in a review folder. Every Wednesday, the CSRs are copied from the Review Folder in advance and submitted for review by a committee comprised of a representative from the claims area, a provider service representative, the systems manager, a business analyst, the on-call system engineer, and the person who submitted the CSR. The CSR is reviewed for clarity of intent, presence of an impact statement, supporting documentation, and steps for testing. If rejected, the submitter can rewrite or make suggested changes to the CSR request or terminate the CSR process at the state's request. After the systems manager signs the approved CSRs, the CSRs are assigned to a systems engineer and tester. If approved, we

present the CSR, along with supporting documentation, to you at the next fiscal agent meeting. The state representative can reject or approve the CSR. Rejected CSRs that require revision are returned to the person who submitted the CSR, and approved CSRs are returned to the business analyst for further action.

Our review process and subsequent response to your customer representative for review demonstrates our understanding of the CSR and commitment to meeting your requests.

- **Assessment of any perceived problems that may impact operations.**

The CSR/Plog Review Committee reviews CSR statements for clarity of intent and for discussion around the process for implementing the request. We diligently note any potential problems that may arise when implementing the request. In addition, we present these issues for your review, along with any suggestions or alternatives to the CSR. We offer suggestions and alternatives when appropriate to obtain intended results while minimizing or altogether avoiding any adverse effects. After presenting the CSR to you during the weekly fiscal agent meeting, we route any issues or concerns regarding the CSR back to the CSR/Plog Committee for action. The Review Committee business analyst will not release any CSR/Plog unless it has been reviewed, approved, and signed by the systems manager, Cherie Bergeron.

- **Constraints and assumptions.**

Should there be any unresolved or questionable issues, the review committee and the systems engineer will make an inquiry to the state to achieve clarification and resolution. When there are concerns about meeting deadlines, estimated hours, budget, purpose of the CSR request, or other related constraints, we will address the issue with you in a timely fashion.

- **Proposed:**

  - **Solutions for any perceived problems.**

We will note any perceived problems in the CSR/Plog request for full resolution by the CSR/Plog Committee. If there is an uncertainty about the purpose of the CSR or problems in implementing the CSR request, the committee will promptly seek clarification from the state. These actions are performed in a timely fashion, avoiding unnecessary delays in implementing the CSR.

  - **Approach to implement the solution.**

Our presentation of the CSR will include a thorough description of our approach to implementing the solution. Furthermore, we will acknowledge your revisions to each CSR, changes in priority, or modifications of the expected completion date. The CSR/Plog Committee will provide continuous oversight and make recommendations to address the CSR request within the scope of the budget and time constraints imposed by concurrent CSRs or projects. Our solutions will be based on our experience and judgment of the best approach to addressing the CSR.

- **Schedule for completion.**

We will jointly review priorities, progress, and urgency levels to provide every possible assurance of our ability to adhere to the schedule for completion. When appropriate, we will discuss with you the CSRs delivered during the week. We document these weekly and monthly meetings in writing. The weekly meetings allow us to communicate about our progress and make any necessary revisions to accommodate your concerns and priorities.

- **Estimated effort detailed as appropriate by:**

  - **Labor in hours**

The assigned systems engineer will provide a reasonable estimate of time needed to complete the work requirements of the CSR. The systems engineer will try diligently to adhere to the estimate for the hours of work. Should an issue arise that requires further changes or that appears to be outside the scope of the initial estimate, we will provide you with a revised estimate of work hours to complete the request. All hours of work are recorded in the TLOG system and display in the weekly CSR/Plog Moved to Production report as well as in the monthly Hours report.

It is our intent to support both corrective action and modification maintenance requests from the state and, when permissible, work within a time frame and estimate of work hours that is mutually agreeable for completing a CSR from the state.

  - **Equipment**

Projects that are proposed for major design, planning, management, and implementation may require equipment to achieve the desired goal. In such cases, we will request the state's approval to purchase any equipment. We will always take into consideration the most appropriate selection with regards to need, cost, and time.

  - **General and administrative support in hours**

As detailed in a project plan, we will track and record the time provided by general and administrative support personnel in the TLOG system.

  - **Ongoing support requirements**

We will provide good-faith estimates to meet your ongoing support requirements. Our team will provide consultation to the state in the development of quality maintenance and modification requests. Modification and maintenance requests are tracked through our TLOG system. We combine the output from the TLOG system in the monthly status reports and work with the state during the monthly meetings to prioritize work assignments and to ensure maintenance activities are not adversely impacted when we develop or implement other unrelated system modifications. This includes all maintenance activities necessary to achieve the continued efficiency of the VermontAIM.

- **Provider and/or user training**

The program services unit has implemented a training program for the VermontAIM that is offered upon request. We will provide the state with estimates for provider and user training based on our experience in serving the provider community and the state. We routinely offer training for new providers in a group setting; however, individual training and refresher are offered upon request as well. As changes occur in the VermontAIM, we will provide training to appropriate state and EDS personnel. Training is also offered to providers for the electronic claims submission (ECS) software for electronically submitting claims to EDS.

- **Documentation**

We promptly and thoroughly document all additions or changes to windows, reports, edits, and audits resulting from CSRs. Furthermore, we write and obtain approval for any changes or additions to windows prior to saving them to the user manual. Reviews or the addition of new edits and audits are written to a template and saved to the resolutions manual. When we make changes, we provide you with copies of the changes or additions to the user manual and resolution manual. We also archive the CSR request with supporting documentation in a file drawer for future reference.

- **Contract costs per contract year**

We will make every effort to keep the costs of business within the contract costs per the contract year. Any additional projects that might result in overrides to the contract will be provided to the state for consideration. Prior to implementation, we will obtain approval from you for any additional projects or services beyond the contract. Our history with you has demonstrated our good-faith effort to stay within the contract costs per contract year, and we will continue this approach in our future endeavors.

h. Complete CSRs by the State's "target date." If the CSR cannot be completed by the "target date," the Contractor must submit a revised completion date to the State, and seek State approval of that date.

Should we determine that we cannot meet a target date for a CSR, we will immediately submit a revised completion date and seek your approval of the revised date. There were 64 CSRs reviewed during the past six months. Of the 64 CSRs, four exceeded the estimated date of completion, which translates into a success rate of 93 percent. However, our goal is to achieve 100 percent compliance with the estimated completion date.

MMIS Access Requirements

RFP Reference: 2.6.17, p. 2-49

Today, more than 280 state and EDS personnel have rapid access to the VermontAIM. There are also 7,000 active providers who regularly access the eligibility verification system. We have more than 21 years of experience supporting the OVHA and the connectivity between the state and EDS. We also maintain connectivity between the EDS Vermont account and the GovNet network. EDS' experience extends to Delaware, Rhode Island, New Hampshire, Idaho, and several other states where we provide access to the MMIS through state-run networks. EDS has the ability to draw from an extensive knowledge bank for network support.

In our response to 2.6.17, we will describe the many methods available to the state and other authorized users to access the VermontAIM system.

Contractor Responsibilities

RFP Reference: 2.6.17.2, p. 2-50

a. Provide and maintain:

- **All telecommunications circuits between the Department of PATH Central Office in Waterbury, VT and the Contractor's facility.**

The EDS account facility is currently connected to GovNet and will continue to use this as the communications backbone for the MMIS, providing connectivity between the Department of PATH's central office in Waterbury, Vermont, and our office in Williston.

- **Direct connect and/or dial-up capacity.**

Through EDSNET, our proprietary network, EDS maintains connectivity to other facilities and states, as well as to GovNet (direct connect) to provide access to the MMIS for Vermont state users. We also maintain dial-up capability for all EDS account personnel.

- **Eligibility verification with automated voice response, seven-days-per-week, 24-hours-per-day, excluding State-approved downtime. RFP section 2.7.1.A contains additional description of REVS.**

We will continue to provide uptime 24 hours a day, 7 days a week for remote eligibility verification (REVS) and automated voice response (AVR). All planned downtimes and maintenance windows will take place after receiving state approval.

- **Remote user access to voice mail and e-mail.**

EDS users have access to their voice mail, regardless of location, and authorized EDS users may connect to their e-mail remotely as well.

b. Ensure that the appropriate levels of security and access are established to prevent unauthorized access, and/or inappropriate use and updating.

Restricting access to authorized users only is a primary security function that we provide. We will restrict the availability of data to appropriate staff and other designated individuals and organizations using standardized system applications and data security capabilities. EDS will provide a secure environment for both online and batch access to the MMIS data through the use of fully implemented and documented security software. Our security procedures and controls will prevent unauthorized access and inappropriate use and updating.

c. Prepare data transfer to EVAH (e.g., report data, file extract data, billing information) for users for statistical data manipulation.

EVAH will continue to receive data from the MMIS as it does today. With the MMIS data transferred to EVAH, users will have the ability to perform statistical data manipulation using the BusinessObjects tool. For more information on the EVAH system, please refer to our response to RFP requirement 2.7.10 in the "Ad Hoc (EVAH) Subsystem" subsection in the "G. Overall Approach" section.

d. Provide online:

- **Inquiry and update access to files through dial-up or other telecommunications links for other State entities (e.g., contractors) performing MMIS-related responsibilities.**

State entities will have inquiry and update access to the VermontAIM through the use of online screens. Any authorized user on GovNet, whether in the Department of PATH or a state contractor, will have access to the MMIS online windows through GovNet.

- **Security and access measures (e.g., user names, passwords) that ensure appropriate levels of online update and inquiry are granted to users based on each individual's work requirements.**
- **Hardware, software and communications support for:**
  - **Online access including line charges for Department of PATH LAN.**
  - **Interfaces with the Department of PATH LAN and PCs.**
- **Direct user access seven-days-per-week, 24-hours-per-day.**
- **Remote user access from 6:00 a.m. to 6:00 p.m., local time, Monday through Friday, and additional access with one workday's notice.**
- **Access to designated State personnel within five workdays of the request.**
- **For users to access new fields as authorized by the Department of PATH.**

The type of access granted will depend upon the state's specifications and will be user-specific. The online system has the capability to maintain user security settings such as IDs and passwords, window-specific security, and expiring passwords. In addition, the EVAH system has the ability to grant access to specific fields for authorized users. EDS will maintain the security settings for all the users on the online system based on requests received from the state. In addition, we will process security requests received from the Department of PATH within five days from receipt of the request. For most requests, actual processing time will be significantly less than five days.

Remote access to the online system for all users will remain, as it is today, from 6 a.m. to 6 p.m., local time, Monday through Friday. State users will be given additional access time, as requested, with one workday's notice. Authorized EDS users will have access to the MMIS 24 hours a day, 7 days a week.

We will retain the hardware, software, and telecommunications lines (including charges) necessary to maintain our connectivity to GovNet. This will enable EDS to interface with the Department of PATH's LAN, as well as other state entities.

e. Establish a central point of contact to coordinate with the State's central point of contact for MMIS access

Our systems administration team will continue to serve as a central point of contact with the state to coordinate MMIS security and access requests. The designated systems administrator receives requests from the state through e-mail and promptly performs the necessary updates for the request.

f. Maintain:

- **State-of-the-art and user-friendly, access, inquiry, and update capabilities that allow authorized Department of PATH personnel to access MMIS files for reporting, based on user needs.**

We will provide and maintain online windows with graphical user interfaces (GUIs) developed using Sybase's PowerBuilder product. The PowerBuilder-designed windows are being implemented as part of the HIPAA project and will be available in July 2003. The GUI windows are easy to learn and extremely functional for users, offering the state-of-the-art, user-friendly access, inquiry, and update capabilities that will enable authorized Department of PATH personnel to access MMIS files for reporting, based on user needs. These windows feature standard user interfaces similar to those found in Microsoft Windows, including scrollbars, context-sensitive help, and multiwindow capabilities. For example, a beneficiary window and a claims window can be open simultaneously on a user's desktop, and users can navigate using either drop-down menus or hierarchical menus.

- **Agreements and contracts for maintenance for each access mechanism.**

We understand the importance of each access mechanism and will therefore maintain each mechanism as appropriate. We will work with you to develop any agreements and contracts necessary to ensure ongoing connectivity to the MMIS.

Electronic Claims Submission (ECS)

RFP Reference: 2.6.18, p. 2-52

EDS supports multiple submission options available for providers to submit claims electronically and enjoy the many benefits of ECS, such as fewer claim rejections and faster turnaround on payment. Using the required HIPAA specifications, providers can configure their existing computer systems to create electronic files for submission directly to EDS. They may also choose to use a clearinghouse or take advantage of our free software, Provider Electronic Solutions. No matter what option providers choose, EDS will have already tested and approved providers to enable them to submit electronic claims using HIPAA-compliant standards.

> The free billing software which EDS provides to providers is second to none. There would be very few problems with billing if all providers could use this software.
>
> --Alecia Armstrong, president
> Vermont Mental Health
> Counselors Association

We designed the ECS options with the objective of providing a faster and more efficient method of claims submission and processing, which results in faster claims payments to providers. ECS also reduces errors, since the claims are sent directly from a computer system or clearinghouse to our system with no intervention.

One way in which EDS has successfully used ECS is through the free software we offer to the providers. Our newly updated, HIPAA-compliant Provider Electronic Solutions software demonstrates our commitment to offering more convenient electronic options to the provider community. Provider Electronic Solutions software supports the processing of claims transactions for claim types, including:

- Dental
- Home Health
- Inpatient
- Nursing Home
- Outpatient
- Professional

This software is the direct result of visionary leadership. It gives the OVHA the tools to deliver manifold benefits to the providers of health care services. Extensive up-front editing allows for the ability to correct many of the common errors that cause claims to deny. The results are a significant improvement in the number of claims paid on the first submission as well as an improvement in cash flow for all providers. In addition, the Provider Electronic Solutions software contains a mechanism to quickly and accurately determine beneficiary eligibility, resulting in fewer denials.

While the software is extremely user friendly, individual or group training on the software is still always available for the providers. In addition, we increased our electronic data interchange (EDI) support and the EDI coordinators, Nancy Gagné and Mary LeFebvre, work closely with the Provider Services Unit to prepare workshops on billing procedures and instructions on how to successfully use the software. Support and education is imperative for providers, especially during HIPAA implementation. We are here to ensure all providers' questions and issues are addressed for ECS to be a successful method for everyone.

Providers using our HIPAA-compliant software or any other vendor-approved software will have from July to October to adapt to the system changes and billing processes mandated by HIPAA. We will lead all providers through education and testing of their systems, resulting in claims being submitted by providers in HIPAA-compliant standards. These efforts will ensure providers can continue to successfully submit electronic claims in 2004 and beyond.

Contractor Responsibilities

RFP Reference: 2.6.18.2, p. 2-52

a. Provide:

- **ECS (i.e., data entry and transmission) software for use by all providers to submit claims electronically.**

  EDS has developed HIPAA-compliant software—available for free, including updates—for providers to use in submitting claims electronically. The electronic claims submission software for Vermont is Provider Electronic Solutions, which is the same product that Vermont uses today. Provider Electronic Solutions gives PC-based providers the data entry and batch submission capabilities needed to submit claims electronically. Our free software will enable providers to submit claims over the Internet or through modem transmission. All claim transactions entered through the Provider Electronic Solutions software are routed through the translator server for mapping and then routed to the Vermont MMIS servers for processing. The translator will be used for both the upload and download of information for the providers.

- **Technical assistance to respond to providers who utilize ECS and are experiencing use and/or transmission problems.**

  In Vermont, EDS' EDI Coordinators Nancy Gagné and Mary LeFebvre are available to assist providers who experience transmission problems or have difficulty using the Provider Electronic Solutions software. They have the technical ability to assist providers with any questions. Electronic claims submitted by the providers are routed directly to the translator server for processing.

The translator only accepts electronic claims that have passed all editing requirements. Claims rejected during editing are reported back to the provider shortly after submission, informing the provider of the reason for rejection. Our EDI coordinators will also assist providers who have questions about why their claims were rejected. In addition, Nancy and Mary have a new joint e-mail address, designed specifically to enable providers to submit any questions or concerns they have by e-mail, if desired.

- **A HIPAA compliant ECS protocol**

EDS has been heavily involved in the legislative and regulatory processes to establish the HIPAA requirements. Our system is designed to support the HIPAA standards for transactions, code sets, and identifiers, and to comply with HIPAA security and privacy requirements. We have created HIPAA-compliant software for the providers, and once implemented, we will meet all HIPAA transaction set regulations.

- **Software and hardware to monitor transmission and output data at Contractor's Vermont facility.**

Providers that are submitting electronic claims either over the Internet or by modem transmission will send their transactions directly to a Web application. The Web application then sends these transactions to the translator that is located at an EDS facility in Connecticut. The translator will accept HIPAA-standard transactions and will convert them into transaction formats specific to the Vermont MMIS. Providers may also send their claims to EDS on tapes or diskettes. We will load these transactions and send them to the translator for processing. The EDI coordinators have the software and hardware that is necessary to access the translator to monitor all transmissions, as well as check any output data.

b. Accept claims from providers via:

Requirement	EDS Response
Telecommunications devices	Yes
Direct computer exchange	Yes
Tape	Yes
Clearinghouse organization	Yes
Diskettes	Yes
Other media	Yes

There are many different forms of media from which providers may select for sending electronic claims to EDS for processing. Some of these include telecommunication devices, Internet downloads, and magnetic tapes and diskettes. In addition, providers may also choose to send claims through approved clearinghouse organizations. With EDS, providers have numerous ECS options, allowing them to select the most efficient method for successful claims submission. These options allow for a fast turnaround in processing, resulting in quicker claim payments to the provider.

c. Ensure that technical assistance is provided for designing the interface requirements of the provider's computer software to meet current or revised billing requirements

To meet the standards mandated by HIPAA, EDS has created Vermont MMIS HIPAA technical specifications and companion guides that assist providers in creating electronic claims files for EDS. The specifications and guides contain the necessary information for providers and their vendors to write programs with all required data elements. These documents will ensure that all required data fields are properly completed so that the claim files can be successfully processed. The EDI coordinators are also available to provide assistance to ensure that providers are complying with the rules and regulations as mandated by HIPAA.

d. Provide ECS software to providers that:

- **Is "user friendly"**

Provider Electronic Solutions is the software developed by EDS to allow electronic claims submission by Internet, modem, tapes, diskettes, and clearinghouse organizations. The software is very easy to load and takes the provider through step-by-step setup instructions. One of the features available in Provider Electronic Solutions that eases the data entry workload is called Auto plug. Auto plug allows for the creation of a reference list, which enables providers to instantly fill out some of the fields on the required windows. The software is also equipped with a help function that assists with any questions providers may have on fields within the software. If providers need help with any of the fields, they simply place the cursor on the field in question, click the designated function button, and the help window for that field will come up for the provider to review. In addition, some of the help windows will list valid values to facilitate billing completion for the provider.

- **Requires little user training**

Providers using the software for electronic billing will find the software intuitive and easy to use. EDS' Provider Electronic Solutions software is a Windows-based application that relies on many of the same functions and features offered in Microsoft Windows. Although minimal training is required to use the Provider Electronic Solutions software, EDI Coordinators Nancy Gagné and Mary LeFebvre are available for on-site installation and training with the provider community.

Providers have agreed that the best training on the software is hands-on training. Therefore, we will provide ongoing training to providers on a group or individual basis, as appropriate. In addition, there are help fields within the software, and information about billing is available in the user manual. Once providers have used the software for a short time, they find they are able to complete their billing with complete ease.

- **Allows for as much editing as feasible before transmission**

The Provider Electronic Solutions data entry software has editing capabilities to ensure the presence and validity of required fields. The software has many edits that are unique by claim type and were developed according to MMIS claim submission specifications. All required fields are checked for presence and format to make sure the field is properly completed prior to transmission.

e. Include all appropriate ECS information in the Provider Manual.

Detailed and user-friendly billing instructions for all providers are key to accurate and timely claims adjudication. We develop, design, and distribute provider manuals and training materials with the state's approval. As an addendum to the provider manual, we have developed companion guides. These guides provide comprehensive and detailed electronic claims submission information for the providers to use when billing their claims electronically. This information is available to all providers and can be easily accessed from the Web site.

f. Distribute ECS software updates to providers within seven workdays of system change implementation.

The Provider Electronic Solutions software has a feature enabling providers to obtain new upgrades immediately upon implementation. These upgrades are available when billing requirements change or when updates are made to the software for any reason. While we will directly notify the providers when an upgrade is ready to be downloaded, users will also be prompted with a message from the software that asks if they want to check for upgrades.

Providers can use the Provider Electronic Solutions software to download updates directly. Once a provider has downloaded the file, he or she will simply execute an application in the software to automatically install the upgrade. After this simple installation, providers can begin using newly upgraded software immediately.

g. Create incentives to increase provider participation in claims submission via ECS.

We will actively continue to promote to the provider community the cost-effectiveness and efficiency gains associated with electronic data interchange. These benefits and efficiencies will serve as incentives to encourage increased provider participation in claims submission through ECS.

We will also work with the state to offer additional incentives for providers to use the most effective transmission media. We will continue to inform providers about the variety of electronic methods available for electronic billing and work with them to finalize appropriate formats for the data transfer of claims data. We publish information about these electronic options in the provider enrollment packet, in the Advisory newsletter, the remittance advice banner page, and during provider visits. We want to fully support the state in helping the provider community to take advantage of the time-saving, cost-saving, error-reducing benefits of electronic claims submission.

h. Maintain:

Requirement	EDS Response
The capability for providers to accept Remittance Advices (RAs) through HIPAA-compliant EDI	Yes
ECS logs of all transmissions (e.g., successful, failed).	Yes
All current EDI standards	Yes
The capacity to transmit Remittance Advices as part of a HIPAA-compliant claim transaction.	Yes

HIPAA requires that providers and payers exchange data in standard formats. To meet HIPAA requirements, we use a translator to process transactions exchanged by the MMIS and providers. We have developed a Web application that meets the requirements for functional acknowledgments and new data formats. This Web application offers increased security, faster transmission, and a simple user interface. It enables providers to submit batch transmissions and provides the ability to deliver electronic remittance files for providers to download. Providers who do not currently have access to the Internet will be able to dial into the Web server through Microsoft Windows' Dial-Up Networking application.

The translator is also made up of several programs that log events to a single file that will be available to the EDI coordinators. The log file will provide an audit trail of the movement of data through the system and will alert account staff of situations that require intervention.

i. Update ECS software, hardware and processes to remain current with technology and provider needs.

We continually upgrade the ECS software and hardware to match the changes we see in technology and to remain current with technology and provider needs. The most recent and significant change to our software and hardware came with the implementation of HIPAA. We have upgraded our hardware to be able to accept file layouts in the HIPAA formats, and we will continue to make enhancements as changes are needed. Providers that choose to use our free software product, Provider Electronic Solutions, will find it has been updated to meet all of the changes required by HIPAA, along with many new, useful, and exciting enhancements. The product functions remain the same and will look familiar to the providers, making the transition to the new HIPAA-compliant software effortless.

j. Designate an appropriate signer for provider agreements; the Contractor is authorized to sign provider agreements.

We will maintain Trading Partner Agreements for billing agencies, clearinghouses, and providers submitting electronic claims. Our EDI coordinators are authorized by the state to sign and maintain the agreements. The agreements are kept in a secure file at the EDS office in Williston.

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System and Acceptance Testing

RFP Reference: 2.6.19, p. 2-53

The system and acceptance testing provides a roadmap for both the OVHA and EDS to validate that the system is ready for production. Our comprehensive and thorough test plan encompasses the following subsystems: claims; drug rebate; early and periodic screening, diagnosis, and treatment (EPSDT); financial; Enhanced Vermont Ad Hoc (EVAH); long-term care (LTC); management and administrative reporting subsystem (MARS); prior authorization; provider; recipient; reference; surveillance and utilization review subsystem (SURS); third-party liability (TPL), and the voice response system (VRS).

The decisions made in the various committees of the Vermont Legislature result in requests for modifications to Vermont's health care coverage programs. Our in-depth understanding of the system and experience in testing the system allows us to leverage our experience to develop and thoroughly execute tests that meet these time-sensitive requests. By forming a committee that includes cross-unit team members to review requests for the testing of all enhancements and modifications, we have strengthened our proposed resolution to meet our quality assurance expectations.

Contractor Responsibilities

RFP Reference: 2.6.19.2, p. 2-54

a. Ensure that the ITF-type model office environment has the capability to:

- **Simulate the actual production environment.**

  To successfully demonstrate how we will validate the acceptance testing subtask, we offer a model office environment that mirrors our production database. The VermontAIM uses copies of production input and master tables to simulate an actual production environment. Financial cycles that parallel the current production system are run twice a week, allowing the testing coordinator to review the test results in a timely manner and retest when necessary. This identical-to-production environment provides a roadmap for the OVHA and the Vermont-based team to verify that the system is production ready. Because our ITF model replicates our production environment, we are able to identify and resolve issues that might otherwise have caused concern upon promoting the code to the production environment.

- **Allow for unique identification, and processing of test provider and beneficiary data, and claim processing files.**

The business analyst performing the testing can manipulate the beneficiary, provider, and reference files as needed to obtain a true test of the specific conditions during claims processing. Claims submitted through all media available will be processed with a unique identifier, such as an internal control number (ICN), for claim tracking purposes. The ICN identifies the day of receipt of the claim, the submission media, batch range, and sequence number. An example of where additional identifiers might be required can be seen with the General Assistance (GA) Program where a beneficiary is not eligible for Medicaid benefits, but is eligible for emergency services when a valid GA voucher is present. In this case, the beneficiary could be identified by Medicaid ID number, and program enrollment would be the assignment of the aid category—GA or GE. We set up an edit (ESC 625) to allow reimbursement for these beneficiaries under the funding source for the General Assistance Program only when a valid voucher was on file. For beneficiaries without a valid voucher on file, the claim sets the edit and reimbursement for the service is denied. The claim history windows carry the funding source for reporting of expenditures by agency.

- **Mirror actual production except for the change being tested.**

To set up valid test scenarios, the staff member performing the test of the change has security clearance to the appropriate reference files in the model office testing environment. This may include modifications to the beneficiary, provider, or reference files, which are performed online. Aside from these modifications for the specific change being tested, the model office environment mirrors the actual production environment.

For example, if we receive a request from the Department of Aging and Disabilities to restrict revenue codes WCE (Enhanced Residential Care Home Health Waiver—Tier 1), WCF (Enhanced Residential Care Home Health Waiver—Tier 2), and WCG (Enhanced Residential Care Home Health Waiver—Tier 3) to provider type T14 (Aged/Disabled Home Health Waiver), we would set the RFPR—Procedure code reference file in the provider type restrictions field to include only provider type T14. This change would cause claims for any other billing provider submitting claims with these revenue codes to set edit 711 and be denied as a mismatch between procedure/provider type only in the model office environment.

- **Process test data/files separate from routine processing.**

The model office section of our system runs on a platform separate from the routine processing environment, also known as the production environment. Our test environment includes daily, weekly, monthly, and annual cycles that model production. We have the capability to set these processes up to run as often as needed to be able to retest and validate data.

- **Separate and identify test data/files output from routine processing output.**

Because our model office test system is run on a different platform, the windows, files, commands used to produce output files, reports, and other such data are separate and specific to this system only. Model office screen prints that are used for validation of tests are identified as such in the upper left-hand corner of the window.

- **Test data/files in various formats (e.g., paper, online, electronically).**

We can demonstrate through integrated testing that we are prepared to test data and files in all media. Our Viking data entry software allows us to enter test criteria for paper submission, and our Provider Electronic Solutions software allows for the submission of electronic test cases. We are also able to accept an online file and run it through our model office database.

b. Operate, maintain and support efficient, effective and comprehensive online system and acceptance testing functions, files and data.

EDS' experience within the integrated testing facility (ITF) functions demonstrates our proficiency in operating and maintaining support of the online system for acceptance testing and maintenance of test data.

c. Monitor actual operations against internal controls and test results.

Claims created and loaded to test claim processing edits and audits, beneficiary program benefits, and reference file integrity are monitored by producing screen prints and reports of the results for validation. The model office system runs on a real-time basis, just as with production, which allows the tester to repeat testing as often as necessary to ensure the test plan will be completed within the time specified in the project plan.

d. Identify and report any edit discrepancies, including negative reports.

After running the test, we compare the actual results with the expected results recorded in the written test plan. If the test produces an unexpected result, the tester records the data in the test plan, discusses the correction needed with the person performing the coding, and retests the modifications, recording each step.

e. Correct deficiencies as identified through internal controls and test results.

If we find that a manual function is required as a result of the initial testing, we will re-examine the procedure flow to enact necessary changes to correct any deficiencies and retest as often as necessary to meet deadlines. We will record the results of each test in the test document.

f. When a new edit or audit is designed, process sample test claims, verify results for accuracy, and submit results to the Department of PATH.

As the Vermont-based team receives requests for the design of a new edit or audit, we create a CSR, detailing the steps to be taken to complete the task. The test plan includes reference files that need to be created and dates that need to be included, as well as a plan for testing and notifying the provider community. An example of this process can be seen in the creation of edit 254 as the result of a legislative mandate, eliminating chiropractic visits for adults effective November 1, 2002. We met the request promptly and processed sample test claims, documenting and verifying the results for accuracy, and submitting the results to you for review. Our testing coordinator will continue to work closely with your designated appointee when verifying test results. We can perform this task online or through a paper trail of documentation sent using our courier.

g. Retain test outputs separate from regular outputs for the duration of the contract period, and clearly label these outputs as "test outputs".

EDS has incorporated enhancements to its CSR/Plog finalization process to ensure that all requests are fully documented and labeled as test outputs before being stored for historical purposes. We have an area within our office that is designated as the storage area for CSRs/Plogs. At the present time, we are microfilming this documentation on a yearly basis. However, under the new contract, we will replace the existing microfilm process with a document imaging system. A further explanation of the document imaging system will be covered under another segment of the enhancements proposed.

h. Provide the State with online inquiry and update access to view results of the ITF.

We will provide the state with online inquiry and update access for viewing acceptance test data from the ITF. We will also coordinate a schedule between the state's designated appointee and the testing coordinator for the sharing of the acceptance testing function.

i. Produce and review all control reports generated for each update and processing cycle.

The VermontAIM will produce a complete set of control reports generated for each update in the model office processing cycle for review.

j. Maintain staff dedicated to oversee, operate and review test output for quality assurance and data/file integrity.

Our Vermont-based team currently has two dedicated business analysts—Judy Isham and Perry Melvin—who are dedicated to overseeing, operating, and reviewing test output for quality assurance and verification of data/file integrity. Judy and Perry share test results, request provider community notification, update documentation, and work with other units within EDS to ensure that we consistently deliver a quality product.

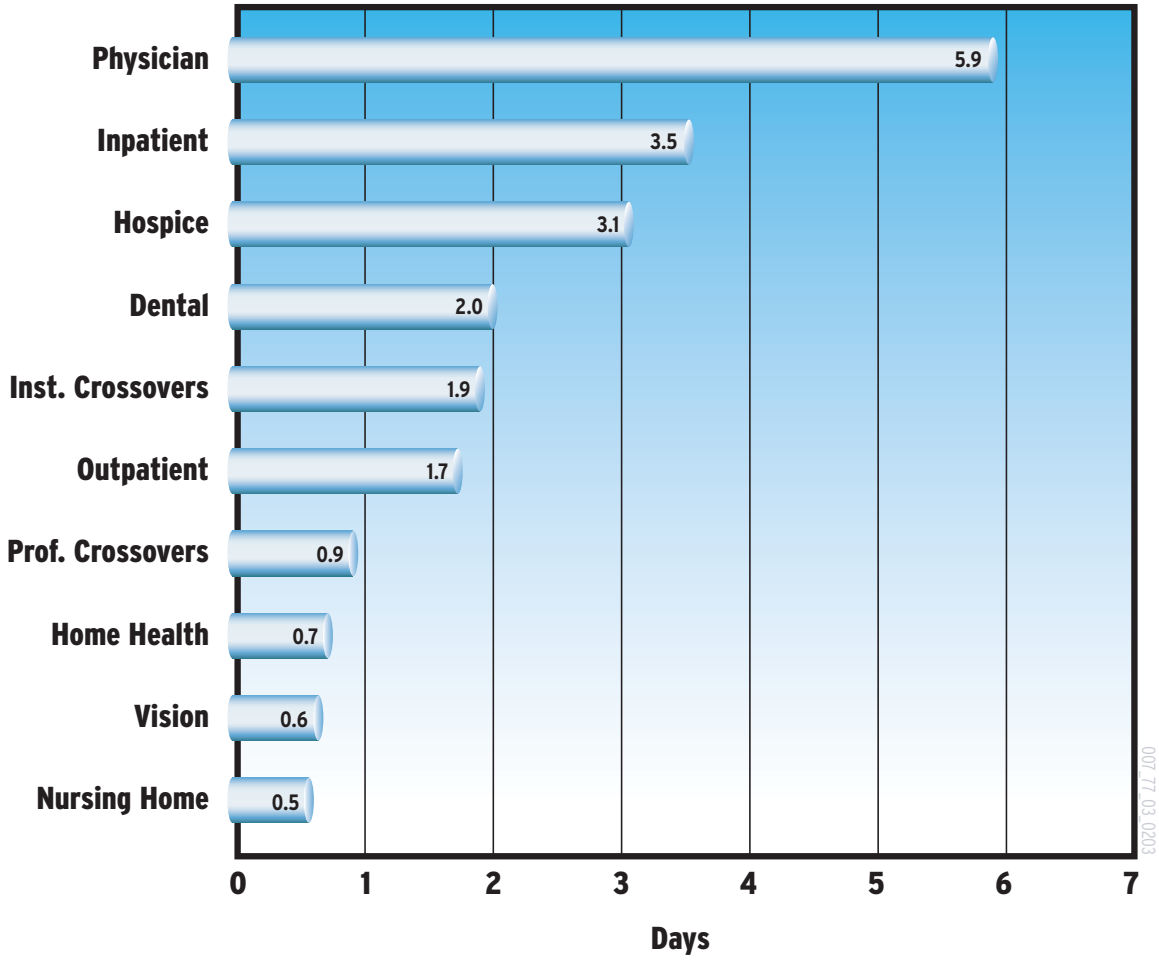
Timeliness of Processing

RFP Reference: 2.6.20, p. 2-55

The VermontAIM system supports timely claims processing by automatically applying the Department of PATH's complex pricing structure along with edits and audits to all claims received. A high level of electronic claims submission—80 percent to 85 percent—also supports timely processing. We expect the percentage of electronic claims to rise with the implementation of the Health Insurance Portability and Accountability Act (HIPAA).

The report depicting the average days from receipt to adjudication clearly shows that on average all claims are adjudicated in fewer than six days from date of receipt—well below the required 30 days.

EDS Processes Claims Much Faster Than Required



EDS has a record of far exceeding the 30-day turnaround standard for processing claims from receipt to adjudication. The average turnaround time ranges from .5 days to 5.9 days.

Contractor Responsibilities

RFP Reference: 2.6.20.1, p. 2-55

a. Process:

- **ECS claims within 24 hours of receipt.**

  Our Vermont electronic data interchange (EDI) coordinator Nancy Gagné and her support team ensure that all electronic claim submission (ECS) claims received daily are loaded into the MMIS within 24 hours of receipt. We receive ECS claims by electronic transmission, diskette, and tape.

  For tracking purposes, we log all electronic media received at time of receipt and at the time of load. We check the production load summary report daily for any files that may have errors. If an error is identified, Nancy, Perry Melvin, or Mary Lefebvre then contacts the provider for resubmission. **We process more than 3.5 million ECS claims annually.**

Praise of Online Billing and Customer Service

"Online billing works great—customer support for this service is also top-notch!"

--Martha Stretton, Ph.D.

- **Paper claims with 30 calendar days of receipt.**

  Our courier, Vern Johnson, makes two daily trips to the post office to pick up mail and drop it off in the mailroom. From the mail room, paper claims are delivered daily to our document control team, which opens, sorts, batches, and films claims before they go to the data entry team for processing. Claims ready for data entry are placed on shelves and keyed in the order they are received. We process clean paper claims within 30 days of receipt. On average, paper claims are processed within 10 days of receipt.

b. Properly adjudicate 100% of all:

- **Clean claims within 30 calendar days of receipt.**

  All claims that do not set edits or audits in the VermontAIM system are considered to be clean claims. All clean claims process and adjudicate within 30 days of receipt. **On average, clean claims submitted electronically adjudicate within 48 hours of receipt and clean paper submissions within 10 business days.**

- **Drug transactions within 30 calendar days of receipt.**

  Currently, Vermont's Pharmacy Benefits Manager (PBM) is responsible for processing drug transactions. Once pharmacy claims are processed by the PBM, they are transmitted to EDS for payment processing. The pharmacy claims/transactions received are paid in the next appropriate weekly payment cycle.

- **Provider-initiated requests for adjustment within 60 calendar days of receipt.**

  The Vermont adjustments team will continue to maintain an adequately staffed adjustments unit to handle voids, credits, and debits in a timely manner. We will process adjustments within 60 days of submission, except where the state-approved processing methods require more than 60 days. The typical adjustment is a request to modify the original submission from the provider, changing units of service, procedure code billed, or the billed amount on the claim. We process an adjustment to a paid claim to correct claim data and/or alter payment.

  While providers initiate most adjustments, the Department of PATH and EDS personnel may also initiate adjustments if the situation warrants. Once an adjustment request is received, it is scanned, batched, and given to the adjustments team to process within 60 days. **Our adjustments team processes more than 80,000 adjustment requests from providers every year.**

c. Meet timely filing criteria, including:

- **Adjudication adjustments must be completed within 24 months from the date of service.**

  In following the guidelines of the Department of PATH, the adjustment team will not process any adjustments when the claim is submitted more than 24 months from the date of service (DOS). Adjustment requests that cannot be processed due to age are returned to the providers with an explanation of the policy. Edits in the MMIS will not allow payment on an adjustment more than 24 months from date of service without a state override.

- **Properly process received claims within six months from the date of service.**

  The VermontAIM audits all claims submitted for timely filing guidelines set forth by the Department of PATH. Claims received within the timely filing limit (section 1.2.15 of the Provider Manual) are processed and adjudicated within 30 days of receipt. Claims received that suspend for timely filing must have a previously denied submission in claims history or an authorization from the Office of Vermont Health Access (OVHA) to be overridden for edit 418 (Claim not filed within the time frame allowed).

- **May not process a claim that is older than 24 months from the date of service without an override authorization from the State.**

  All claims that suspend for edit 403 (Claim past two-year filing limit) must have a valid authorization from OVHA to be processed for payment.

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Correctness of Payments

RFP Reference: 2.6.21, p. 2-56

To ensure the correctness of payments, the state hired the independent auditing firm KPMG-Peat Marwick to perform an on-site review of the claim administration operation and the readjudication of a random sample of claims.

This sample included 400 claims paid during the period from January 1, 2000, to June 30, 2001. The claims were reviewed to:

- Assess the accuracy and consistency of claims processing
- Benchmark the performance of EDS in the areas of financial accuracy, payment accuracy, processing accuracy, and turnaround time
- Review the interpretation and application of benefit plan provisions
- Assess the limitations of the claims adjudication system

The chart below lists the findings submitted as a result of this audit.

KPMG Claims Processing Audit Findings

Performance Measurements	EDS Results	Industry Standards
Net Financial Accuracy	99.9 percent	99.0 percent
Absolute Financial Accuracy	99.8 percent	99.0 percent
Payment Accuracy	99.0 percent	97.0 percent
Processing Accuracy	98.5 percent	95.0 percent

Although initial findings from KPMG-Peat Marwick identified six claims processed in error, we were able to provide documentation and explanations to show that all six claims were processed according to OVHA policy. For example, on two nursing home claims, EDS paid the total allowable amount without applying the deductible, which resulted in what the auditor believed was an overpayment. Both claims were for nursing home stays in which patients were discharged before the last date of the month. According to OVHA policy claims procedures, deductibles are applied to nursing home claims only if patients are in the nursing home on the last date of the month.

Contractor Responsibilities

RFP Reference: 2.6.21.1, p. 2-56

a. Ensure that all payments made through the MMIS to enrolled providers are for approved services, and in accordance with Federal and State payment laws, regulations, procedures and guidelines.

All services approved for reimbursement by the Department of PATH are fully edited for correct pricing and limitations by the edit/audit logic within the MMIS. Our Utilization Review team, under the direction of Ramona Godfrey, works closely with Gloria Jacobs and Roger Tremblay of OVHA to implement new codes, rates, and limits. We follow all regulations regarding the federal and state payment laws when reimbursing provider claims.

b. Identify claims and drug transactions that have been incorrectly processed, and enact appropriate action to correct processing outcomes.

EDS' proven claims pricing function automatically calculates the allowed amount for either a service or a claim. We use a number of pricing methodologies that include level 2, level-of-care, per diem, resource-based relative-value scale (RBRVS), lab, max fee, anesthesia, transportation, and pricing formulas. The pricing function includes the ability to accommodate deductions to the calculated allowed amount, including recipient co-payments, spend down, or payments from other insurance carriers. The pricing methodology applies for new day claims, crossovers, and adjustments. The system maintains date-specific prices on the reference- and provider-specific rate tables.

When a provider identifies that an error has been made in the payment of a claim, the provider can submit an adjustment to correct the error. If a provider gave two units of a service but billed for only one, for example, then the claim would pay less than the provider expected. The adjustment would correct the claim in history and provide the additional payment.

When a processing error is identified by the provider during a communication call, the communication clerk pulls a copy of the claim and resubmits it for payment. If the claim was inappropriately denied, the clerk resubmits it for payment. If the claim was keyed incorrectly, the clerk submits an adjustment request. Any processing errors are then forwarded to the claims processing team lead so additional training can be provided to team members.

c. Provide the State with immediate verbal notification, and written notification within 24 hours of the discovery of:

- **Overpayments, duplicate payments or incorrect payments, regardless of cause with recommended adjustment process to recoup overpayments or mistakes.**
- **Any errors that result in potential provider overpayment or other incorrect payment, and recommend a Corrective Action Plan.**

When we identify an error in payments to a provider type or group, we notify the appropriate staff at the state and take actions to correct the situation. The issue that caused the overpayment or underpayment is identified on a corrective action plan form that states the issue, responsible party, actions to be taken, and resolution. We again notify the state during the weekly fiscal agent meeting.

The following exhibit shows a copy of the corrective action plan form.

Corrective Action Plan

Corrective Action Plan

Date: _____

Responsible Manager **Priority**

	Barb Davis		Urgent
	Cherie Bergeron		Very High
	Claims Manager		High
	Valerie Lewis		Low

Problem Description: *(Please attach any supporting documentation)*

_____

_____

_____

_____

_____

Action Steps:

_____

_____

_____

_____

_____

*******For EDS Internal Use Only*******

Request Completed: Yes _____ No _____

Comments: _____

_____

_____

_____

_____

_____

When we identify an issue in claims payment, we promptly develop and document a corrective action plan.

Data Entry

RFP Reference: 2.6.22, p. 2-56

We discuss the contractor responsibilities for data entry in this section.

Contractor Responsibilities

RFP Reference: 2.6.22.1, p. 2-56

a. Key paper claims into the MMIS within a maximum of 15 calendar days from the Internal Control Number (ICN) date.

Based on our understanding of the staffing levels required to meet Department of PATH performance standards, EDS will maintain and staff a data entry unit adequate to key hard copy claims within a maximum of 15 calendar days from the internal control number (ICN) date. **We currently exceed this standard by keying <u>and adjudicating</u> paper claims within an average of 10 days from receipt.** Every year, our data entry staff keys more than 1 million paper claims.

b. Maintain a maximum error rate of 3% on all keyed claims, computed weekly.

Currently, our approach to managing the data entry unit's error rate includes cross training each data entry specialist on all claim types to improve accuracy and productivity. A new data entry operator's claims are verified until we determine the operator is fully trained on that claim type. We establish production standards for each claim type based on the complexity of the claim, the average number of claim line items per claim, the number of fields entered, and the volume of attachments. To ensure that we meet the state's performance standards, we also use claim stub files that automatically edit for beneficiary name/number mismatch, illogical dates, provider name misspellings, and invalid procedure/diagnoses codes. This automated error checking allows us to maintain an exceptionally low data entry error rate. **In fact, in multiple single state audits, no data entry errors have been detected, allowing us to continually exceed performance standards.**

With this new contract, we will add two supervisors to the claims department who will perform weekly quality control audits of that data entry team. Random samples will be taken and verified against the original claims for accuracy.

c. When the error exceeds 3%, the Contractor must provide:

- **Corrective action for reducing the error rate.**
- **Results from prior period's corrective action.**

If the data entry error rate exceeds the three percent mandated by the state, we will develop a corrective action plan and provide it to the state. **In the more than 21 years EDS has**

served the state of Vermont, we have never had to implement a corrective action plan for data entry errors. We understand the need for accurate data entry of paper claims and the nuisance a keying error causes for the provider. Dubravka Abramovic and her team continually strive for excellence and do not hire error-prone data entry operators. Each operator hired must take a data entry test that detects errors; only those operators who excel on the test are hired by EDS.

When a quality control audit reveals an error rate that exceeds the standard, a corrective action plan will be completed and monitored. We will update the state on results of the corrective action plan in the weekly Fiscal Agent Meeting.

d. Provide standard monthly reports to the State depicting:

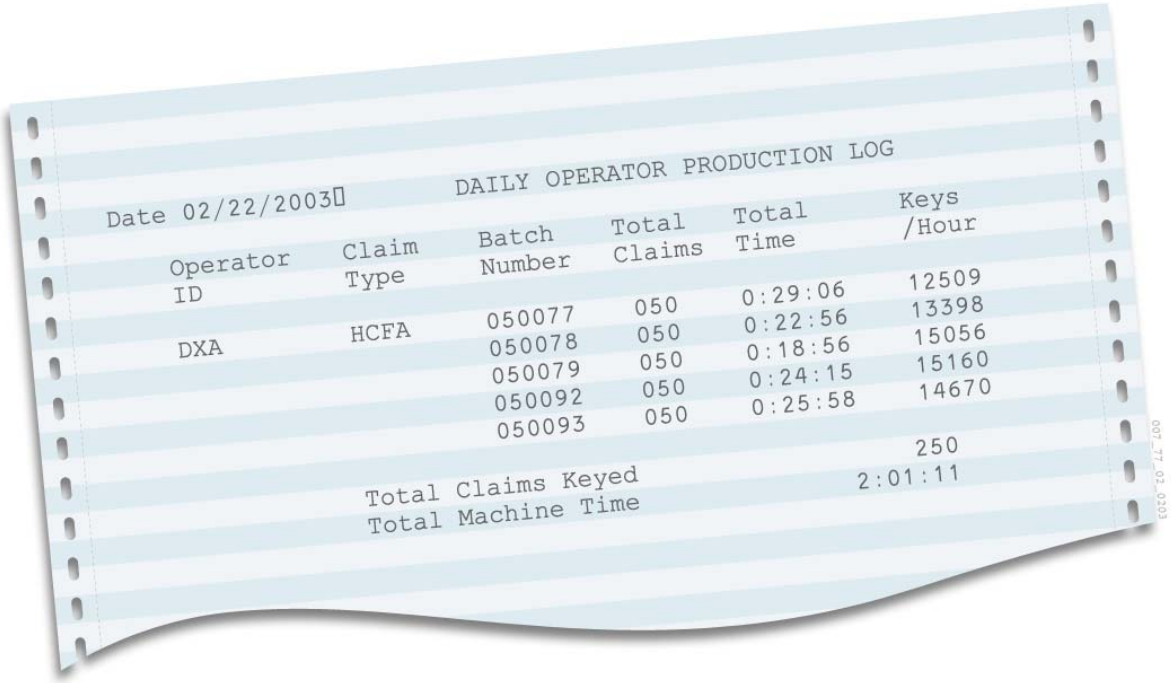
- **Overall data entry error rate.**
- **Error rate by individual performing data entry.**

Because of the relationship between accurate claims payment and accurate claims entry, we use a data entry system that provides quality reporting. This quality review (also known as sampling) is accomplished through a verification feature of the Viking data entry system. During the claim verification process, if an error is detected, the system notifies the data entry specialist. As a result, staff can correct data entry errors before releasing the claims to the system. This automated edit checking prevents incorrectly keyed data from affecting timely processing or erroneous denial.

The Daily Operator Production Log depicts the keystroke rate and errors by data entry specialist. Monthly reports from the QC audits will be made available for state review.

The following graphic depicts a sample Daily Operator Production Log.

Daily Operator Production Log



DAILY OPERATOR PRODUCTION LOG

Date 02/22/2003

Operator ID	Claim Type	Batch Number	Total Claims	Total Time	Keys /Hour
DXA	HCFA	050077	050	0:29:06	12509
		050078	050	0:22:56	13398
		050079	050	0:18:56	15056
		050092	050	0:24:15	15160
		050093	050	0:25:58	14670
Total Claims Keyed					250
Total Machine Time					2:01:11

EDS uses automated reports to verify the timeliness and quality of individuals' data entry work.

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Resolutions and Suspense

RFP Reference: 2.6.23, p. 2-57

We discuss our approach to contractor responsibilities in this section.

Contractor Responsibilities

RFP Reference: 2.6.23.1, p. 2-57

a. Resolve claims suspended for error correction or rejection within 30 calendar days of initial suspension.

Maintaining an adequately staffed resolutions team is critical to resolving claims pended for edits and audits in the VermontAIM system. Our resolutions/adjustment unit can quickly acclimate to new policies or edit and audit enhancements. The unit incorporates the procedural changes needed to efficiently operate and maintain the claims correction function and to resolve suspended claims well within 30 days of suspension.

Complicated claims correction and resolution procedures involve many unique Vermont policies, which means a significant learning curve for a new contractor. Our resolutions team is fully versed in the complexity of the Vermont Medicaid policies and processes to support accurate claims payment. All claims requiring manual resolutions must go through the following procedures:

- The Vermont AIM system suspends a claim for an edit.
- A resolutions staff member manually reviews for keying errors that may have caused the suspension.
- A resolutions staff member compares the claim against the online resolutions document to determine next steps.
- A resolutions staff member either denies the claim or forces the edit based on approved procedures.

b. Coordinate with the Department of PATH in resolving claims according to Federal and State laws, regulations and policies.

Our resolutions and utilization review units coordinate with the Department of PATH in resolving claims in accordance with program policies and procedures as outlined in the Welfare Assistance Manual (WAM), as well as all state and federal laws, regulations, and policies. The procedures and policies followed by the resolutions unit have been developed to support and comply with these regulations.

Dubravka Abramovic and her team meet regularly with the Department of PATH staff in their Edit/Audit meeting to address questions on processing and to clarify any processing policies for new programs and/or legislative changes. The focus of this meeting is to work jointly with the Department PATH staff to suggest edit changes, address problem edits (those where multiple claims fail and add to suspense numbers), and work creatively to educate and improve claims submission accuracy by the providers. This joint meeting has helped to improve suspense levels and has been a factor in reducing suspense percentages since 1999.

c. Staff and coordinate with the Department of PATH an edits/audits workgroup whose function is an ongoing analysis of resolution, edit and audit issues.

The edit/audit team works closely with the Department of PATH and staff from all areas of EDS—claims, utilization review, provider services, and systems—in developing new edits and audits and in implementing timely updates to the online resolutions instructions. We make any changes in accordance with Department of PATH policy and procedures.

Two recent examples illustrate the value of the work produced by the edit/audit work group. In December 2001, the edit/audit team suggested that our current edit 009 (beneficiary name/number does not match our files) be split into two separate edits. Claims with name/number mismatches for baby claims billed under the mother's ID would continue to suspend. All other mismatches would automatically deny. **When approved, this change resulted in the overnight reduction in the suspense rate of 5,000 claims.**

Another success of the edit/audit team has been significantly reducing the number of suspended claims by allowing all ICN numbers to be split into region codes for attachment and non-attachment batches. This change enables the system to automatically deny claims that require attachments when none is sent. The decrease in suspended claims means less manual review, less room for error, quicker turnaround of provider payment, and a lower claims volume.

To illustrate the impact of this change, we have included a chart that lists the number of claims that failed the edits or audits affected by the ICN number change on February 28, 2003. **Before the change to ICN numbers, all of these claims would have suspended for manual review. After the change, 41 percent of the claims were automatically denied.**

Reduction in Claims Suspense Due to Edit/Audit Workgroup Project

Edit/Audit	Claims that Suspended	Claims Auto Denied	Decrease in suspended claims
Name/number mismatch	588	406	40.85%
Modifier/procedure	1308	601	31.48%
Late billing (6 months edit)	1837	940	33.85%
Units min/max	394	157	28.49%
Medicare A	30	35	53.85%
Medicare B	778	584	42.88%
Late billing (2 years)	187	172	47.91%
Other insurance	3364	1343	28.53%
Late Billing (12 months)	2129	212	9.96%
Edit 435 - total component	10	181	94.76%
Procedure/diagnosis mismatch	909	90	9.01%

Before the edit/audit team implemented a change to automatically deny claims that are improperly sent without attachments, all of these claims would have suspended on February 28, 2003. As a result of the change, the number of suspended claims fell 41 percent.

d. Edits/audits must include, at a minimum, all edits/audits currently performed under edits/audits.

The VermontAIM system currently supports 630 edits and audits. The system will continue to uniformly apply those edits and audits to all claims passing through VermontAIM. An edit is a system check that compares the data submitted on the claim with predefined content rules, reference files information, or relationships among claim data and multiple reference files, such as procedure, diagnosis, provider, and beneficiary.

The system uses three types of standard edits as illustrated in the following table.

Standard Types of Edits

Type of Edit	Purpose	Examples
Presence	Checks the claim for the existence of required data	• 004—Provider number missing/not on file • 041—From date of service is missing or invalid • 007—Procedure requires modifier
Validity	Checks the claim for the validity of data formats and values	• 070—Procedure/modifier combination is invalid • 001—Provider/claim type mismatch • 003—Recipient ineligible on dates of service
Relationship	Compares claim data with appropriate associations or limitations	• 132—Lab panel 80050 excludes component codes • 820—MH service cannot be billed same day as MR services • 830—Total OB services cannot be billed with partial OB service

The VermontAIM contains a series of edits that validate such criteria as eligibility and authorization. This data, such as beneficiary eligibility and prior authorization (PA) of services, is passed to the VermontAIM from other agencies. Although this data is updated frequently, the most recent information may not be available at the time a claim encounters the edit. A provider could submit a claim requiring PA, for example, before EDS receives the PA from the Department of PATH contractor. The edits above are examples of edit failures we would suspend.

An audit is a system check that compares the data on the claim to relevant data already captured in claims history or another claim in process. We use two types of claim audits to automatically disposition a claim or suspend a claim for review, as illustrated in the following table.

Types of Audits

Type of Audit	Purpose	Examples
Limitation	Applies criteria so that the quantity of services or dollar amounts billed do not exceed PATH-specified limits or service parameters	• 721—Rehab therapy (speech) limited to two units (1hr)/day • 750—Pre-cut dressings limited to 400 per calendar month • 751—Insulin pump batteries limited to nine per three months (90 days)
Duplicate	Compares the current claim to the beneficiary's paid claims in history or other claims in process to ensure that the claim is not paid twice	• 501—Exact duplicate claim • 503—Suspect duplicate claim • 531—Suspect duplicate nursing home/inpatient, hospice

When a claim suspends for an audit that requires the manual review of claim history, we retrieve the pended claim using the Claim Selection Correction window. This window displays all information necessary to review the claim. Resolutions/adjustments specialists can display any claim in related history that is causing the suspension. The resolutions/adjustments specialist then uses documented procedures in the resolutions users manual for determination and disposition.

In addition to the complex network of edits and audits in place to assure correct processing of all claims, EDS will also implement the McKesson ClaimCheck Claim Review. This software is designed to manage medical coding complexities. ClaimCheck Claim Review evaluates billing information and coding accuracy of professional claims submitted for processing. The Current Procedural Terminology (CPT) manual, published by the American Medical Association, guides the ClaimCheck Claim Review coding criteria and protocols.

We will work closely with the Department of PATH to fully integrate ClaimCheck Claim Review into the MMIS. This enhancement will identify four primary types of coding errors:

- Procedure unbundling
- Separate billing of incidental and integral procedures
- Billing of mutually exclusive procedures
- Incorrect use of CPT coding rules

ClaimCheck Claim Review software enables the consistent application of auditing criteria to all claims. The weekly claims processing cycle creates files of claims that have passed daily and weekly MMIS edits and audits.

We will process these files through the monthly ClaimCheck Claim Review to determine where ClaimCheck Claim Review editing would have resulted in potential denials. EDS and the Department of PATH staff can download the output to a desktop version, allowing the review and analysis of claim activity to determine where edit and audit enhancements can be made. These enhancements will continue to increase savings, reduce inappropriate provider billing, and improve MMIS data integrity.

The total estimated savings is projected to be 4.1 percent of Medical benefit dollars, or more than $1.8 million. This figure is based on the one year's worth of data EDS provided to McKesson for the evaluation.

Financial Management

RFP Reference: 2.6.24, p. 2-58

We will continue to share the commitment with the Department of PATH to maintain accurate accounting of Medicaid finances and timely payment to those who provide Medicaid services. Strict internal accounting controls, system audit trails, automatic cycle balancing, precise accounting, and reporting functions for claim and nonclaim transactions provide the data necessary to effectively manage the Vermont Medical Assistance Program.

Medicaid programs are called upon every day to do more with fewer benefit dollars and budgets while providing access and care to an ever-growing Medicaid client population. Accurate and timely financial processing is critical to the state's ability to meet these aggressive program goals. EDS' Medicaid financial operational experience, both in Vermont and across the country, uniquely positions us to continue to serve the state's Medicaid program by bringing repeatable processes and documented procedures for effective financial management.

Effective support of the financial management functional area protects Medicaid finances, supports Medicaid program administration, maximizes federal funding, and continues to maintain good relationships with the providers who are essential to the success of the Medicaid program.

Contractor Responsibilities

We address the financial management requirements under the following headings:

- Bank Reconciliation
- Cash Management
- Expenditure Summarization
- HCFA-64 Reporting Data
- Fiscal Workgroup

Bank Reconciliation

RFP Reference: 2.6.24.1.1 p. 2-58

a. Obtain written approval from the State for any and all agreements between the Contractor and any bank involving Medicaid funds.

We will continue to obtain written approval from the state for any and all agreements between the contractor and any bank involving Medicaid funds. This process will ensure that the state is aware of all bank agreements with regard to Medicaid funds.

b. Maintain:

Separate Vermont bank disbursement account to handle claims payments funds.

In accordance with the state of Vermont's requirement to maintain a bank disbursement account, we will preserve the current account at Bank North. This account will continue to be used solely for the disbursement of claims payment funds.

Monthly general ledger and trial balance that reconciles to the bank statement.

The reconciliation process commences once the monthly account reconciliation package (ARP) process is complete and after Bank North receives the bank statements. The Disbursement Account Book Balance Worksheet and Individual Reconciliation are completed to verify any outstanding balances. The information necessary to complete this process will remain on the Financial Control Summary Report (FNDR57BB), ARP adjustment sheet, and the ARP Outstanding and Processed Check Report.

c. Provide documentation that the disbursement account will be insured to the maximum amount held in the account on any given day.

The Vermont Medicaid account maintains two separate bank accounts: a disbursement account and an investment sweep account. On a daily basis the balance of funds from the disbursement account are transferred to the investment sweep account excluding the dollars necessary to cover paper checks and any bank charges. Mandatory electronic funds transfer (EFT) was implemented for automated banking which greatly reduced the number of checks issued and therefore reduced the manual effort of the treasury to deposit funds daily. The mandatory EFT greatly reduced the number of checks that were being sent to providers; however, because of these checks, the investment sweep account was set up to cover the daily check balances. If the state desires a zero balance account, EDS is willing to comply with this specification.

Funds are covered normally under the Federal Deposit Insurance Corporation (FDIC) up to $100,000, but because we roll over the funds to the investment sweep account there is no set limit of balances held in the account, and are 100 percent covered under the U.S. Federal Government Securities. Under the new contract, the state will retain all interest incurred on the investment sweep account. We will make available all bank documentation for the state's review at any time.

d. Electronic funds request and supporting documentation to the Department of PATH for payment data.

We will continue to send all electronic fund request and supporting documentation to the Department of PATH for payment data in order that the account is funded properly and to ensure providers are accurately paid in a timely manner. We will continue to produce all of the necessary reports and data to ensure accurate and appropriate disbursement of Medicaid funds. An example of a report would be the weekly draw request, which provides the financial cycle payment information required to determine the amount needed to fund the accounts.

e. Be responsive and accommodating to State bank reconciliation requirements.

We will continue to build on the solid foundation and procedures currently in place, which allows us to be responsive and accommodating for all of the state's bank reconciliation requirements.

The general purpose of conducting a reconciliation of the bank statement to the book balance is to make sure that all transactions are accounted for on both the bank's books and EDS' books and to determine the correct balance of both the book and the bank. At any given time the bank balance and the book balance will not equal one another due to timing issues. Timing issues arise from the bank making adjustments to the bank balance during the month that we are unaware of and at the same time we have made transactions that the bank is not yet aware of.

During the reconciliation process we will determine what the difference is between the bank's ending balance and the EDS ending book balance. To ensure that the book balance and the bank balance reflect the same amount, we will perform a thorough reconciliation on a monthly basis.

Cash Management

RFP Reference: 2.6.24.1.2, p. 2-58

We will recover and credit any and all misspent funds as well as establish, monitor, and manage accounts receivable (A/R) to recover funds owed by providers. EDS will also provide a monthly summary report of activity and collections, including earnings worksheets. We will continue to accomplish this process by our comprehensive management of all financial activities including the in-depth monitoring and reporting of claims payments and provider earnings. Our tenure as your fiscal agent enables us to be receptive and flexible to all state cash management requirements.

In conjunction with the state, the Vermont-based team continually reviews the A/R balances and has implemented the following process to ensure that all A/Rs are promptly addressed. Program Services Team Lead Niki Holton sends out a first notice letter to a provider when the A/R is 60 days old. If Niki does not receive a response from the provider within 30 days, a second notice is generated. If after 30 days (from the second notice) she has not received a response, she escalates this issue to the Office of Vermont Health Access (OVHA) to determine next steps. This process has allowed us to maintain very low outstanding receivables with the current A/Rs being at less than $40,000. In fact, Niki has collected more than $250,000 in outstanding A/Rs during this current state fiscal year.

Expenditure Summarization

RFP Reference: 2.6.24.1.3

Prepare:

a. Expenditure summarization category (planned) data for the Statewide accounting system (VISION), as directed by the State.

The VermontAIM system does not currently prepare expenditure summarization category (planned) data for the statewide accounting system (Vision). Since the procurement is described as a takeover currently functioning "as is," this would be considered an enhancement to the current system. Discussions between the state and EDS will have to take place in order to understand and comply with this requirement.

b. Other reports and/or files required by the Administrative Services Division of the Department of PATH.

We will provide the necessary files and/or reports required by the Administrative Services Division of the Department of PATH in order for them to accurately manage their expenditures and comply with the state's budget requirements.

The Vermont-based team works closely with the state's fiscal workgroup to review current financial issues and to discuss future enhancements. A recent outcome from an earlier meeting with the workgroup was a breakout of the General Assistance (GA) Claims Report that EDS generated through BusinessObjects.

HCFA-64 Reporting Data

RFP Reference: 2.6.24.1.4

Generate HCFA-64 data and worksheet, as directed by the State.

EDS originally manually produced the 1115 Waiver section of the HCFA-64 report. However, due to an enhancement we implemented to the VermontAIM, this section of the report is now systematically generated. Since this enhancement has been automated, it has proven to be less time consuming to generate. The importance of this section is to report to CMS expenditures for the 1115 Waiver program and to demonstrate that expenditures are budget neutral compared to regular coverage. We understand the importance of accurately reporting this information to the Department of PATH, which ensures that the state has the necessary information to complete the federally required HCFA-64. We will continue to assist the state in generating the HCFA-64 data and worksheet.

Fiscal Workgroup

RFP Reference: 2.6.24.1.5.2

a. Provide appropriate staff for the Fiscal Workgroup.

EDS has always and will continue to provide knowledgeable staff who have an in-depth understanding of the MMIS financial subsystem to work with the state's accountants to meet the objectives of the fiscal workgroup. Our strong relationship with you allows us to effectively resolve any financial issues as well as to recommend future enhancements. One recommendation that came from fiscal workgroup was the automation of batch cash controls. Because the check receipt information is now available in the system, we have the capability to create reports that allow us to continually monitor cash transactions on any given day.

b. Meet regularly with designated State personnel for purpose of:

- **Resolving Financial Subsystem and fiscal funds flow issues.**
- **Internal audit of reported expenditures data.**

Cherie Benoit and Cherie Bergeron from EDS, and Joan Adams, Deb Stemple, and Carol Butts from the state meet periodically to resolve financial subsystem and fiscal fund flow issues.

An internal audit of reported expenditures data does not currently exist. Since the procurement is described as a takeover currently functioning "as is," this would be considered an enhancement to the current system. Discussions between the state and EDS will have to take place in order to understand and comply with this requirement.

The AIM system includes dynamic financial management and accounting processes to report the financial status of Medicaid and state program expenditures. Our system accounts for and reports all benefit dollars paid and recovered in accordance with both state and federal requirements. The Vermont-based team's successful, proven financial management and accounting services system highlights:

- Accurate Vermont expenditure budgeting
- Balance mechanisms within the MMIS to enhance controls
- Opportunity for maximization of federal funding
- Timely, comprehensive, and meaningful management reporting

Recent Enhancements

A recent enhancement and modification to the financial subsystem was the automation of cash control procedures. This enhancement directly impacted Deb Stemple's workload (OVHA employee) by saving an average of four hours a week, or 208 hours per year, which is about a 10 percent improvement in productivity.

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Mailroom Support

RFP Reference: 2.6.25, p. 2-59

Our mailroom support staff handles more than 2 million pieces of correspondence and claims every year. The team is responsible for all paper claims sent to EDS for processing and all notification sent to providers. The mailroom is the first line in the quality control of claims received, verifying that required fields are filled in and that claims are signed. Mailroom staff batch all claims by claim type and image the claims for storage purposes.

Contractor Responsibilities

RFP Reference: 2.6.25.1, p. 2-59

a. Properly distinguish paper claims and attachments.

Our trained mailroom staff first distinguish paper claims and attachments by sorting the claims. All claims with attachments are sorted into categories that are separate from claims without attachments. Each claim attachment received with a claim is carefully kept with the claim from the time the mail is opened through the end of the process.

Paper claims and their associated attachments receive internal control numbers (ICNs) during the filming process. By assigning the same ICN to a paper claim and its associated attachments, we assure the attachment remains associated with the claim. These procedures help EDS to properly distinguish paper claims and attachments.

b. Pre-screen and sort paper claims.

The Vermont-based team uses skilled staff who work from documented procedures to ensure that the more than 1 million paper claims we receive yearly are prescreened and prepared for entry into the VermontAIM or mailed back to providers, as appropriate.

Mail picked up by the EDS courier from post office boxes designated for claims is routed to a claims control clerk. The claims control clerk removes the claims from their envelopes and sorts them manually by the following claim types:

- American Dental Association (ADA) dental claim form
- HCFA-1500 claim form
- UB92 claim form
- UB92 with attachments
- HCFA-1500 with attachments

- Vision prescription forms
- Medicare crossover claims
- Adjustment request forms
- State's LTC turn-around documents (TADs)

Our mailroom staff is very familiar with the various claim forms and follows state-approved procedures to determine claim types. Accompanying attachments and documentation are retained with the claim throughout claims processing. As indicated in the list above, claims without attachments are separated according to the type of claim form.

As they sort claims by claim type, control clerks review the claims for missing data, such as a missing provider number or signature. If necessary, we then return the claim to the provider for correction.

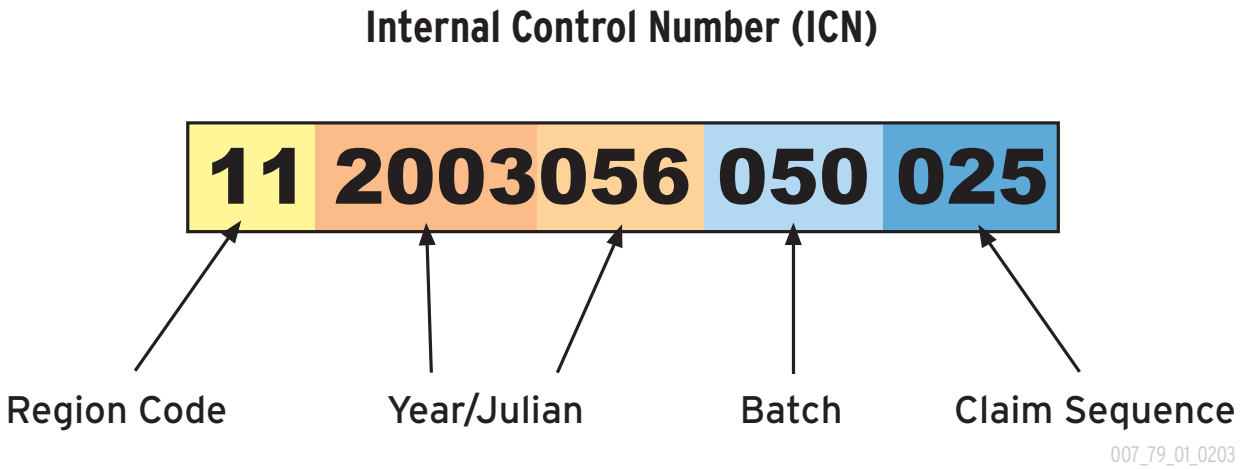
Sorted claims that are ready for processing remain in their claim type categories and are counted and batched in groups in preparation for scanning, data entry, and adjudication. Claims without attachments are batched in groups of 50, claims with attachments in groups of 25. Each batch has a cover sheet. This process serves as a quality control mechanism to assure that all received claims are entered into the system because the system also counts the claims, expecting 25 or 50 in each batch, according to claim type.

Using trained personnel and documented procedures to sort and prepare claims in this manner ensures the most efficient scanning, data entry, and adjudication of the claim.

c. Assign:

- **An ICN to all paper claims, batch as appropriate.**
- **The appropriate attachment code to paper claims to ensure proper association with TPL edits during the claims payment process and reporting.**

We begin the claim control process by assigning unique ICNs and batches to claims within 24 hours of receipt. The ICN serves as the permanent tracking number for all claims and remains constant from receipt through adjudication of the claim. The ICN contains the assigned batch number, which identifies the type of claim, as well as the region identifying the input media, the year, the Julian date signifying the date of receipt, and the sequence number identifying the claim's number within each batch.



The EDS mailroom staff receives and sorts hardcopy claims and attachments. In the VermontAIM MMIS environment, hardcopy claims are assigned an ICN during the filming process. The attachments to the claims receive the same ICN to identify it as being associated with the claim. This assures that the TPL attachments are associated with the proper claim and will therefore be considered as the claim is being resolved. The ICN assignment occurs within 24 hours of receipt of the claim. After claims are filmed, the tapes are developed and stored for future reviews.

d. Refer questions concerning attachments to the department of PATH or appropriate Contractor staff in order to properly handle paper claims.

All claims received with an attachment not currently recognized by EDS will be directed to the appropriate Department of PATH staff member for review. During the weekly fiscal agent meeting, any unusual attachments or questions are brought to Gloria Jacobs or Roger Trembley for further review. The availability of PATH staff at the meetings assists us in quickly resolving any issues.

e. Implement and operate a courier service to distribute mail in-house and between the Contractor's Vermont facility and the Department of PATH in Waterbury, Vermont.

Vern Johnson is our experienced courier who picks up mail from the state site and delivers it to another site or brings it back to the EDS location for in-house delivery. Vern picks up mail and delivers it twice each workday—once in the morning and once in the afternoon.

Should we have other priority mail requests that arise outside of Vern's schedule, we handle these issues as they occur. Mail that is brought to the EDS location is placed in a designated location for in-house delivery, and is delivered within one business day.

In total, Vern travels 450 to 500 miles a week as a courier for the Vermont Department of PATH. In his more six years with EDS in Vermont, he has covered more than 160,000 miles in collecting and distributing mail.

f. Prepare and control incoming and outgoing claims-related mail, paper claims, attachments and other correspondence are retrieved and delivered at/to any site designated by the State, in the most effective and efficient means available.

We constantly review our incoming and outgoing mail processes and procedures to ensure adherence to our quality standards and to identify new technologies or procedures that can further enhance our performance for the Department of PATH. We also continually monitor mail service to ensure that the most efficient procedures are used. **Our current mailroom staff brings more than 31 years of Vermont Medicaid expertise.** Vern has delivered and picked up mail at PATH for more than six and a half years and is very familiar with the location of all PATH staff offices. This expertise, along with our monitoring and detailed documentation of mailroom procedures, ensures that mail is picked up and delivered in the most efficient manner possible.

One responsibility of the document control team is the mailing of the weekly remittance advice (RA) to all providers with claims active during that billing cycle. **Yearly, the team mails more than 103,000 RAs to the provider community.**

g. Retrieve and deliver mail between the Contractor's location and the State once in the morning, and once in the afternoon each workday, and the State's request.

EDS will pick up mail at Department of PATH facilities once in the morning and once in the afternoon each workday. We will document delivery schedules for the various types of correspondence that is picked up. Our mailroom staff is knowledgeable about the various types of state correspondence, delivery requirements, and the various state sites.

h. Maintain controls to ensure no mail, claims, tapes, diskettes, cash, or checks are misplaced after receipt.

We comply with state and federal requirements by following controls to ensure that no mail, claims, tapes, diskettes, cash, or checks are misplaced after receipt. The EDS Vermont mailroom staff immediately delivers nonclaim correspondence as well as direct deliveries, certified mail, and deliveries from outside courier services such as Federal Express or United Parcel Service (UPS) to the appropriate personnel or department. We have implemented strict controls regarding the receipt, processing, and distribution of Vermont Medicaid program claims, tapes, diskettes, cash, and checks to eliminate the risk of material being misplaced, delivered to the incorrect department, or delayed in processing.

The mailroom staff currently processes nonclaim correspondence and other mail using the following guidelines:

- The claims control team lead or designated backup logs certified mail, places it in a designated area until delivery to the designee, and then distributes it to the addressee. Certified mail is delivered to the receiver within the same day, and a signature is obtained from the receiver. The correspondence log is checked at the end of each day to ensure that all mail was delivered.
- Correspondence marked "to the attention of" or addressed to a specific individual is delivered unopened to the addressee's unit. This type of correspondence is placed in a designated area until delivery has occurred. We make delivers of such correspondence within the same day.
- Mail that appears to contain a check—a window envelope—is immediately pulled and placed in a lockbox for separate processing by administrative personnel who work in a secure environment. Financial correspondence, such as checks, are logged with the sender and receiver information; check number, dollar amount, and business purpose. Checks are delivered to the receiving EDS unit on the day of receipt. The receiving EDS unit notes on the mailroom log that the correspondence was received.
- If the EDS mailroom receives cash, the mailroom employee immediately brings the entire mail packet in which the cash was received to the claims control team lead. The claims control team lead logs the sender's and receiver's information, dollar amount, and business purpose, then secures the cash in a lockbox and contacts the appropriate EDS unit. The receiving EDS unit signs off the mailroom log for tracking purposes.
- Tapes and diskettes are delivered the same day to the computer operations team for transmission into the MMIS. An automated log containing the ICN and batch numbers is generated, and a copy of this log is delivered to the Provider Electronic Solutions software coordinator. The mailroom staff documents tapes and diskettes with the senders' information on a tracking log as they are received. Upon delivery to the operations area, an operations designee signs the log.

Our comprehensive control processes for correspondence include signoff, correspondence tracking, and escalation procedures. Our awareness of the sensitivity of these documents, coupled with our current expertise, ensures that we receive and deliver documents appropriately and in a timely manner.

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Communication Tools

RFP Reference: 2.6.26, p. 2-60

We recognize and welcome your decision to require the latest communication tools available to increase productivity and enhance communication between the state and our team. We will be upgrading our existing telephone system to handle additional telephone lines and to provide staff with voice mail. Based on our experience and the ability to work with major vendors, we have identified and established relationships with the best-in-class vendors. EDS will leverage these vendor relationships with the preferred vendors for the upgrade to our telephone system, enabling us to offer the best quality products at a cost savings and allow for smooth installations and service. This is the only upgrade or replacement of communication tools that is necessary to meet your requirements.

Contractor Responsibilities

RFP Reference: 2.6.26.2, p. 2-60

We present the following approach to meet the contractor responsibilities.

a. Install and operate a telephone and e-mail system at the proposed Vermont facility by January 31, 2004 that allows for:

- **Each staff person to have voice mail**
- **Each staff person to have an e-mail address**
- **Direct connectivity to each staff person**
- **State staff at the Contractor's site to send and receive email and telephone calls.**

EDS will install an upgrade to our existing telephone system at the 312 Hurricane Lane office in Williston, Vermont. The telephone system upgrade will be installed and operational by January 31, 2004. The telephone system upgrade will allow for each staff person to have voice mail and the additional telephone lines will allow state staff to seamlessly make and receive telephone calls. Because our current e-mail system allows each person to have an e-mail address and to possess direct connectivity to the Internet, an upgrade or replacement system is not needed.

After seeking state approval of EDS' recommended telephone upgrade system, we will begin installation of the upgrade to our telephone system under the leadership of Valerie Lewis. Valerie will work closely with our selected vendors to schedule installation during nonbusiness hours to minimize interruption of service to users, beneficiaries, and providers. Valerie will also monitor the vendor installation performance to ensure they are on schedule and taking all measures to prevent disruption of service.

In addition, Valerie will work with the telephone system vendor to schedule and provide training to all staff on the new system. Training will include setting up and changing voice mail messages, the protocol for receiving and returning voice mail messages, and managing voice mailboxes.

b. Seek State approval for the system selection, setup and connectivity.

We will seek your approval for the telephone system upgrade selection, setup, and connectivity. In making our recommendations, we will leverage our industry knowledge and contacts with vendors to provide you with the most efficient and cost-effective solutions.

c. Make changes to telephone and e-mail set-up as necessary to meet business needs or modified State requirements.

We will make changes to the telephone system and e-mail set-up as necessary to meet business needs or modified state requirements. Before making any modifications, we will seek your approval of the new message or configuration. In addition, we will implement these changes outside of business hours so as to avoid impact on providers, beneficiaries, or other stakeholders. We are sensitive to your needs and committed to making changes quickly and seamlessly to the beneficiaries and providers. Our experience with Vermont MMIS and numerous other Medicaid programs gives us a solid understanding of the types of issues that arise while changes are being implemented. With this experience and knowledge, we will be able to make changes as smoothly as possible.

k. Approach to Relations With State Personnel, Providers, and Other Stakeholders

RFP Reference: 3.2.2.10(k), p. 3-16

Maintaining good relations with state personnel, providers, and other stakeholders is integral to the continuing success of the Vermont Medicaid Program. Our approach to these groups is that we are all part of the Vermont Medicaid team and we will continue to work together to provide the best possible health care for the program's beneficiaries.

The members of the Vermont-based team consider themselves part of your team and are committed to maintaining both structured and informal interactions with the Department of PATH, providers, and other stakeholders. We assure smooth policy implementations and enhancements to support the evolution of the Vermont Medicaid Program. As we have for more than 21 years, we will continue to provide high performance levels and excellent service to respond to Vermont's changing business needs.

Approach to Relations With State Personnel

Open and regular interaction with state personnel is a key ingredient to maintaining the solid foundation on which the MMIS operates and can continue to grow to meet the business needs of the state.

Our team is accessible 24 hours a day, 7 days a week. During the past 21 years, Client Delivery Executive Barbara Davis has always been available by phone. Although there have been only a handful of occasions when this level of contact was needed, it has always been available.

During business hours, every EDS employee has e-mail capability along with a current Vermont state government telephone and e-mail directory in each of our business areas. Each employee is encouraged to check e-mail on a regular basis but not less than three times each workday. By maintaining this open form of communication, the state is assured of reaching all pertinent personnel when needed.

As we continue to move forward in our efforts to increase accessibility, the telephone system at the account will be upgraded to provide direct lines and voice mail to all staff members as required in this RFP.

We also use our courier for nonelectronic, written correspondence. In 1993 we developed the S-Log system as a tracking mechanism for written correspondence from the state that requires our action. When such correspondence is received, it is entered into the S-Log system and assigned a sequential number. The document is photocopied and the original filed

with the S-Log documentation. The S-Log sign-in sheet lists to whom the document was sent, the date it was received at our facility in Williston, the date on the document itself, the name of the individual sender, a brief description of the documents (for example; rate changes and procedure code additions/deletions) and a section to enter a response date if required. Copies of the document are then distributed to the appropriate manager or team member required to complete the request.

On-Site Staff

To assure accessibility to information on a timely basis, Louise Brooks one of our reporting specialists, works at the state offices in Waterbury three days each week. Louise, a 21-year veteran of the Vermont-based team, is available to assist state employees with questions ranging from the way a claim is processed to designing and running queries in Enhanced Vermont Ad Hoc (EVAH). In addition, EDS employee Ramona Godfrey, RN, who has nearly 18 years of clinical review experience with Medicaid, works at the state offices in Waterbury one day each week. Ramona spends her time with the nursing staff at the Office of Vermont Health Access (OVHA) working on medical procedure coding and review issues.

We also provide a dedicated office at our Williston site for use by state employees. This office is used regularly by the acting deputy director and school-based health services coordinator.

Regular Meetings

On a monthly basis, Director of the OVHA Paul Wallace-Brodeur and Client Delivery Executive Barbara Davis meet in an effort to discuss upcoming changes to programs and possible implementation issues that may occur. These meetings also focus on provider items that have been received by the OVHA. Meeting minutes are taken and copies are distributed to the appropriate managers for follow up.

Twice a month, Pat House, Barbara Davis, and Director of Computer Services/IT Manager Judy Higgins, meet to discuss the oversight of HIPAA, the vision of the MMIS, and the EDS corporate capabilities.

Each week, the fiscal agent meeting provides a structured forum for the Vermont-based management team and the state to communicate directives related to policy changes, system modifications or enhancements, provider correspondence, training or billing concerns, and claims processing statistics. The claims processing statistics are broken down by claims to be keyed and claims awaiting resolution. These numbers are posted and updated daily on the bulletin board in the claims processing area. All account employees or visitors to the account are able to monitor these numbers. Fiscal agent meeting minutes are taken and distributed by the administrative assistant. These minutes act as the official record for documenting changes to claims processing procedures and billing instructions to providers.

In addition, several operational meetings occur on a regular basis. For example, in an ongoing effort to help Vermont achieve fiscal goals, the state's third-party liability (TPL)

staff and our TPL staff meet on a biweekly basis to discuss current status and identify enhancement possibilities or processing improvements. Meeting minutes are taken and distributed so follow up and progress continue with each meeting. With the joint effort of the Vermont-based team and the state, we have consistently exceeded the monetary goals for TPL recoveries.

Systems Manager Cherie Bergeron is also active on the Vermont Health Access Team (VHAT), which meets monthly at the state offices in Waterbury. VHAT includes members from the Department of PATH, EDS, and other stakeholders as necessary. The goal of this meeting is to determine the impact of proposed legislative or state plan changes to the Vermont Health Access Program systems. The dialog between EDS and other stakeholders at these meetings is critical to providing uninterrupted service to all programs.

EDS Service Excellence Dashboard

With the Service Excellence Dashboard, EDS provides an additional and unique mechanism for the state to communicate directly with EDS. The Dashboard enables the state and EDS to monitor client satisfaction based on client input and review. The Service Excellence Dashboard is a highly visible, global communications vehicle for the consistent reporting of client relationship status. It enables EDS leaders to focus on problems and attend to them quickly.

As a key component of the Service Excellence initiative, the Service Excellence Dashboard provides graphical, up-to-the-minute status of how EDS is performing on delivery to each of our clients. Every account has its own client detail page, which displays client satisfaction levels among the service offerings in the company. The Service Excellence Dashboard accommodates management comments and client feedback. It enables EDS leaders to focus on problem areas and ensure that we are addressing them appropriately. At a glance, senior leadership, client executives, and their support teams are able to see which client support teams need assistance. The Service Excellence Dashboard allows calls to be answered very quickly.

As clients provide feedback on the client survey, their results are posted on the Service Excellence Dashboard next to the EDS client executive's ratings. This allows a comparison of the EDS client executive's assessment of our performance to that of the client's view.

The OVHA has consistently ranked its satisfaction with the Vermont account's performance as good or excellent.

Approach to Relations With Providers

The Vermont-based team works very closely with the state to provide continued support to and communication with providers. The *Vermont Health Access Advisory* newsletter, a joint effort between the state and EDS produced every other month, is an important link between the providers enrolled in Vermont Medicaid and the programs administered by the Office of Vermont Health Access. *The Advisory* conveys information about the most common billing

errors and how to resolve these errors to improve the providers' payment turnaround time. It also serves as a source of advice and clarification on state or federal policies and procedures.

As we strive to provide the most accurate information to the providers about the OVHA policies, ongoing meetings with John Dick, the policy and planning chief, and the provider representatives are held to clarify and update the provider manual and supplements. Recently, the manual and supplements have been placed on the Web for those providers who have Web access, thus further automating the communications process between our office and the provider offices.

> "EDS is now offering workshops on billing procedures and has been increasingly responsive to individual providers to help resolve such difficulties."
>
> --Alecia Armstrong, president, Vermont Mental Health Counselors Association

To monitor the satisfaction levels of our providers, we send a survey each year to a random sample of 1,000 actively enrolled providers. This survey includes questions related to claims processing, adjustment processing, provider services telephone responses, on-site visits by provider representatives, and staff professionalism. Vermont providers have consistently rated EDS above average on these surveys.

Our provider representatives are actively involved with several provider associations throughout the state, including Vermont Patient Accounts Managers (VPAM), the Healthcare Finance Managers Association (HFMA), the Vermont Mental Health Counselors Association, and the Community Mental Health Centers (CMHC). Our provider representatives attend scheduled provider association meetings to assist with billing concerns or explain upcoming changes. They also periodically present workshops on topics that concern providers, such as the adjustment process. We ask providers to evaluate each workshop so we can continually improve our service.

The provider representatives also work closely with providers in a one-on-one setting. Each provider representative is assigned a geographical territory within the state in order to better serve the providers. The provider representatives are responsible for scheduling regular meetings with the providers they serve. Prior to meeting with a provider, they review the billing history of the provider through the use of EVAH. This helps them identify areas within the provider's billing where additional training would benefit the provider. These same BusinessObjects reports can be used in follow-up to verify the provider's understanding of the training they received. Program Services Manager Valerie Lewis conducts additional follow up by contacting providers who have had recent site visits for feedback about the visit. The feedback we received is provided to the state through the fiscal agent meeting.

> "Primary Care Health Partners has enjoyed a positive working relationship with EDS and its employees. EDS has assisted PCHP staff with many special projects and requests and has been responsive to our questions and inquiries. We have enjoyed and learned much from our working relationship with EDS."
>
> --PCHP

Training Forums

EDS considers continued training an integral part of our fiscal agent responsibilities. We fully recognize the necessity of training for new staff and ongoing training for all team members about updates to the MMIS. Chris Haskins is available upon request to train any person granted access on the VermontAIM system. Ann Markle and Louise Brooks coordinate the training for all EVAH users.

In 2002, we converted our platform for EVAH from Ingres to DB2 and upgraded to the most recent version of BusinessObjects. At the completion of the conversion, we conducted two weeks worth of refresher courses and full-day hands on training workshops for all state and EDS personnel with EVAH access. We provided an overview of how a claim is processed in our system to better prepare the users to achieve the most accurate reporting. All authorized users were required to attend to receive the updated version of software.

We will take the same hands-on, dedicated approach to meeting all training needs surrounding the operation of the MMIS so the state can feel confident in the skills of the individuals entrusted with the fiscal agent responsibilities for Vermont's Medicaid Program.

Approach to Relations With Other Stakeholders

We have a full understanding of the relationships required between EDS and other vendors supporting the many Medicaid programs. To ensure that no disruption of service occurs, we have established several points of contact with whom other stakeholders can communicate. These individuals have become subject-matter experts to these stakeholders and the solid relationships with them have evolved based on the commitment, trust, and efficiency with which the concerns are addressed.

EDS Points of Contact

Area Description	Point of Contact
Contract Compliance – overall	Barbara Davis
HIPAA compliance – overall	Chrissie Racicot
PBM contractor	Cindy Littlefield
Recipient benefit counselor	Chris Haskins
Global clinical record contractor, technical	Bob Randall
Centers for Medicare and Medicaid Services (CMS)	Louise Brooks
BusinessObjects support for OVHA and DDMHS	Louise Brooks
BusinessObjects support for other state entities and the EDS staff	Ann Markle
Drug manufacturers	Chris Dapkiewicz

Area Description	Point of Contact
Banks	Cherie Benoit
Office of Investigations, Office of Inspector General	Cherie Bergeron
Medicaid Fraud Unit	Judy Isham
Vermont Program for Quality in Health Care	Cindy Littlefield
Anthem Health Care (state audit reports)	Ann Markle
Legislature regarding changes and impacts upon MMIS	Cherie Bergeron
Ombudsman's office	Niki Holton
Vermont Patient Accounts Managers	Barbara Jackson
Healthcare Finance Managers Association	Chris Haskins
Bi-State Primary Care Health Partners	Valerie Lewis
Community Mental Health Centers	Chris Haskins
New Hampshire/Vermont Strategic HIPAA Implementation Plan (NHVSHIP)	Sarah Johnson
New England Medical Equipment Dealers (NEMED)	Chris Haskins

Through the years the Vermont-based team has established many solid relationships with other stakeholders by recognizing the importance of consistent communication with our point of contact employees. These continued relationships will ensure uninterrupted service for all programs

I. Use of Subcontractors

RFP Reference: 3.2.2.10(l), p. 3-16

During the Operations Phase, we will use Health Management Systems (HMS) as a subcontractor if the optional enhancements we have proposed for the TPL subsystem are implemented. HMS will provide ongoing TPL data matching services, which is a small portion of the total amount of work to be performed. For more discussion about these enhancements, see the"J. Enhancements/Modifications Narrative" section of this proposal.

We have served as prime contractor on many large-scale, multiple-subcontractor Medicaid projects, and we have the local experience necessary to manage subcontracts. HMS is a pioneer in applying information management techniques to enhance client recoveries and reduce program costs with recoveries of more than $1.2 billion in Medicaid funds. HMS, a Medicaid TPL services contractor since 1985, has served as a TPL contractor for health and social service agencies in 28 states and the Centers for Medicare and Medicaid Services.

Client Delivery Executive Barbara Davis will serve as focal point for all work performed by subcontractors. **We accept full responsibility for subcontractor activities and will be the state's single point of contact.** We will measure quality and reimburse subcontractors only upon satisfactory delivery of a product. We measure quality by providing timely deliverables, exceeding expectations, and satisfying the state with the work we perform. In addition, we will ensure that any subcontractors with access to data strictly adhere to the privacy standards established by HIPAA for the performance of business associates. Barbara will meet with the state to share status on subcontractor work as needed and will meet regularly with each subcontractor partner to discuss tasks, performance, and any issues the state or EDS identifies.

We include a statement in all subcontracts stating that we will monitor the performance on a regular basis and terminate the contract if subcontractors do not meet deliverable requirements or do not deliver quality products and services. For example, we will put in place a process whereby Barbara and the leadership team will review the weekly/monthly TPL data matching reports for accuracy and completeness. During a monthly status call with the subcontractor, we will review the results and discuss any open issues or concerns. We also will use the meeting as an opportunity to advise the TPL subcontractor about any state or legislative changes that may affect the TPL data matching process. We give a 30-day termination notice to noncompliant subcontractors that are unable to correct deficiencies. We ensure that the vacancy will not affect the state and the provider and client communities by carefully managing the selection of a new subcontractor and the transition period.

A subcontractor may not terminate or change its relationship with us without prior and expressed approval as specified in the contract. To avoid unnecessary project interruption, we will work the state's legal and contracting staff to obtain all necessary approvals before replacing the subcontractor.

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m. Cost Containment Mechanisms

RFP Reference: 3.2.2.10(m), p. 3-16

Containment mechanisms save dollars that are critical to the Department of PATH in fulfilling its mission. As economic challenges and budget pressures increase, cost containment mechanisms become ever more critical in helping the state serve its needy population. As a result, we take seriously our commitment to identifying opportunities to contain costs.

EDS has an established history of supporting the state in identifying cost containment mechanisms. For example, **we recently implemented J-codes as a measure that will save the state $350,000 every year.** We celebrate with you that this savings can be channeled back into the program to help make up for budget shortfalls.

In developing this proposal, we have worked diligently to identify cost containment mechanisms. We have discussed in the "Addendum" section of the Price Proposal a proposal to pay crossovers up to the Medicaid allowed amount rather than paying the coinsurance and deductible amounts, which often exceed Medicaid's payment. **The result of this initiative would be an annual savings of more than $5 million.**

In this section, we propose cost containment mechanisms that feature the specialized skills of subcontractors who bring unique expertise in pharmacy benefits management and disease management. These subcontractors are:

- **Heritage Information Systems (Heritage)**, a pharmacy benefits management company that performs clinical management services and pharmacy auditing services for some of the largest payors in the country, including 13 Medicaid states
- **TrestleTree,** a privately owned company developed to provide a fresh approach to disease management that reduces costs of care by identifying target populations with laser accuracy, investing the time of health professionals, documenting the individual life/health story of each person identified with the disease-state, and providing focused intervention to influence the pharmaceutical choices made by the patient

Both of these subcontractors have established records in achieving quantifiable cost savings for their clients. For example, Heritage's service offerings have offered the following savings opportunities:

- Return on investment for retail pharmacy audits of more than six to one
- Recoveries of seven to eight percent of all home infusion therapy/durable medical equipment dollars spent by the plan

And within one year of receiving TrestleTree's disease management services, the company's first client reduced its medical claims cost for participants by 42 percent—a first-year return on investment (ROI) of 2 to 1.

We provide further information about potential cost containment mechanisms and the subcontractors that we propose to work with in providing these offerings in the following sections:

- Heritage Pharmacy Benefits Management
  - Retail Pharmacy Audits (Heritage)
  - Home Infusion Therapy/Durable Medical Equipment (HIT/DME) Audits (Heritage)
  - Heritage Organizational Overview
- TrestleTree Disease Management
  - Overview of Pilot Evaluation Projects (PEP)
  - TrestleTree Organizational Overview

Heritage Pharmacy Benefits Management

As the Department of PATH works to increase the state's control over fiscal agent and program expenditures, addressing rising prescription drug costs will be key. A pharmacy benefits manager with a proven record in Medicaid can offer significant support in developing cost-savings mechanisms.

EDS selected Heritage Information Systems because of its record of proven cost containment in the pharmacy benefits arena. Additionally, Heritage brings experience in serving Medicaid populations in 13 states.

Heritage services can provide the following benefits:

- Identify fraud, abuse, and waste in the drug program
- Support the recovery of fraudulent payments
- Reduce future fraud, abuse, and waste by the sentinel effect of pharmacy audits
- Identify overpayments relating to infused and injectible medications, services billed in association with the administration of HIT, and DME items
- Improve provider education as a result of immediate feedback on the specific criteria, claim, and clinical issues that result in a recommendation for approval or denial of a drug claim
- Reduce administrative costs in the PA area as the result of fast response and reduced need for manual support
- Ability to place more drug classes on prior authorization and screen for more clinical issues while handling only denials at the state/fiscal agent help desk

We provide further detail regarding the Heritage offerings for cost containment in the following sections:

- Retail Pharmacy Audits
- Home Infusion Therapy/Durable Medical Equipment Audits
- Heritage Organizational Background

Retail Pharmacy Audits

Fraud and abuse have been prevalent in the third-party pharmacy benefit system since its inception. As the industry and its payment mechanisms evolve, so do the methods of fraud and abuse. **Today, both fraudulent and legitimate claims can be generated, submitted, and approved for payment in a matter of 15 seconds.** With virtually 100 percent of prescription claims being processed online, most human intervention has been removed from the adjudication process, and the pharmacy benefit is largely unmonitored. Combined with most plans' decisions to forgo explanation of benefit (EOB) forms for pharmacy benefits, the pharmacy payment system is more prone to undiscovered abuse than other types of health care fraud. As a result, pharmacy programs must audit if they wish to manage pharmacy benefits.

Some payors are interested in realizing immediate returns on their audit investment while others are more interested in the long-term benefits of an established "sentinel effect" in their network. This "sentinel effect" is achieved when providers realize that they put themselves at risk by defrauding a particular payor and either stop committing fraud or focus their fraudulent activities on other payors who are not actively auditing. Pharmacists are more likely to engage in fraudulent or abusive billing systems when there is no audit program in place.

> *According to statements taken by Heritage auditors in a particular fraud case in Ohio, the president of a small pharmacy chain was quoted as telling his staff to "stop submitting bogus claims to a third-party agency for which Heritage had started auditing and to start defrauding another organization which had no audit program in place."*

Heritage's program meets both these short-term and long-term objectives. Our direct-mail audit program identifies potentially fraudulent pharmacies and begins to establish a sentinel effect. On-site audits bring immediate returns in the form of fraud and abuse recoveries, or recoveries for compliance violations. Compliance violations usually take the form of inadequate records, documentation shortfalls, or subtle manipulation/gaming of the system. While compliance violations may not always constitute fraud, they represent loss to the payor and are recoverable.

Heritage is prepared to be as aggressive as the state desires in identifying both noncompliance and fraud. Your financial returns will be directly related to how aggressive you want to be in addressing identified discrepancies. The combination of Heritage's pharmacy auditing technology, proven audit methodologies, and on-site audit experience will maximize the return on the state's audit investment.

Phase 1: Set-up

Heritage's ranking program profiles each pharmacy in the network, calculating an array of statistics, standard deviations, and other markers for each pharmacy. The program then electronically compares profiles to those of known fraudulent providers. This allows Heritage to target the providers more likely to have engaged in fraud or abuse and minimizes the audits of pharmacies where there is likely to be no fraud. The ranking process allows Heritage to spend its client's audit dollars wisely, that is, on providers from whom recovery is more likely.

The following graphic illustrates a typical ranking. The stores are listed by total risk index and each marker is color coded for the individual provider based on the number of standard deviations from the network mean.

Typical Ranking of Fraudulent Providers

Each network pharmacy is profiled using numerous quantitative "program-metrics" that are calculated at the store and network levels.

Number of Standard Deviations from Mean:	Color:
More than 3	
More than 2, less than 3	
More than 1, less than 2	
More than the Mean, less than 1	

	A	B	C	D	E	F	G
	150000	1000	2.2	77.2	671.22	27.5	2
	7000	85.99	51.6	73.2	888.58	30.1	1
	29000	85.9	73.2	66.3	594.29	41.3	1.
	5000	127.17	55.6	85.1	1430.66	44.4	1.
	4000	131.58	24.3	127.4	608.57	45.9	2
	89000	100.59	61.5	64.2	1625.98	31.8	1.
	13000	74	57.4	68.1	463.73	30.9	1.
	245000	52.9	48.2	65.3	851.74	20.5	
2889672MI	199000	63.12	57.5	48	985.08	24.4	1.
2502020MI	143000	55.93	51.7	58.4	747.73	23.1	1.
3029138MI	87000	62.75	56.9	59.1	542.28	24.1	1.
3349010MI	74000	57.96	53.5	67.1	797.82	25.1	1.
1774295MI	47000	52.48	62.3	64.6	483.96	20.3	2
2570941MI	44000	93.07	21.9	73.6	900.29	23.2	
2859109MI	26000	67.36	56.7	68.7	532.11	24.6	1.
3513082MI	6000	75.93	70.2	52.7	398.65	32.1	1.
3513940MI	370000	51.73	52.4	58.9	685.28	20.7	1.

Using quantitative program metrics, the system profiles each network pharmacy and helps auditors focus their efforts on pharmacies with a greater likelihood of fraud.

The top-ranked pharmacies are tentatively selected for audit and a list of pharmacies is forwarded to the state for approval. This set-up phase generally takes about 30 days from the time that Heritage receives viable data.

Phase 2: Direct Mail Audits

To maximize audit exposure, Heritage implements a direct-mail audit program that involves an EOB-type mailing to members. Much like the pharmacy-ranking program, the direct-mail system selects members whose profiles are consistent with those used as unwitting vehicles for pharmacy fraud. Approximately 50 such beneficiaries per pharmacy are selected to receive audit letters.

Heritage's professional mailing explains to the beneficiary that an audit is in process, and asks the beneficiary to review and verify a list of selected prescription claims that were billed on his or her behalf. The letter includes full-color images of most prescription drugs billed, so patients can confirm that the drug they received looks like the drug pictured. This allows us to identify product-substitution schemes, brand/generic-switching, and phantom billings.

Audit Response Form

"Any" Insurance Company
Audit Response Form

Pharmacy: **ABC Pharmacy**
123 Main Street, Anytown, USA

Patient Name: **James Blank**
Card Holder's Name: James Blank ID#: 012345678

Drug: **CLARITIN-D TAB CR**

Date	Rx#	QTY	CoPay	Plan Payment	Correct	Not Correct
2/14/97	0624740	90	12.00	77.80	✓	_____
5/25/97	0624740	90	12.00	77.80	✓	_____

Drug: **ORUVAIL CAP 200MG ER**

Date	Rx#	QTY	CoPay	Plan Payment	Correct	Not Correct
3/27/97	6016534	240	12.00	246.50	_____	✓
6/11/97	6016534	240	12.00	246.50	_____	✓
7/17/97	6016534	240	12.00	246.50	_____	✓
Patient Total:			$30.00	$510.36		

If any of the pictures above do not look like the drugs you received from ABC Pharmacy, please describe the drug you received in the box below.

Drug Name	Color (red, blue, etc.)	Shape (round, etc.)	Form tablet, cap, etc.)	Words/#s (markings)

"I have reviewed the listed claims, and my responses are accurate to the best of my knowledge."

Signature: James Blank Telephone:_____ Date:_____

Comments: PLEASE FOLLOW UP ON THIS!

By reviewing forms with pictures and descriptions of the drugs, beneficiaries can easily help identify product-substitution schemes, brand/generic-switching, and phantom billings.

The patient checks off which prescriptions and refills he or she received and returns the form in a prepaid return mail envelope. Heritage's average response rate for such mailings is higher than 72 percent. Some members will not respond, and some will respond immediately. Other members will bring the form to their pharmacist—a desirable outcome in that it generates an awareness of the audit and fosters a sentinel effect. The results of notifying the pharmacy are several:

- Honest pharmacists are validated and will appreciate the effort
- Pharmacists who contemplate cheating will likely reconsider
- Fraudulent pharmacists realize that they are likely to be caught and may stop, though it is usually too late to escape detection

Letter responses are logged at Heritage, and any negative or questionable responses are flagged for review by pharmacist auditors. These negative responses are one of the factors that trigger specific pharmacies for on-site audits. Since all responses are logged in on a claim-by-claim basis, Heritage generates very detailed pharmacy-specific final reports for the plan. The direct-

mail phase can be in place within 60 days of receipt of data, and it generally takes six to eight weeks to attain the 70 percent response rate.

Phase 3: On-Site Audits

On-site audits are the next step in the audit process. Providers are selected for on-site audit based on one or more of the following:

- Evidence of potential wrongdoing (per responses in direct-mail audit)
- Client request for on-site visit
- Complaints or tips
- Qualitative or quantitative outliers (high position in the ranking)

Pharmacies selected for on-site audit are generally notified of the upcoming audit in writing two weeks prior to the audit. One week before the audit, a Heritage representative telephones the pharmacy to:

- Make sure the pharmacy received its audit notification and read it
- Answer any questions the pharmacist may have about Heritage and the audit
- Put the pharmacist at ease with regard to the audit
- Obtain directions, store hours, and other relevant information

Heritage draws a sample of paid claims for review by auditors in each audit. Depending on the state's preference, Heritage may draw either a targeted claim sample or a statistically representative sample that allows for an extrapolation of overcharges. The extrapolation formulae are based on proven statistical models and yield a reliable estimate of overcharges for each pharmacy.

While on site, the sample claims are compared to on-site records that may include:

- Hard-copy prescription files
- Computer files and records
- Third-party signature logs
- Refill authorization logs
- Computer printed daily transaction logs
- Purchase invoices
- Other relevant information

Auditors review each claim to assess compliance with the applicable rules, regulations, and guidelines set forth by the state and federal governments and the plan. Where claims violate these guidelines, discrepancies are documented, applicable pharmacy records and documents are electronically scanned into laptop computers, and a list of discrepancies is compiled.

At the end of the audit, the auditor prints the list of discrepancies and reviews it with the pharmacist in charge. At this time, the pharmacist is given the opportunity to produce any additional documentation that may mitigate the discrepancies. Any additional documentation is considered and a new discrepancy list is produced before the auditor leaves the pharmacy. The pharmacist signs the report to indicate that he or she has had every opportunity to produce documentation.

This process minimizes the need to administer a post audit appeals process. In Heritage's experience, much of the documentation received after an audit is unreliable since it often cannot be established whether the documentation existed at the time of the audit or was manufactured post audit.

Generally, the on-site visits are completed in a half-day, and final reports are delivered to the plan within three weeks of the completion of each audit. At that point, the state may request repayment from the pharmacy, withhold payment from the pharmacy, or further a case against the pharmacy.

Phase 4: In-Depth Audits

Occasionally, fraud is suspected or discovered during the on-site audit. The investigation and quantification of fraudulent dollars requires a more involved on-site audit that can vary from a single day to a week or more, depending on the scope and type of fraud, and the level of cooperation received from the pharmacist.

In this phase, auditors develop the fraud case against the pharmacy by collecting evidence from pharmacy documents and from interviews with pharmacy staff, members, and physicians. Heritage's investigators are expert in conducting a professional, efficient investigation.

Where warranted and with the client's authorization, Heritage acts as an advocate in presenting audit results and evidence to law enforcement or judicial authorities. Heritage offers the following services:

- Prepare the case for the prosecution
- Organize the evidence
- Determine the best strategy for prosecution whether at federal, state, or local level
- Establish contacts for the client
- Serve as intermediary between judicial authorities and client

The prosecution of fraud is the most effective tool in establishing a sentinel effect. All in-depth time and materials expenses are subject to the plan's prior approval. Before conducting the in-depth audit, Heritage will meet with the client to establish the scope of the specific investigation and the desired outcome.

Retail Pharmacy Audit Potential

Heritage has been conducting retail pharmacy audits for more than 20 years for a variety of payors—including Florida Medicaid, Michigan Medicaid, and Hawaii Medicaid—with great success. **Heritage has realized significant savings for its clients with return on investment (ROI) of more than six to one.** The long-term savings associated with the sentinel effect exponentially increase the overall savings associated with Heritage's auditing services.

Home Infusion Therapy/Durable Medical Equipment Audits

The purpose of a home infusion therapy/durable medical equipment (HIT/DME) audit is to identify overpayments relating to infused and injectible medications, services billed in association with the administration of HIT, and DME items. Because a single provider will sometimes provide both HIT and DME services, records relating to these services may be found in the same chart. DME often supports HIT; therefore, the audit generally includes both HIT and DME categories. However, should the state prefer to focus on one of the two areas, the audit can be limited to either HIT or DME.

Heritage auditors will conduct selective site visits to assess the appropriateness of claims. Auditors travel to the provider site and review patient charts to identify potential overpayments. The site visit begins with an entrance interview, during which the lead auditor discusses protocols and procedures with the provider, establishes appropriate contacts, and asks a variety of questions about pharmacy practices. The lead auditor will also answer any questions posed by the provider at this time.

The chart review involves the review of both financial and clinical charts. Auditors fully document discrepancies and inappropriate billings. To maintain a permanent record and appropriately document findings, auditors will digitally scan any records relating to apparent discrepancies or overpayments. Chart reviews generally include an auditor's review of the following items:

- Prescriptions/physician's orders/certificates of medical necessity (CMN)
- Delivery records
- Nursing notes/home visit documentation
- Prescription compounding records
- Medical progress notes
- Billing records (usually HCFA-1500 forms)

Therapy is examined longitudinally to target any breaks, discontinuations, changes, or other modifications that could affect billing. Through review of the paid claim data and via an on-site chart and compounding-record review, Heritage generally identifies a variety of issues and overpayments falling into categories including the following:

- Payments for prescription drugs or items in excess of the contracted price, per diem, or reimbursement rate
- Claims submitted after termination of coverage or after patient is deceased

- Rental payments that exceed the purchase price of DME-related equipment
- Mismatch of therapy and equipment (for example, an enteral pump billed during parenteral therapy)
- Solutions used for compounding multiple patients billed as single-unit solutions (for example, double-billing for individual vials)
- Provider billed for the wrong drug
- Home-health services billed during admissions or inpatient stays
- Provider billed a larger quantity than ordered by the physician
- Provider billed inappropriate per-diem or supply charges (may include unbundling)
- Items not ordered by the physician or orders not documented in the patient chart
- Billing for items that are not covered and should not be reimbursed
- Billings do not match the quantity a provider purchased in that time period
- Duration of therapy exceeds that ordered by the physician
- Inappropriate dosage of medication (taking into account the weight of patient as available and appropriate)

Where possible, Heritage's audits are provider-friendly and seek to keep the provider involved in the process. For instance, entrance and exit interviews are conducted in each audit, giving the provider an opportunity to ask questions and obtain a comfort-level with Heritage's processes.

The exit interview generally involves the review of a printed list of discrepancies. Auditors generate such a list on site, using a portable laser printer. This list is reviewed with the pharmacy staff to determine if any additional mitigating documentation can be provided. If not, the provider is asked to sign the document, affirming that he or she is unable to provide any additional documentation. This eliminates any surprises to the provider and facilitates the recovery process.

HIT/DME Audit Reporting

Heritage will submit a final report to the state, documenting the audit methodology and its findings. The final report will include an executive summary that provides vital statistics relating to the audit, such as location and duration, auditor and provider contacts, and types of findings.

The report will also include a claim-level reporting of all documented overcharges. This report will include the claim number, date, patient ID, drug/procedure code, discrepancy, payment information, and a calculated overcharge amount. The claim-level report is comprehensive and also includes a comment field for the auditor to further describe the problem or issue relating to the claim. In this way, the report includes enough specificity and detail to be a stand-alone implement for the recovery of overcharges.

HIT/DME Audit Potential

Heritage has audited numerous home infusion providers for numerous payors across the country. In Heritage's experience in these audits, the recoverable issues are often driven by the same underlying factors:

- Centralized billing offices
- Complex billing requirements (for example, compounding, nursing services, DME)
- Ambiguous HCFA-1500 forms

These audit drivers have consistently produced recoveries that amount to 7 percent to 8 percent of all HIT/DME dollars spent by the State. For a typical client, that figure translates to roughly $1.80 per covered life in the first year of audit.

Heritage Organizational Overview

Founded in 1980 as an auditing and consulting company focused on prescription drug plans, Heritage now employs a staff of 74 full-time personnel and 15 consultants that includes registered pharmacist auditors, clinical pharmacists, health care information analysts, pharmacist researchers, biostatisticians, systems analysts, programmers, and health care consultants. Delivering pharmacy benefit management solutions is the exclusive mission of Heritage. As such, 100 percent of Heritage's efforts are devoted to developing and deploying its suite of advanced cost containment and quality improvement services.

Those include:

- Clinical Management Services
  - Population-based disease management programs
  - Retrospective drug utilization review (retroDUR)
  - Prior authorization programs
  - Case management applications
  - Prospective drug utilization review (proDUR) consulting services and systems
  - Expert, Web-enabled drug program management information systems
  - Counter-detailing and provider education tools
- Pharmacy Auditing Services
  - Retail pharmacy audits
  - Claims processor/fiscal agent audits
  - Mail service pharmacy audits
  - HIT/DME
  - Other pharmacy-related health care audits

Heritage provides its services to some of the largest payors of prescription drug benefits in the country, including 13 Medicaid states:

- Texas
- Florida
- Missouri
- Idaho
- Kansas
- Minnesota
- Michigan
- Delaware
- Rhode Island
- West Virginia
- Hawaii
- Washington, D.C.
- Wyoming

Heritage's main office is in Richmond, Virginia, with satellite locations in Miami, Florida; Philadelphia, Pennsylvania; Jefferson City, Missouri; and Hawaii.

Heritage Auditing Services

The audit team is led by a vice president of auditing services with more than 10 years of pharmacy-related audit experience and a CPA audit manager with years of experience as a senior manager in a large accounting firm. Additionally, the CEO, senior vice president, vice president of clinical services and vice president of account management all support and provide leadership for the audit function.

Currently, Heritage employs a staff of more than 30 full-time employees in the auditing department. Included in that number are 12 full-time auditors, all of whom are registered pharmacists or Pharm.D.s. with real life experience in the pharmacy industry that makes them ideal auditors, as they are more apt to identify discrepancies resulting from fraud, abuse, or noncompliance with the plan's policy. Furthermore, licensed pharmacist-auditors automatically enjoy a high level of credibility with the pharmacists being audited.

Rounding out the audit staff are experienced pharmacy technicians and audit analysts who assist the pharmacist-auditors with reporting and analyzing the findings. Heritage also employs two investigators with extensive law enforcement experience and health plan fraud unit experience that investigate beneficiaries suspected of "doctor shopping" and assist in performing in-depth audits.

TrestleTree Disease Management

The mission statement created by the Department of PATH outlines its ultimate goal to assist Vermonters in finding "a path to a better life." The agency expounds upon this mission statement with a vision statement that supports the premise that "Good health supports happiness and success." These values underscore the need for Vermonters to be treated as individuals able to grow and change. The statement further pledges to "help people discover their strengths and realize their full potential." As your current fiscal agent, EDS continues to support these values and presents a potential alliance partner whose commitment to "reduce health care costs by investing in the growth potential of people" aligns perfectly with the visionary plans set forth for Vermont.

Initially, EDS considered TrestleTree as an alternative solution to meet the state's objectives outlined in section 1.1.2 for bidders to "propose cost containment ideas for increasing the state's control over fiscal agent and program expenditures." After reviewing TrestleTree's offering and exploring its organizational mission, we were excited about the opportunity to present a new partner that will proactively promote your vision for the citizens of Vermont.

TrestleTree offers Vermont a unique approach to disease management (DM) services. TrestleTree's approach is a unique blend of tools, specialized training, and expertise. This blended approach creates a path that allows Vermont to combine the vision for good health with the cost containment objectives. Unlike other DM service offerings, TrestleTree's approach encompasses patient-focused interventions designed to modify health behaviors, improve health care outcomes, and offer quantifiable reductions in medical and pharmaceutical expenses.

This optional enhancement recommends a pilot program. This approach allows the Department to fully analyze the benefits associated with the TrestleTree offering:

- Intervention alternatives that result in the improved health of Vermont beneficiaries
- Clinical monitoring, program trending, and financial analysis
- Reduced benefit expenditures for pilot participants

With the current budget restraints, perhaps the element of this offering that provides the most imminent value for Vermont is *the cost to implement this pilot program—nothing*.

We have waived the administrative fee normally incurred with the initiation of a new pilot program. Instead, we propose a payment schedule that is contingent upon the financial savings achieved.

The following section documents some of the clinical improvements achieved for a client receiving TrestleTree services:

- A 300 percent reduction in illness-related work absenteeism (as compared to pre-TrestleTree work year)
- Sustained, regular monitoring of illness consistent with disease-specific best practice protocol, according to the reports of 90 percent of participants

Ultimately, the benefits associated with the contingency payment schedule and the reduction in benefit expenditures are compounded when you realize your vision of improved health outcomes for the citizens of Vermont. We summarize our approach for Vermont in the following sections:

- Overview of Pilot Evaluation Project (PEP)
  - Personalized Health Management
  - Coaching Techniques for Better Health Management
  - Savings Analysis
  - Monitoring and Reporting Capabilities
- TrestleTree Organizational Overview

This document will explain how TrestleTree staff invest their time and effort to meet both the unique health challenges and great potential for health success of each participant.

Overview of Pilot Evaluation Project (PEP)

To demonstrate the viability and benefits of TrestleTree's offering, we recommend a Pilot Evaluation Project (PEP). Initially, we voluntarily enroll 300 to 500 Medicaid beneficiaries to participate in this evaluation project. The pool of available participants would be developed after an analysis of Vermont's medical and pharmaceutical claims data. This data offers the best opportunity to identify potential participants who have claim records indicating one of the following disease states:

- Diabetes
- Asthma
- Coronary artery disease (CAD)
- Chronic obstructive pulmonary disease (COPD)
- Hypertension
- Dyslipidemia

With a partner to guide them toward a path of healthier living, individuals laboring with chronic illnesses can improve their health outcomes and spend less on medical care. Once this pool of potential participants is identified, TrestleTree will proactively target these beneficiaries to encourage voluntary participation in the PEP. Pilot sites to conduct these outreach activities are typically identified during the analysis phase. We will target our outreach activities at the treatment centers that specialize in treating the targeted disease categories.

We recommend a 12-month PEP with interim evaluations at six- and twelve-month intervals. Neither the state of Vermont nor the Vermonters participating in the program will incur costs associated with the services provided by TrestleTree. Instead, we propose a quarterly evaluation of medical and pharmacy claims data to document the financial impact and the actual benefit savings that will determine TrestleTree's contingency payment amount.

Personalized Health Management

Intensive time with a skilled, trusted health care professional ranks as key and essential to interrupting a negative, costly course of illness for people struggling with diabetes, asthma, CAD, or COPD. TrestleTree uses pharmacists as health coaches to offer beneficiaries:

- Personalized care to those who need it most
- Ongoing connections that lead to a new path of health behaviors

Instead of relying on a nurse call center approach or educational pamphlets to elicit healthier behaviors, TrestleTree's staff of pharmacist health coaches proactively develops dialogue through ongoing monthly contacts with assigned patients. Pharmacist coaches provide strategies for health success and evaluate a beneficiary's medications for safety and savings.

Key ingredients for success—Interaction with the coaching staff creates a focused level of intensity to improve the participant's health care regime and creates an unprecedented level of trust with each program participant. TrestleTree's interactive involvement is key to its success. Its coaching techniques have proven essential to achieving benefit savings for its clients:

- **Disease-State Knowledge—**Each TrestleTree pharmacist health coach possesses cutting-edge information about medication safety, disease-specific best practice protocols, and evidence-based medicine guidelines. The participants receive the best information available about medication safety issues, disease-specific guidelines for adherence to a treatment protocol, and empowering information about health behaviors that can lead to a healthier lifestyle.
- **Clinical Health Coaching—**TrestleTree supplements the pharmacists' clinical knowledge with the specific coaching techniques necessary to drive health behavior changes. While most health care professionals are limited to directing or telling a patient what he or she must do, our pharmacists receive specialized training to *influence* a participants behavior patterns. To *influence* is to understand the context of the person, to spend adequate time to set goals, establish accountability, and to listen as well as tell. TrestleTree's health coaches employ a unique strategy that changes the dynamics associated with the participant's health care behavior and, ultimately, achieves significantly better health care outcomes.
- **Diverse Demographics and Domain Expertise—**Diversity is a leading contributor to the factors that distinguish the TrestleTree team of pharmacist health coaches. While the coaching staff maintains a high level of professionalism and the highest levels of pharmaceutical training, their diverse cultural backgrounds allow them to understand a beneficiary's circumstances. The coaching staff speaks multiple languages and brings knowledge of disease-states specifically related to age, gender, culture, or job-specific issues. TrestleTree leverages this diversity to improve the health outcomes across Vermont's entire disease population.

Coaching Techniques for Better Health Management

TrestleTree's health coaches are guided by several proven strategies designed to help participants lead healthier lives.

- **Establish a Potent Working Relationship—**Initially, each TrestleTree participant spends one hour with his or her pharmacist health coach. The coach listens, assesses, and builds a one-on-one health care connection with the participant. Arrangements are made to connect participants with their health coach on a regularly scheduled basis. All communication occurs through teleconferencing.
- **Work Multibehaviorally on Disease State—**Recent health behavior research suggests that simultaneously addressing three health behaviors (for example, weight loss, exercise, smoking reduction) potentiates change. In other words, simultaneously working to change several health behaviors of the participant lets the participant see results within each behavior category. Consequently, each TrestleTree participant will work with the coaching staff to develop a Life Map. This map identifies numerous, diverse health behavior goals to promote quick movement toward behavioral outcomes.
- **Work Within a Stages of Change Framework—**Behavior changes that apply to medication adherence, disease monitoring, weight loss, exercise, stress management, smoking reduction, and food choice restructuring are achieved only when an individual adequately prepares for the ardent work necessary to achieve the benefits associated with the change. Spontaneous action seldom results in lasting change. TrestleTree's health coaches are rigorously prepared to understand and implement a stage-of-change assessment across each clinical behavior for each participant. This assessment supports the appropriate formation of goals for each stage to achieve maximum results.
- **Establish Accountability for Each Participant—**After the participant/family member's 60-minute initial intervention appointment, monthly next-steps interventions will be scheduled in 30-minute increments. This approach creates a formidable health care relationship designed to assist each participant in moving toward the action and maintenance stages for each critical health behavior. When high positive clinical outcomes are achieved, there is a direct correlation between the participant's high-touch accountability and the guidance received from a health coach partner.
- **Rigorously Assess Clinical Outcomes—**TrestleTree's coaching staff conducts a monthly audit of clinical health behavior outcomes. While it is clear that participants change over time, the coaches focus health behavior change for each participant. Monthly outcomes audits are a vital tool to assess the quality and effectiveness of TrestleTree's program.

Pharmacist health coaches receive intensive training in creating health change-focused relationships with their patients. They develop individualized plans for modifying health behaviors that are linked to successfully avoiding costly catastrophic health events and provide follow through in patient participation. Coaches have T-Rx, a proprietary software tool designed to address both safety and savings in the patient's pharmaceutical utilization. T-Rx allows the pharmacist coach to observe in real-time the patient's medication regimens and potential drug interactions between all types of medications: prescription, over-the-counter, and herbal. T-Rx

also monitors the overlap of every beneficiary's prescription drugs to the state's formulary. Coaches can examine formulary issues, including generic utilization, formulary brand utilization, and therapeutic equivalent information, for potential state and patient savings while patients also receive safety recommendations for each prescription.

Savings Analysis

TrestleTree seeks to employ an "absolute savings" strategy to examine claims savings or document a client's ROI. We deploy this strategy using an observational time series design: the change in outcomes (medical claims) is computed from a modeled baseline to the same program period for the same cohort of participants. This approach provides the most direct assessment of TrestleTree's impact on medical services. TrestleTree's impact on pharmacy claims can be easily derived from an analysis of the patient's pharmacy-spend data subsequent to the intervention of the pharmacy coach using the T-Rx on safety and savings. Increased compliance to approved formularies by the participants translates to a decrease in pharmacy expenditures for participants enrolled in the TrestleTree program. We capture and track this data using pharmacy claims data.

Monitoring and Reporting Capabilities

TrestleTree is committed to the regular, ongoing quality assessment of its interventions and the impact of coaching on clinical outcomes. Pharmacist health coaches conduct monthly audits of each participant's progress on the following clinical health outcomes: disease-state monitoring, medication adherence, food choice changes/adherence to treatment plan, weight loss, smoking reduction, and exercise adherence. Each participant creates a multidimensional goal plan at the beginning of the coaching relationship and updates this plan continually through monthly interventions with the coach. TrestleTree provides quarterly reports to each client about the clinical health behavior achievements of the participants and conducts an annual analysis of savings in medical/pharmacy claims through the methodology described above.

Outcomes Examples—Results of the most recent clinical outcomes audit for TrestleTree's participants reveal the following clinical achievements:

- Eighty percent of participants are engaged in regular, ongoing, weekly exercise.
- Eleven-pound average weight loss for all participants—this figure represents a range of zero to 80 pounds and includes asthma participants for whom weight loss was not a behavioral goal.
- Eighty percent of participants have initiated and maintained disease-appropriate alterations in food choices, such as the reduction of sodium or fat.
- Participants report a 300 percent reduction in illness-related work absenteeism (as compared to the pre-TrestleTree work year).
- Ninety percent of participants report sustained, regular monitoring of illness consistent with disease-specific best practice protocol.

A recent assessment of TrestleTree's disease management program for a corporate client was conducted by the international benefit consultant, Watson Wyatt. Using an observational times series design, Watson Wyatt assessed medical claims savings by computing outcome from baseline to the program period for the same cohort of participants (a classic "before-to-after program" design). Results of this study produced several data points that were particularly pleasing to TrestleTree's client. Most notable were the following:

- TrestleTree's program resulted in a 45 percent reduction in medical claims during participation in the program.
- The client realized a 1.5 to 1 ROI for the first year of participation in the program. This ROI increased to a 2-to-1 return during the last two quarters of the program year. Watson Wyatt's trend analysis indicated that these savings or the client's ROI would continue to increase throughout the year and suggested continued upward movement for the second year.

TrestleTree Organizational Overview

This overview validates TrestleTree's record of success and articulates the value its services can provide to the citizens of Vermont.

TrestleTree is a privately owned company that evolved in response to three ominous vectors converging in the health care sector:

- Soaring volume of medical claims with 70 percent of health care dollars being spent on 20 percent of the population
- Reduced availability for health care professionals to interact with their patients
- Exploding pharmacy spending enhanced by industry's direct-to-consumer marketing strategies

The intersection of these ominous trends demanded a fresh approach to disease management: an approach built on the following fundamentals:

- Laser accurate identification of target populations
- Critical investment of time by a highly trained health professional
- Documented records to capture the individual life/health story of each person identified with the disease-state
- Focused intervention to influence the pharmaceutical choices made by a patient and reduce the use of higher-priced drugs when safe, lower-priced formulary brand alternatives or generic equivalents were available.

Consequently, TrestleTree has stepped into the eye of this health care storm and made an immediate impact with its revised approach to disease management. TrestleTree's unique approach has produced results that align with Vermont's vision: providing a path to better health for all Vermonters.

TrestleTree's first client is a leader in the trucking industry—J.B. Hunt Transportation. Like Vermont, TrestleTree proposed a pilot program for this organization. **Within one year of receiving TrestleTree's disease management services, this client reduced its medical claims cost for participants by 42 percent—a first-year ROI of 2 to1.**

Participants reported an average weight loss of more than 11 pounds. More than 80 percent of the participants adhered to a weekly exercise program. Exceeding the national average by nearly 65 percent. Participants also made significant food choice changes, and the coaches continually monitored their disease markers.

These results prompted J.B. Hunt to expand TrestleTree services across its entire trucking organization. This decision has created significant savings for the company's bottom line but has also created a staff of health-conscious employees.

Containing Vermont Medicaid Costs

The Department of PATH has the exciting opportunity to take advantage of the cost containment mechanisms proposed by EDS to protect future Medicaid program costs by selecting these proposals. The results for the state will be:

- Reduced pharmaceutical expenditures
- Improved compliance with drug formularies
- Decrease in fraud, abuse, and waste
- More efficient, less costly, and improve prior authorization processes for drugs
- Highly individualized disease management for targeted populations with chronic diseases
- Reduced claims payments for patients with the most significant health care costs
- Healthier patients with chronic illnesses

EDS looks forward to the opportunity to partner with the Department of PATH to bring these cost savings innovations.

n. Assumptions or Constraints in Developing and Completing the Work Plan and Schedule

RFP Reference: 3.2.2.10(n), p. 3-16

When determining the assumptions or constraints in developing and completing the work plan and schedule for the Operations Phase, EDS was able to focus its planning on the most positive of all assumptions. That assumption is that EDS and Vermont currently have an outstanding record of partnership and cooperation. Building on this solid groundwork, we developed the Operations work plan and schedule with the following assumptions:

- EDS and the state can immediately begin to focus on enhancement tasks
- EDS understands the Department of PATH's requirement that the their fiscal agent must know the Vermont Medicaid Program and all of its nuances
- EDS values the Vermont provider and recipient communities and will continue to provide correct, on-time payment of all claims
- EDS remains focused on the delivery of services and will have limited takeover tasks which could impact that service delivery
- EDS is prepared for a seamless transition of all takeover and operational phases of this project

We have identified a few constraints that may transpire during the Operations Phase of this contract. Possible constraints include:

- Scheduling changes
- Unexpected personnel changes
- New federal or state regulations
- Budgetary issues

However, it is our expectation that, together with the state, we will deal with those issues as they arise with the same urgency and efficiency that we do today.

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o. Critical Path Diagram

RFP Reference: 3.2.2.10(o), p. 3-16

On a day-to-day basis, EDS works closely with state staff to provide the state and the provider and beneficiary communities with the highest level of Medicaid service. There are literally hundreds of interrelationships of tasks in a Medicaid fiscal agent operation and, yet, no effective manner in displaying those tasks in a critical path diagram.

As you review the Operations Gantt Chart, you will notice that the majority of the state's requirements are shown to be 783 days of duration starting on January 1, 2004, and completing on December 31, 2006. It is our belief that every task on the Gantt chart is and will continue to be critical. Because these tasks are all critical to the function they support, they are all on a critical path. The Operations Gantt Chart, with more than 600 tasks and subtasks, will be a much more valuable tool for the state to evaluate our understanding of the scope of work required in operations.

We recognize the importance of a critical path diagram for the start up of contract operations. However, as the incumbent, we won't have to go through this complex phase of contract start-up activities. Please refer to the Operations Gantt Chart for a list of the standard, repetitive tasks that comprise the Operations Phase.

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p. Gantt Chart

RFP Reference: 3.2.2.10(p), p. 3-16

The Operational Gantt Chart developed for this project graphically depicts the duration, relationship, and dependencies of each task, subtask, activity, and subactivity throughout the Operations Phase. Our Operations Gantt Chart provides day-to-day picture of the type of activities that occur today and will continue to occur from 2004 through 2006, with some change in operations when various enhancements are implemented. The following describes each column of the Gantt Chart:

Gantt Chart Column Descriptions

Column	Description
ID	This first column on the left of the Gantt Chart is a sequential series of numbers from one to the last activity on the Gantt Chart. This identification number (ID) numbers helps readers discuss line items by quickly referring to the line's ID.
WBS	Microsoft Project generates a WBS number that indicates the relationship between tasks, subtasks, activities, and subactivities. The WBS ID number is sequential within each of the tasks and identifies work plan elements. Inserting, moving, or deleting a Microsoft Project task or subtask automatically updates the related identification numbers and displays the current order of tasks. The WBS number provides a unique identifying value that accounts for work plan tasks and subtasks. The number, divided into segments, is separated by a decimal point. Segments correspond to a task outline level.
Task Name	The task name proves an English (textual) description of the task, subtask, activity, or subactivity.
Duration	The number in the duration column indicates the number of days—exclusive of weekends and state holidays—required to complete the task, subtask, activity, or subactivity.
Start	The start column indicates the day the work is scheduled to begin for the task, subtask, activity, or subactivity.
Finish	The finish column indicates the day the work is scheduled to finish for the task, subtask, activity, or subactivity.
Task Bar	Lines in the main body of the chart depict the calendar duration of the work required to complete the task described on the same line.

The Operational Gantt Chart is available on the following pages as well as on the proposal CD-ROM. Please note: You will need Microsoft Project 2000 on your PC to open the Gantt Chart file.

q. How the Work Plan Provides for the Handling of Potential and Actual Problems

RFP Reference: 3.2.2.10(q), p. 3-16

This section discusses how our work plan provides for handling of potential and actual problems. Because this project does not involve a transition of contractors, the Operations Phase with EDS will continue very much as it operates today. Of course, as the enhancements are implemented, they will be taken into consideration and fit into the scope of day-to-day operations. As with today's tasks and the tasks associated with the new contract, they require careful planning to avoid or resolve problems.

A key factor in preventing major issues is the early identification and resolution of problems. Our work plan supplements the experience and foresight of our Vermont leadership team.

In addition, we used one of the most powerful project management tools available today, Microsoft Project 2000, to create our work plan. Microsoft Project provides us with the following capabilities:

- Tracking actual progress against planned progress
- Integrating with Microsoft Outlook calendars, task lists, and journals
- Tracking resource expenditures
- Warning when resources are over-committed—assigned to too many activities
- Reporting percentage of project completion and remaining effort required

Microsoft Project's management reports will provide an ongoing source of valuable data to keep managers aware of the assignment and expenditure of resources. With this level of accurate, reliable data, the leadership team is better prepared to avoid entirely or to mitigate the impact of potential problems.

In addition, Microsoft Project helps us to manage workloads by creating individual task lists and events in the Microsoft Outlook calendar so that team members know exactly what task or subtask they should be working on and when it must be complete. Microsoft Outlook task lists and journals help to ensure that we accurately record actual effort and work completed in the project plan by automatically updating the effort expended and percentage completed as individuals perform their daily tasks.

Microsoft Project also produces reports that show managers when tasks will most likely be completed ahead of time. This information allows us to provide extra resources to other tasks that may need additional support.

EDS and the state will use the frequent checkpoints and review periods built into the work plan to identify potential and actual problems. The state has reserved 10 days to review and approve deliverables. The 10-day review period provides sufficient time for a thorough review by all state personnel affected by that deliverable. EDS' internal review of designs and deliverables will tell us early in the process where problems may arise.

Finally, we believe that our approach to the Operations Phase—dividing all work into well-defined segments—will reveal any potential for problems before they occur. The purpose of the work plan is to make the project team perform in-depth planning to determine the exact type of work, time frames, and resources needed to complete the scope of work on time. This planning process requires us to divide the work into easily managed segments that enable us to predict potential problems with a great degree of accuracy. This early warning gives us the ability to apply extra resources or plan additional time for task completion when necessary.

The EDS work plan for operations provides a powerful project management tool. In planning the needs of complex projects over time, our work plan provides the opportunity to predict and prevent problems, helping to provide the state with on-time, successful completion of each step of the project. Using this tool as well as our combined weekly meetings and ongoing communications, both the state and EDS will be able to address any areas within daily operations that require adjustment and make plans accordingly.

r. How the EDS Approach to the Operations Scope of Work Clearly and Unambiguously Accommodates Existing Technology and Meets Stated Technical Requirements

RFP Reference: 3.2.2.10(r), p. 3-16
2.9, p. 2-179
2.10, p. 2-184

EDS' approach to the Operations Scope of Work will clearly and unambiguously satisfy the state's requirements to:

- Accommodate existing technology
- Meet stated technical requirements

Accommodate Existing Technology

Our approach to Takeover and Operations is clear and unambiguous: With EDS no Takeover is necessary; Operations will continue without the potential delay associated with a transition in contractors. We will continue to operate the VermontAIM MMIS and EVAH using technology we have in place today. This approach will fully accommodate the use of existing technology and preserve the investment in system upgrades and technology that you have recently made.

All other contractors must replace the platform and network (as described in detail in RFP sections 2.9 and 2.10); install the VermontAIM MMIS on that platform; and complete unit, system, and operational testing before January 1, 2004. We will, however, continue to operate on the currently installed stable technology environment, which will provide you with the following benefits:

- No disruption to Medicaid and other Vermont programs supported by the VermontAIM
- No risk of a late implementation due to equipment not arriving on time
- No risk of incorrect payments or increased denials due to a flawed system installation or inadequate testing in the new environment
- No delay in payments to the state's 6,000 providers
- No delay in turnaround of EVAH reports
- No delay in the implementation of legislative mandates that arrive each July

This approach means operations will continue with the technology described in RFP sections 2.9 and 2.10. Please refer to "Approach to Infrastructure" and "Approach to Facilities and Infrastructure Acquisition and Installation" in the "Work Plan and Schedule (Operations)" subsection for our detailed response to RFP sections 3.2.2.10(d) and (e).

Takeover projects in other states (for example, Mississippi) have resulted in payment problems and other issues like high claim backlogs, inexperienced staff due to failure to hire current fiscal agent staff, and lack of responsiveness to needed system changes due to inexperience with the takeover system.

Because we are the current contractor, we can continue any customer service request (CSR) work already in progress during the takeover. Likewise, we will not require any system freezes to accommodate transfer of the MMIS to a new data center. In addition, we do not require providers to use new claims submission software, eliminating the possibility of reduced electronic claims submission rates and the need for special training to accommodate different software for a function that remains unchanged.

Vermont can avoid all of these problems and continue to enhance the system without interruption by retaining EDS.

Meet Stated Technical Requirements

Our system currently meets the technical requirements described in RFP sections 2.9 and 2.10, with more detail provided in our response to section 2.11, "Approach to Infrastructure" in the "Work Plan and Schedule (Operations)" subsection. These sections describe the technical platform and environment of the current VermontAIM MMIS. Because EDS is the current contractor, we already meet all stated technical requirements.

We understand that the platform conversion represents a major change to the current technical environment; however, the conversion will occur in the first year of operations and will comply with a design and follow work plans that are approved by Vermont.

J. Enhancements/ Modifications Narrative

RFP Reference: 2.8, p. 2-159

In our narrative response to the RFP requirements for the Enhancements/Modifications Phase, we provide a comprehensive look at the people, processes, and services we provide the Vermont Medicaid Program.

We have organized the material to correspond with the RFP response requirements in the tabbed sections described below:

- **Project Organization and Staffing**—Our team brings extensive credentials in the operation and enhancement of Medicaid systems and affords the state an extraordinary staff dedicated to service excellence. The state can feel confident that the EDS team is fully committed to supporting the state's goals and requirements. In addition, the continuity of leadership and operational and technical resources will provide a smooth transition from the Enhancements/Modifications Phase back to Operations. The systems engineer (SE) staff that will perform the enhancements and modifications will be enhanced with the best technical talent from our central support centres in Vancouver, Washington and Richmond, Virginia.

- **Project Management and Control**—The state gains stability and uninterrupted service as a result of our ability to leverage best practices for project management and control designed for large-scale implementations. To support the reliable, on-time implementation of enhancements and modifications to Vermont's Medicaid Management Information System (MMIS), we will enhance our approach with the latest-generation tools and methodologies. We will upgrade our project management and control methodologies based on the Global Solutions Management System (GSMS) methodology, which will further strengthen our discipline and consistency in software development.
- **Work Plan and Schedule**—Our work plan and schedule provide a comprehensive look at all aspects of our enhancements and modifications. To ensure that we have answered all of your questions, we are responding to each of the lettered requirements in 3.2.2.10, and, in addition, we are responding to the enhancements and modifications requirements located in Section 2.8 of the RFP.

Overall, our Enhancements/Modifications narrative provides the following assurances:

- **EDS is the only contractor with significant Vermont Medicaid Program experience**—Our staff already understands how the program operates and the issues that are important to the state.
- **We have the experience with the VermontAIM system**—In addition to building and supporting the VermontAIM during the past 11 years, we successfully transitioned from an Ingres database to IBM DB2 during the implementation of the Delaware MMIS system. This direct experience will support the timely and accurate implementation of enhancements and modifications.
- **We are the only contractor who has implemented these mandatory and optional enhancements for other Medicaid clients**—We are the only contractor with experience in the AIM claims engine, which is critical for the integration of ClaimCheck and ClaimReview. Additionally, we are the only contractor who has integrated Web functionality with a client/server MMIS and who has deployed an MMIS that is fully Health Insurance Portability and Accountability Act (HIPAA) compliant. This experience will assist us in better understanding the changes required for the provider enrollment enhancement and will serve us in implementing the type/specialty to taxonomy conversion in particular.
- **EDS is a low-risk contractor**—We base our work plans and staff estimates on recent, relevant experience, which reduces risk.
- **We fully understand your goals and objectives**—We have developed approaches that exactly meet your expectations.

PROJECT ORGANIZATION AND STAFFING (ENHANCEMENTS/ MODIFICATIONS)

RFP Reference: 3.2.2.8, p. 3-11

As the developer of the current MMIS and its components, EDS is best qualified to implement the mandatory and optional enhancements and modifications. Our system knowledge combined with previous experience in other states implementing similar types of enhancements and modifications uniquely qualifies us to successfully complete each of the mandatory and optional enhancements.

To successfully complete each of these activities, the Enhancements/Modifications team will work under the direction of EDS Enhancements/Modifications Manager Sean Daly. This team, comprising SEs and other technical staff from the current Vermont on-site team, will be supplemented as needed with technical support from EDS' Vancouver and Provost Support Centres.

Sean's 12 years of experience designing and implementing client/server systems and seven years of Medicaid-specific system experience give him the technical and industry knowledge needed to manage a smooth implementation of the mandatory and optional enhancements and modifications. In addition to his technical expertise, the state will benefit from Sean's project management and leadership experience gained through leading EDS' Delaware Medicaid team responsible for the recent on-time, within budget implementation and CMS certification of the Delaware Medicaid program's new MMIS.

Our team brings extensive credentials in the operation and enhancement of Medicaid systems and provides an extraordinary staff dedicated to service excellence. You can be assured that the EDS team is fully committed to supporting the state's goals and requirements.

We discuss our staffing approach and organization in the following sections:

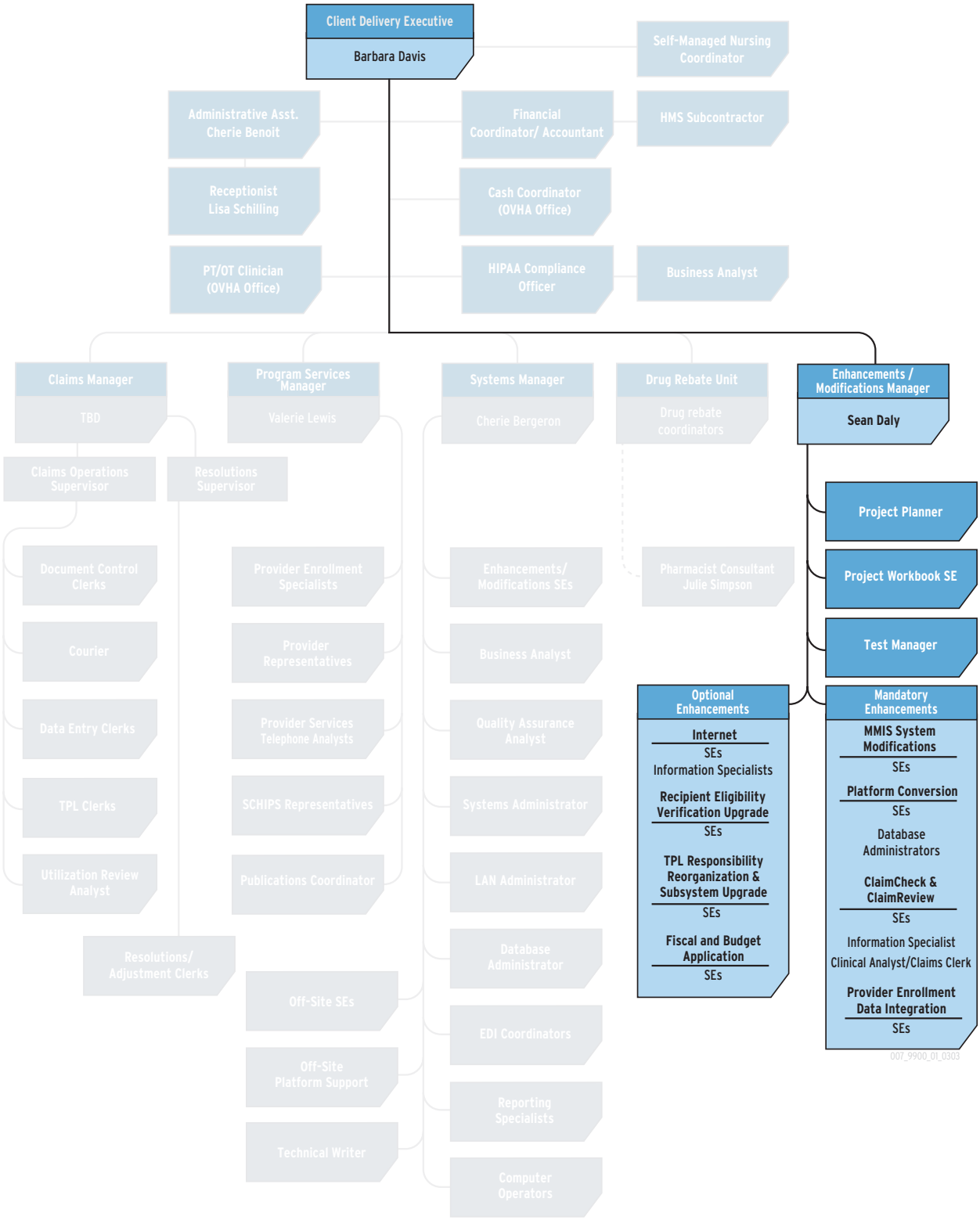
- Organizational Charts
- Management and Key Staff References
- Resumes or Vitae
- Staff Responsibilities
- Additional Staff

Organizational Charts

RFP Reference: 3.2.2.8.1, p. 3-12

The Enhancements/Modifications Phase organization depicted in the chart on the following page will be in place in January 2004. We designed this chart to show the enhancements/modifications team as separate from the operations team. However, Enhancements/Modifications Manager Sean Daly will report to Client Delivery Executive Barb Davis for this project. Barb will remain your single point of contact for all project activities, both operations and enhancements/modifications.

Enhancements/Modifications Phase Organizational Chart



Staff Loading Charts

The following chart shows estimates of staff effort by month for each of the mandatory and optional enhancements. The time for the staff members listed in the “Leadership” category will be distributed across each of the mandatory enhancements proportionally.

Staff Effort—Enhancements/Modifications Phase
All Enhancements—Mandatory and Optional

	2004 (Enhancements/Modifications Phase) All Enhancements																	
Job Titles	Oct-03	Nov-03	Dec-03	Jan-04	Feb-04	Mar-04	Apr-04	May-04	Jun-04	Jul-04	Aug-04	Sep-04	Oct-04	Nov-04	Dec-04	Jan-05	Feb-05	Mar-05
Leadership																		
Enhancements/modifications manager	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Project planner	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0	0	0
Project Workbook SE	0	0	1	1	1	1	1	1	1	0	0	0	0	0	0	0	0	0
Test manager	0	0	0	0	0	1	1	1	1	1	1	1	1	1	0	0	0	0
MMIS System Modifications																		
SEs	0	0	0	4.5	8.75	9.5	9.5	9.5	9.5	9.5	9.25	9	9	8.5	4	0	0	0
Platform Conversion																		
SEs	0	0	0	18.1	16.6	15.1	15.1	15.1	15.1	12	12	11	5.5	0	0	0	0	0
Database administrators	0	0	0	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	0	0	0
ClaimCheck and ClaimReview																		
SEs	0	0	0	4	4	4	4.5	5	5	1	.5	0	0	0	0	0	0	0
Information specialist	0	0	0	1	1	1	1	1	1	1	1	1	1	.5	0	0	0	0
Clinical analyst/claims clerk	0	0	0	1	1	1	1	1	1	1	1	1	1	1	1	0	0	0
Provider Enrollment Data Integration																		
SEs	0	0	0	2	3	4	4	4	4	4	3.5	3	3	2.5	2	0	0	0
Internet – Optional																		
SEs	0	0	0	1	3	5	5	5	5	5	3.5	2	2	1.5	1	0	0	0
Information specialists	0	0	0	1	1	1	1	1	1	1	1	1	1	1	1	0	0	0
Recipient Eligibility Verification Upgrade – Optional																		
SEs	0	0	0	1	1	1	1	1	1	1	1	1	1	1	1	0	0	0
TPL Responsibility Reorganization and Subsystem Upgrade – Optional																		
SEs	0	0	0	2	4	6	6	6	6	6	5	4	4	3	2	0	0	0
Fiscal Agent and Budget Application – Optional																		
SEs	0	0	0	2	2	4	4	4	4	4	4	2	2	2	1	0	0	0

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Management and Key Staff References

RFP Reference: 3.2.2.8.2, p. 3-12
2.6.14, p. 2-45

While supporting the Vermont Enhancements/Modifications Phase, Manager Sean Daly will be working for Client Delivery Executive Barbara Davis and will collaborate closely with Systems Manager Cherie Bergeron. Both managers will be heavily involved in the work required by the enhancements and modifications. References and resumes for Barbara and Cherie are located in the "Project Organization and Staffing (Operations)" subsection.

Enhancements/Modifications Manager **Sean Daly**	
Sean has 12 years of experience with large-scale database and transaction processing systems, including experience with large system transfers, modifications, and development efforts; training and implementation tasks; and operation and maintenance. He has designed, led, and implemented client/server systems for most of his 13 years with EDS. His vast experience encompasses systems architecture, design, development, deployment, and operations. Sean has worked on two complete MMIS implementations and large enhancements for the Idaho AIM and Delaware MMIS. As the systems architect and claims technical lead for the Delaware MMIS (a successful transfer of the Idaho AIM, which is based on the VermontAIM), Sean brought the system forward to full HIPAA compliance and converted it from Computer Associates Ingres to DB2. This was the first system in the nation to be HIPAA compliant.	Sean's responsibilities as the enhancements/ modifications manager include: • Overseeing the daily operations of the enhancements/modifications team • Successfully leading his team from project start-up through requirements validation, detailed design, construction, system testing, user acceptance testing, and implementation • Overseeing the implementation of new system enhancements and modifications to ensure they are on time and within budget • Providing uninterrupted service to the state, providers, and beneficiaries in ongoing fiscal agent operations
Experience with system development and consultation. During Sean's 13 years with EDS, he has worked on two complete Medicaid implementations for Delaware and Idaho, as well as other large enhancements to AIM systems, including his current role as testing manager for the Idaho HIPAA implementation. Additionally, he has experience developing and enhancing systems supporting commercial insurance and EDS customers in the communications and retail industries. He was most recently the claims technical leader and overall systems architect for the Delaware implementation of the first HIPAA-compliant MMIS, and did so on time and within budget. He has been involved with every step of the design of EDS' solutions for the mandatory and optional enhancements in this proposal: choosing the solution, selecting the team, developing the work plans, and reviewing every word in the "J. Enhancements/Modifications Narrative" section for accuracy.	

Experience with project implementation (time lines and costs). As part of Sean's role on the Delaware MMIS implementation, he was responsible for determining the overall staffing required for the SE team. During the implementation, he managed a team of 30 claims area SEs to ensure that they met their deliverable dates and stayed within their budget. Sean was also involved in reviewing the project management plans including EDS' bid for the Vermont Coverage and Services Management Enhancement (CSME) project.		
Ability to provide staff development and education. He trained the Delaware MMIS implementation team in the techniques needed to convert system code from Ingres to DB2. In addition, Sean developed the training plan successfully used in the Delaware MMIS implementation to help prepare the SEs for this programming task. He has also taught courses in C programming, claims processing within the AIM environment, and UNIX shell programming.		
Depth and breadth of knowledge of provider relations, health care policy and politics, government technology, and information management. During his 13 years with EDS, Sean has held a variety of project roles, from gathering customer requirements as a business associate to designing and implementing a large-scale Medicaid implementation as a technical lead. He uses his knowledge of health care policy and politics and information management to guide his approach to technical design and implementation in the Medicaid environment. His overall knowledge of Medicaid enables him to implement technical solutions that have a positive impact on operations. For example, Sean has worked closely with EDS' Medicaid customers to implement cost savings plans, such as the implementation of early refill drug utilization review alerts for Delaware and Idaho. Due to the budget crisis brought on by today's economy, he has worked closely with EDS' Delaware team to determine areas in which program cost savings can be realized, such as the proposed implementation of ClaimCheck and ClaimReview for Vermont. The state realized many benefits from the implementation of these program cost savings, and the beneficiary population experienced minimal to no impact.		
Delaware Department of Health and Social Services Mr. Norman Clendaniel, Medicaid Implementation Project Director Division of Social Services Biggs Building 1901 N. Dupont Highway New Castle, Delaware 19720 302 255 9762 nclendaniel@state.de.us August 2000 to December 2002	Delaware Department of Health and Social Services Ms. Kay Holmes, Chief – Managed Care/Quality and Claims, Division of Social Services Lewis Building 1901 N. Dupont Highway New Castle, Delaware 19720 302 255 9529 kholmes@state.de.us August 2000 to December 2002	Idaho Department of Health and Welfare Ms. Julie Grunder, Medicaid Automated Systems Specialist 450 West State Street Boise, Idaho 83720 208 334 0682 grunderj@idhw.state.id.us August 1996 to August 2000

Resumes or Vitae

RFP Reference: 3.2.2.8.3, p. 3-12

The subsequent pages contain the resume for Enhancements/Modifications Manager Sean Daly. Sean will be working for Client Delivery Executive Barbara Davis. However, the enhancements implemented by Sean's team will affect all areas of the fiscal agent operation. For this reason, Sean will remain in close contact with Barbara's other managers, who will remain focused on operations during this time. Resumes for Barbara and her leadership team can be found in the "Project Organization and Staffing (Operations)" subsection. We are repeating the following table as a reminder of the broad base of experience brought by the entire leadership team.

Key Personnel Years of Required Experience

Required Experience	Barbara Davis	Cherie Bergeron	Valerie Lewis	Sean Daly	All Key Personnel
EDS	22	17	20	13	**72**
Management	30	15	15	5	**65**
Medicaid claims processing systems	27	17	8	7	**59**
Client/server nonmainframe systems	12	10	10	12	**44**
Table- and Web-based applications	12	10	6	12	**40**
Application interface design and implementation	22	7*	NA	12	**41**
Transfer, modification, and implementation of an MMIS	28	7*	5	7	**47**
Medicaid provider relations	18	6	8	NA	**32**
Other medical claims processing systems	9	NA	9	1	**19**
Governmental information technology projects	27	NA	12	7	**46**

* In management oversight capacity only

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Sean Daly

Enhancements/Modifications Manager

"I will use my AIM system knowledge and expertise to ensure that the implementation of your enhancements and modifications are delivered on time and without negatively impacting the continuing operations of the VermontAIM.

Additionally, I have specific experience leading teams performing many of the types of modifications that will be needed for Vermont, including the transition of the Relational Database Management System (RDBMS) from Ingres to IBM DB2 and provider system changes. My knowledge in these areas will significantly reduce the risks associated with implementing these enhancements."

Sean Daly is the enhancements/modifications manager for EDS' contract to provide Medicaid fiscal agent services for Vermont. He brings 12 years of experience in large-scale database and transaction processing systems, including experience with large system transfers, modifications and development efforts, training and implementation, and operation and maintenance. Sean has designed, led, and implemented client/server systems for most of his 13 years with EDS. His vast experience encompasses systems architecture, design, development, deployment, and operations.

Key Medicaid Experience

Sean has worked on two complete Medicaid Management Information System (MMIS) implementations for Idaho and Delaware, and has worked on large enhancements for these states. During his 13 years with EDS, he has worked on Medicaid systems teams in roles ranging from that of a systems engineer writing claims system code to a systems architect supporting a major Medicaid implementation. Sean has been a consultant for the New England and Idaho HIPAA implementations and is currently serving as the testing manager for the Idaho HIPAA implementation.

Furthermore, Sean is a key technical architect for EDS' Medicaid business and is frequently consulted for his expertise in evaluating how best to leverage technology to solve business problems. An example of this is the PowerBuilder deployment for Vermont and three other states (Rhode Island, New Hampshire, and Idaho). Sean determined that the PowerBuilder windows that had been developed for the Delaware Medicaid implementation could be leveraged to other states and worked with the EDS team to determine how to accomplish this task. This project will provide the states with the latest, most user-friendly online screens at a fraction of the cost of new development.

Career Feature

As the systems architect and claims technical lead for the Delaware MMIS (a successful transfer of the Idaho AIM system, which is based on the VermontAIM), Sean brought the AIM system forward to full HIPAA compliance (the first system in the nation to be HIPAA compliant) and converted it from Computer Associates Ingres to IBM Data Base/2 (DB2).

EDS Experience

System Test Manager, Idaho Department of Health and Welfare ..... November 2002 to Present
EDS has provided Medicaid fiscal agent services for Idaho's Department of Health and Welfare since 1978.

- Responsible for writing the Idaho HIPAA test plan for Release 2
- Interacts with the Idaho Department of Health and Welfare customer and their project management contractor to achieve approval for deliverables
- Staffs and directs the technical testing team responsible for the creation of automated testing tools, which decreases the amount of hands-on testing and reduces overall scope and expense
- Leads the operational and technical testing teams in their execution of systems test
- Consults with the platform support team on configuration of the additional development environments needed to support the HIPAA project, and on issues surrounding PowerBuilder implementation and their new production server

Systems Architect, Delaware Department of Health and Social Services ..... August 2000 to November 2002
EDS has provided Medicaid fiscal agent services for Delaware's Department of Health and Social Services since 1990.

- Determined the hardware and software needed for the implementation, including Sun server hardware and systems software (including DB2)
- Designed the data communications network to allow for high-speed connectivity for superior desktop application performance
- Piloted the Ingres to DB2 conversion prior to proposing DB2 for Delaware
- Developed and presented Ingres to DB2 conversion training to the technical team
- Worked with the team to ensure that the system was made HIPAA compliant
- Served as the technical lead responsible for project management, team leadership, and end solution architecture from requirements determination through construction, testing, and implementation for the Claims Adjudication, Claims Control & Entry, Point of Sale (POS), Reference, Managed Care, Provider Electronic Solutions, Electronic Claims Clearinghouse, Prior Authorization, Prospective Drug Utilization Review, and Internet teams – a total of 30 SEs at peak staffing

Technical Lead, Idaho Department of Health and Welfare ..... August 1996 to August 2000
EDS has provided Medicaid fiscal agent services for Idaho's Department of Health and Welfare since 1978.

- Implemented a state-of-the-art client/server MMIS serving as technical leader for the eligibility verification system, electronic claims submission, and claims administration
- Improved run-time and system responsiveness of the claims processing system by 50 to 75 percent (depending upon claim type), which enabled the system to process more claims in a shorter period of time and reduced network congestion for POS claims processing
- Worked with the state to design and implement several new claims edits and audits
- Designed, managed, and implemented a project to build an external system interface with one of Idaho's PA subcontractors as they implemented a new system
- Trained four SEs in UNIX and the Idaho MMIS

Technical Leader/Team Supervisor, Smith's Food and Drug Centers..... October 1992 to August 1996
EDS provided complete information technology services for Smith's Food and Drug Centers from 1992 to 1997.

- Managed the five-member store systems maintenance team, successfully handling system maintenance and enhancement requests
- Maintained existing system, which freed up staff to focus on a large enhancement project for the customer
- Designed and implemented the computer automated order system, which is a multitier client/server system. Users were able to create warehouse orders and request replacement signage using handheld PCs as they walked the stores' aisles. The project was successfully implemented, and each store realized a significant cost savings in staff.
- Enhanced the network sockets code for the draft management system, (a multitier client/server system), which successfully reduced the average time needed to process a check-clearance request from 15 seconds to 3 seconds
- Managed the five-member client/server UNIX systems administration/database administration team during the implementation of the draft management system

Technical Leader, AT&T Account (Business Communications Services)..... September 1991 to October 1992
EDS has supported AT&T on special projects and call center services since 1989.

- Provided ad hoc reporting support for AT&T business unit senior managers, providing them with the information they needed to manage quality improvement initiatives related to 800-line provisioning
- Provided technical training and experience in C and UNIX systems development to a team of eight SEs who were previously skilled only in mainframe/COBOL development
- Assisted in the development of the "Black Box" interface system for AT&T, connecting several disparate systems used for 800-line provisioning
- Served as technical leader for an ad hoc data retrieval team on an extended temporary assignment to Denver, Colorado

Business Associate/Team Lead, Blue Shield of California.....July 1990 to September 1991
EDS has provided information technology services to Blue Shield of California since 1980.

- Led a business analyst team supporting the claims/financial area for Blue Shield of California

Education and Training

Bachelor of science in computer and information systems, minor in business administration, 1990; University of Oregon; Eugene, Oregon

EDS Systems Engineering Development Program, 1992

Health Insurance Association of America (HIAA) coursework and exams (ongoing)

References

Mr. Norman Clendaniel
Medicaid Implementation
Project Director
Delaware Department of Health
and Social Services
302 255 9762

Ms. Kay Holmes
Chief, Managed Care
Delaware Department of Health
and Social Services
302 255 9529

Ms. Julie Grunder
Medicaid Automated Systems
Specialist
Idaho Department of Health
and Welfare
208 334 0682

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Staff Responsibilities

RFP Reference: 3.2.2.8.4, p. 3-14

The following table identifies the positions that will perform the work of the Enhancements/Modifications Phase and describes their anticipated responsibilities and qualifications.

Staff Responsibilities and Qualifications

Position/Title	Job Description	Qualifications
Enhancements/ Modifications Manager Sean Daly	• Oversees the implementation of enhancements and modifications • Advises client delivery executive of capabilities and risks • Analyzes needs and recommends appropriate planning concepts and tools used for planning, scheduling, and tracking projects • Analyzes project progress/costs and facilitates the development of recommended alternatives • Controls project requirements, scope, and change management issues • Coordinates status review meetings with staff and attends state meetings as requested • Determines, monitors, and reviews all project economics to include costs, operational budgets, and staffing • Develops project control and reporting procedures; manages changes in project work plan • Ensures adherence to legally binding requirements and customer long-term goals • Establishes appropriate metrics for measuring key project criteria • Plans, directs, and coordinates cross-functional team activities to manage and implement projects through implementation to final operational stage • Plans, schedules, monitors, and reports on project progress • Controls project scope in area of responsibility	• Proven information technology experience, including research, strategic planning, and management • Familiarity with MMIS environments involving technologies from Novell, Microsoft, Apple, Cisco, Enterasys, Sun, and Oracle • Demonstrated skill to prepare and publish operating procedures • Experience defining technological needs and analyzing infrastructure, hardware, software, and systems integration • Skill to troubleshoot technology problems from a cross-functional multiplatform standpoint • Excellent written and verbal communication skills, including interpersonal, presentation skills, and multitasking abilities • Customer service orientation, sound organizational skills, budget control, and ability to manage time-sensitive projects

Position/Title	Job Description	Qualifications
Project Planner	• Keeps project documents up to date, such as Gantt charts • Helps enhancements/modifications manager manage the project workflow and deliverables	• Experience supporting Web-based applications • Strong analytical and organizational skills • Detail oriented • Excellent written and verbal communication skills
Project Workbook Systems Engineer	• Participates in the development of test plans and test cases • Designs, codes, tests, implements, and documents changes to the MMIS • Incorporates the latest advances in technology into the MMIS as appropriate • Participates in periodic unit reviews of quality and performance • Keeps the Project Workbook tool current and customizes the content for Vermont	• Well versed in regulatory requirements • Experience with MMIS design, coding, testing, and implementation • Excellent written and verbal communication skills • Bachelor of science degree
Test Manager	• Prepares test plans to manage system testing for each enhancement • Coordinates EDS support of state's user acceptance testing for all enhancements	• Experience leading major testing projects • Strong leadership and management skills • Strong analytical skills • Excellent written and verbal communication skills • Strong customer relations skills • Knowledge and experience in Medicaid or other large-scale health care organizations

Position/Title	Job Description	Qualifications
Systems Engineer (SE)	• Participates in the development of test plans and test cases • Implements customer service requests (CSRs) according to priority set by the OVHA • Designs, codes, tests, implements, and documents changes to the MMIS • Consults with the OVHA and internal users on new changes to the MMIS that support business processes • Maintains a technical relationship with other state agencies, insurance carriers, and federal agencies to facilitate the transfer of information electronically • Incorporates the latest advances in technology into the MMIS as appropriate • Participates in periodic unit reviews of quality and performance	• Ability to lead design team to develop system and subsystem specifications for MMIS system • Bachelor of science degree and proven experience in systems engineering • Excellent written and verbal communication skills • Strong analytical and problem-solving skills • Capable of producing specifications (functional and design) and test requirements and performing acceptance testing
Database Administrator	• Performs database installation and configuration • Handles database change management, including table, index, trigger, and procedure changes • Performs data tape loads and system backups • Performs database space management • Manages database products and utilities • Monitors and tunes database	• Experience with DB2 version 7.0 • Experience writing load and unload scripts • Experience tuning a large production database in a complex networked environment • Ability to interact with executive-level customer, corporate, and account staff • Technical degree or equivalent work experience

Position/Title	Job Description	Qualifications
Information Analyst	• Designs, codes, tests, implements, and documents changes to the MMIS • Incorporates the latest advances in technology into the MMIS as appropriate • Brings specialized technical skills, knowledge, and experience pertinent to the project	• Systems analysis experience • Excellent written and verbal communication skills • Strong understanding of MMIS systems • Bachelor of science degree or equivalent work experience required
Information Specialist	• Designs, codes, tests, implements, and documents changes to the MMIS • Incorporates the latest advances in technology into the MMIS as appropriate • Brings specialized technical skills, knowledge, and experience pertinent to the project • Brings specific expertise in Internet technology and claims engine internals	• Bachelor's degree required • Experience as an information management analyst and two years experience in an MMIS setting • Proficiency with user reporting tools • Strong Microsoft Office skills, including Excel and Access • Strong analytical skills and tenacious attention to detail • Strong project management skills • Ability to manage multiple tasks simultaneously • Good interpersonal and communication skills

Position/Title	Job Description	Qualifications
Clinical Analyst/ Claims Clerk	• Reviews clinical updates from McKesson and works with the OVHA clinical staff to add to Vermont files • Applies knowledge of established clinical guidelines and researches the OVHA questions • Prepares reports for management on McKesson ClaimCheck savings • Inputs data to reference files, resolves edits, and monitors suspense • Verifies reports and documentation for accuracy and completeness • Coordinates the periodic updates and ensures all changes are communicated to the staff and the OVHA	• Firm understanding of the OVHA's policies and guidelines • Exceptional attention to detail • Proven experience in a professional capacity within a computing environment • Strong analytical and problem-solving skills • Ability to multitask • Excellent written and verbal communication skills

Additional Staff

RFP Reference: 3.2.2.8.5, p. 3-14

To supply the staff required to successfully complete the mandatory and optional enhancements and modifications, we plan to complement our solid foundation of Vermont-based staff with expert resources from our central support centres.

Leveraging Experienced Technical Personnel From Central Support Centers

The majority of the staff that will perform the enhancements and modifications will comprise systems engineers (SEs) from our central support centres in Vancouver, Washington and Richmond, Virginia. These SEs are the ideal resource to ensure the successful implementation of VermontAIM enhancements and modifications because they are experienced and dedicated to the Medicaid industry, they are experienced in implementing progressive technical advances and processes relevant to Vermont's requirements, and they are expert resources that can be shared with other states for cost-effective, timely solutions.

Experienced and Dedicated to the Medicaid Industry

Our central support centre staff members have significant experience in the health care industry and have relevant experience with MMIS implementations, enhancements, and modifications similar to those required in Vermont. They have participated in projects ranging from the original implementation of the VermontAIM to the ongoing New England AIM HIPAA remediation. Central support centre SEs bring both broad Medicaid knowledge and specific AIM system experience, so they will be productive from the beginning of the Enhancements/Modifications Phase, without having to compensate for a learning curve. These SEs have worked on modifications similar to those requested in Vermont, such as platform conversion, claims system change for ClaimCheck and ClaimReview, provider enhancements, and Internet enhancements. With this experience, they will make these modifications more rapidly and accurately than any other possible resource.

Our central support centre developmental staff is dedicated to our Medicaid customers. They are able to learn from their experiences and turn them into benefits of function or time/cost savings for other states. For example, support centre staff developed the Project Workbook for the Oklahoma MMIS implementation as a central repository for all project-related communication. The Project Workbook provides a comprehensive journal of all project documentation and includes status reports, work plans, change orders, deliverable specifications, test data, test results, and sign-off documents. Through the linking features included in the Project Workbook, the state and EDS personnel can gain an understanding of the current status of virtually any aspect of the project and of the meetings and decisions affecting the project.

Our customers have been extremely pleased with the ease of use and organization of this tool. We have since used it for the Kansas MMIS implementation, Pennsylvania MMIS implementation, and Idaho HIPAA remediation. We propose to use it during the Enhancements/Modifications Phase for Vermont. The state will benefit from the proven use of this tool in several states.

Progressive Technical Advances and Improved Processes

Central support centre staff members stay current with progressive technical advances and improved processes to benefit all our Medicaid customers. For example, our staff has experience with DB2 on client/server systems. This database platform is the most widely used in the world, and it offers exceptional reliability, performance, and scalability. We recently used DB2 for the Department of PATH when we converted the EVAH system from Ingres to DB2. Additionally, in 2002, we successfully implemented the Delaware MMIS using the DB2 platform. By converting to DB2, the state will be able to take advantage of a wider variety of third-party software unavailable to Ingres.

We also have experience with developing Internet-enabled functionality. For Vermont, this technology will facilitate access to data and enhance beneficiary service and provider relations. Another example of our experience includes the design and development of PowerBuilder windows. We will implement this technology/tool, as well as Project Workbook, for Vermont during the Enhancements/Modifications Phase.

Vermont will also benefit from our improvements in MMIS technology. We implemented the first true client/server MMIS in the nation for Vermont in 1993. Since that implementation, we have built on that technology and applied improvements for six states, with in-progress implementations in three other states. We are excited about bringing those benefits back home to Vermont, helping the state realize its vision for their MMIS.

Cost-Effective, Expert Resources

The use of central support centre SEs permits a great degree of leverage across multiple systems, which controls expense. For example, the same SEs who developed the PowerBuilder windows for the Delaware MMIS implementation formed the core team developing the PowerBuilder windows for the Vermont, Rhode Island, New Hampshire, and Idaho MMIS remediation. All states involved will benefit from the experience gained in Delaware.

PROJECT MANAGEMENT AND CONTROL (ENHANCEMENTS/ MODIFICATIONS)

RFP Reference: 3.2.2.9, p. 3-14

In the Enhancements/Modifications Phase, **we look forward to bringing EDS' best practices for project management and control designed for large-scale implementations.** To support the reliable, on-time implementation of enhancements and modifications to the Vermont MMIS, EDS will enhance our approach with the latest-generation tools and methodologies. We will:

- Increase access to status reports and project plans by making them available online through EDS' Web-based Project Workbook
- Apply the next generation of EDS-standard procedures for project management for large-scale implementations—an approach that supports our technical teams in meeting Capability Maturity Model criteria
- Take the best of these tools and processes forward to future operations projects once they are familiar

By enhancing successful procedures and approaches to project management and control during the Enhancements/Modifications Phase, we take project management and control processes to the next level of industry discipline.

To support the smooth implementation of program enhancements and modifications, the state needs a partner who knows the Vermont MMIS and brings experienced technical personnel who have performed similar enhancements in other states. As the team operating the VermontAIM for the last 10 years, we have unmatched insight into the system itself. Additionally, experienced systems engineers in our central support centers bring experience with similar enhancements—and with these enhanced project management and control tools and methodologies. We have the experience, the processes, and the capabilities to ensure the state's success in achieving its goals and objectives.

Our Approach

EDS is committed to a disciplined approach to project management and control. Most recently, the corporation has brought the best of its corporate methodologies for systems development and project management together in the Global Solutions Management System methodology. This customized project management methodology is based on Carnegie-Mellon University's Software Engineering Institute (SEI) practices and Project Management Institute (PMI) fundamentals. This methodology incorporates the best of our Project Management Version 2.3 (PM 2) and our Systems Life Cycle Version 3 (SLC 3) methodologies discussed in our Operations Phase response to 3.2.2.9(a), "Project Management and Control Methodology." It builds on that foundation by establishing helping our teams meet Capability Maturity Model (CMM) criteria. The CMM is a tool developed by SEI to help organizations improve their software processes. It provides a framework for improving the management and development of software products in a disciplined and consistent way.

The investment in CMM-based software process improvement will help our clients in many ways, including:

- Improved project predictability, with on-time, on-schedule, and on-budget delivery
- Reduced and more predictable development times
- Improved quality and lower defect rates
- Increased client satisfaction
- Increased employee satisfaction and lower employee attrition
- Ability to work seamlessly from multiple sites
- Effective use of the engineering workforce
- Increased effectiveness through reduced learning curves
- Enhanced competitive advantage and company reputation
- Increased organizational capacity for change

We describe our project approach in the following sections:

- **Project Management and Control—**We will upgrade our project management and control methodologies based on the Global Solutions Management System (GSMS) methodology, which will help us improve our discipline and consistency in software development. Technical personnel in our central support centers who will augment the Vermont technical staff in supporting enhancements are already familiar with this methodology for managing systems development projects. In GSMS, as in previous methodologies, project planning is iterative, and assumptions, risks, and estimates in this proposal are re-evaluated at regular intervals to ensure initial planning is still valid. If not, necessary change is incorporated to keep the project on schedule. Work products will be delivered on time to a high quality and maintained throughout the project. Quality control processes will be used throughout the project.

- **Staff Resources and Time Estimating Methods—**We will use the Tracking Log (TLOG) System to carefully track the time of our systems engineers and business analysts against project estimates.
- **Procedures for Sign-off of Completed Milestones and Deliverables—**Working with the state, Client Delivery Executive Barbara Davis and Enhancements/Modifications Manager Sean Daly establish appropriate milestones and deliverables for each project and apply standard processes for walkthroughs and sign-off.
- **Management of Contractor Responsibilities, Milestones, and/or Deliverables—** Enhancements/Modifications Manager Sean Daly will work with the state to develop a detailed project plan. Using this plan, Sean will continually monitor project status, identify issues, and intervene to keep the project on track. The project plan also contains clear milestones and deliverables that give the state checkpoints at various stages of the projects.
- **Assessment of Project Risks and Approach to Monitoring and Managing Risks—** EDS has used its risk management methodology to identify, document, and plan mitigation for potential risks during the Enhancements/Modifications Phase.
- **Approach to Problem Identification and Resolution—**A more formalized Change Control Board and change control process is appropriate for effectively supporting our aim to provide service excellence and client satisfaction throughout an efficient Enhancements/Modifications Phase.
- **Internal Quality Control Monitoring of Relations with State, Providers, and Other Stakeholders—**Leveraging the proven and effective Quality Improvement Plan initiative will support continual improvement in Vermont Medicaid operations.
- **Project Status Reporting—**The state gains easy, online access to project status reports through the Web-based Project Workbook to improve project communication.

We will continue to work with you and to apply our project management and control methodologies to achieve the vision of the state to deliver quality health care to Vermonters.

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a. Project Management and Control Methodology

RFP Reference: 3.2.2.9(a), p. 3-14

Sound planning for reliable, on-time results that meet customer expectations is the aim of every project management and control methodology. For the Enhancements/Modifications Phase, the state will gain each of these benefits as a result of EDS' rigorous approach to project management and control, which is based on Carnegie-Mellon University's Software Engineering Institute (SEI) practices and Project Management Institute (PMI) fundamentals. Our aim is to:

- Implement enhancements and modifications that meet and exceed your expectations
- Communicate clearly, consistently, and thoroughly with all project stakeholders throughout every stage of the project regarding expectations and status
- Meet time schedules to assure the state gets the earliest benefit from enhancements
- Manage state resource support efficiently
- Manage the project in a sustainable manner that protects the investments of our own people

Because the Enhancements/Modifications Phase will include multiple complex changes designed to profoundly modify the MMIS, we will leverage all the depth and strength of our corporate methodology architecture to assure success. Over the last decade, we have significantly strengthened our commitment to these methodologies within the state health care arena. **Our commitment has resulted most recently in the on-time implementation of client/server MMISs for customers in Oklahoma and Delaware.**

Running an effective Enhancements/Modifications Phase will not be business as usual. Enhancements/Modifications Manager Sean Daly and Client Delivery Executive Barbara Davis will work together to bring the corporation's best practices for managing large projects. These include:

- **Enhanced, latest-generation systems development life cycle methodology—**For the Enhancements/Modifications Phase, the technical team will apply EDS' latest generation methodology for project management and systems life cycle development, the Global Solutions Management Systems (GSMS). GSMS supports the achievement of Capability Maturity Model (CMM) criteria. CMM is a benchmark developed by the SEI of Carnegie Mellon University to help organizations improve their software processes. As the Vermont team becomes familiar with these practices, they will be used to support regular operations as well.

- **Online access to project status documentation and communication—**State and EDS personnel will both have immediate, Web-based access to all project documentation and communication through the Web-based Project Workbook. Developed by EDS and used successfully to support implementations in Delaware, Oklahoma, Idaho, Pennsylvania, and Vermont, the Project Workbook has been extremely well-received by customers. This is just one tool we use to promote continuous communication with our customers.
- **Continual communication with all project stakeholders—**EDS' project management and control practices include ongoing communication with the state through requirements validation sessions, status meetings, and reports. We use this communication to ensure we understand your expectations and that you understand where the project stands at every phase of implementation. In addition, our communication planning includes early and ongoing communication with other critical stakeholders, such as providers, who will be affected by the implementation of enhancements and modifications.
- **Robust processes and practices for a smooth implementation—**Among the new procedures that will support this phase are an extended requirements documentation process, a more formalized Change Control Board, and a team dedicated to supporting project plan maintenance. The commitment to these procedures will support a smooth implementation.

Our discussion appears in the following sections:

- Approach to Managing Enhancements and Modifications
- Project Management Tools
- Project Management and Control Procedures
- Project Management Methodologies

The initial section describes our specific approach to managing the implementation of enhancements and modifications for Vermont. Subsequent sections describe supporting tools, procedures, and methodologies that we will implement and rely on throughout the Enhancements/Modifications Phase.

a.1 Approach to Managing Enhancements and Modifications

In this section, we describe the key processes and approaches we will use to manage and control our work in the Enhancements/Modifications Phase. These steps, while presented chronologically, actually overlap and recur as part of a complex and iterative process that we have simplified for the sake of discussion. Each of these major tasks is reflected in our work plan and reflects the influence of our standardized approach to project management and control to assure that the MMIS enhancements meet your expectations and that you can rely on us to deliver those results on time:

- Establish Initial Project Team
- Prepare Initial Project Workbook

- Review Work Plan
- Establish Project Management Control and Reporting
- Develop Requirements Specification Document
- Develop Detailed System Design
- Develop Conversion Plan
- Conduct Development/Testing
- Perform System Conversion
- Prepare/Conduct User Acceptance Testing and Operational Readiness for All Enhancements
- Implement Enhancements
- Contact Provider Community

Establish Initial Project Team

In this phase of the project, Client Delivery Executive Barbara Davis and Enhancements/Modifications Manager Sean Daly begin putting specific personnel against tasks on the revised work plan. Once the staff is identified, key activities include clearly reviewing and communicating roles and responsibilities of each assigned team member; conducting a kickoff meeting; conducting initial team training on processes, standards, and tools; and establishing the project team's relationships with you by introducing key customer personnel.

Prepare Initial Project Workbook

We are proposing the use of our exclusive Web-based Project Workbook as the primary method to document and communicate activities related to the Enhancements/Modifications Phase. The Project Workbook provides online access to the templates and documents used to record and track the project's components, characteristics, specifications, and progress.

This tool supports the state's project by:

- Enabling project managers to document projects to meet your requirements
- Identifying and recording the scope, resources, and work needed to complete the project
- Monitoring project scope effectively

During the start-up phase of the project, we will identify which templates and documents are needed for the project and make additions to support special templates or other customer needs. Typical contents of the Project Workbook include:

- Introduction
- Table of contents
- Glossary of terms
- Workbook review checklist
- Project plan
  - Project summary
  - Project scope statement

- Approach alternatives and recommendation
- Standards and procedures
- Communication plan
- Configuration management plan
- Metrics plan
- Quality assurance plan
- Resource plan
- Resource estimate documentation
- Work breakdown structure
- Project schedule
- Budget
- Risk plans
- Contact list

- Supplier
  - Supplier selection plan
  - Supplier organization plan
  - Supplier procedures
  - Supplier agreement
  - Supplier statement of work
  - Supplier project plan
- Meeting minutes
  - Project review meeting minutes
  - Meeting minutes
  - Kickoff meeting minutes template
  - Meeting minutes template
- Status reports
  - Change Control Board reports
  - Periodic project meeting reports
- Correspondence
  - Project announcement
  - Close-down announcement
  - Postproject review report
  - Memos
- Communications outputs
  - Policy statements
  - Project contact information sheet
  - Success story information sheet
  - Postproject review questionnaire
  - Other communication outputs

- Change control
  - Release summary log
  - Change control register
  - Change control sheet(s)
  - Change assessment sheet(s)
- Project tracking/metrics
  - Assumptions/constraints list
  - Issues/decision log and form
  - Other direct charges expense log
  - Time tracking sheet
  - Variance analysis report(s)
  - Project environmental characteristics
  - Quality assurance audit data
  - Action list
- Overall requirements documentation
- Methodology-related work products
- Other work products
- Subprojects work products

Review Work Plan

Based on our understanding of Vermont's objectives and the RFP requirements, we have included a proposed work plan for enhancements and modifications. During the start-up phase of the project, we will review the revised project scope and create the finalized work plan that reflects our new understanding. Additionally, during this step, we will work with state personnel to review and finalize our communication plan, review our project risk plan, and review our resource plan. These efforts ensure that our plan is sound and properly staffed.

Establish Project Management Control and Reporting

Another key start-up activity is establishing project management control and reporting mechanisms. These activities include identifying a resource to maintain the large project plan and project plans for individual enhancements. We establish procedures for time tracking and for maintaining the Web-based Project Workbook. In addition, we plan and establish responsibilities for weekly status meetings, weekly written status reports, metrics for measuring implementation progress success, and an issue and correspondence tracking system. These measures support Client Delivery Executive Barbara Davis and Enhancements/Modifications Manager Sean Daly in monitoring project progress.

Develop Requirements Specification Document

The key purpose for developing the Requirements Specification Document (RSD) is to use it in discussing our understanding of the project requirements in requirements validation sessions. This communication is critical to assure that the enhancements and modifications meet with your satisfaction. We will develop an RSD for each enhancement project.

Develop Detailed System Design

After the requirements validation sessions, we use state input to develop the Detailed System Design (DSD) document. The DSD is a comprehensive, detailed requirements document that incorporates state input from the requirements validation sessions.

We will base our DSD on a state-approved organizational approach. Sign-off on the DSD for each enhancement indicates that the state and EDS have full understanding of the requirements of the change and assures that the enhancement satisfies state expectations.

Develop Conversion Plan

The Conversion Plan documents our overall approach to conversion. By using a documented, careful approach, we assure that our conversion effort addresses all key variables. We will submit the Conversion Plan to the state for review and approval.

Conduct Development/Testing

With all this planning and state approval behind us, the systems engineers are ready to begin the development work. This effort begins with establishing test and production environments. We submit the outline and sample contents for state review and approval and then follow up with the System Test Plan itself. Once the System Test Plan is approved, we begin construction.

During construction, we install, modify, and enhance system components. We perform system tests and document test results. The state then has the opportunity to review and approve test results.

The final effort in this step is creating or updating documentation. We will develop a sample outline and contents and gain state approval of it. We will then begin developing the documentation.

We will submit updated documentation to the state for review and approval.

Perform System Conversion

In this phase, we construct conversion programs, unit test the conversion process, and perform a preliminary conversion. The results of this preliminary conversion are submitted to the state for review and approval.

Prepare/Conduct User Acceptance Testing and Operational Readiness for All Enhancements

User acceptance testing and operational readiness testing processes verify that the enhancements as installed for Vermont are ready for production processing. The state will work with EDS to perform tests that demonstrate that the enhanced MMIS is ready to process all inputs, price claim records correctly, meet reporting requirements, use a properly functioning data communications network, and back up files properly.

Operational readiness testing includes a volume test with several days of production capacity claim records volumes to demonstrate that the MMIS and our fiscal agent staff are prepared for full production. In addition, our operational readiness testing will include a pilot test of actual claims processing in a full operational environment through the check request process. We will also demonstrate and verify physical plant security, data security, and fire/disaster prevention and recovery procedures.

Following the testing, we will submit an Operational Readiness Report to the state for review and approval. We then prepare an Acceptance Test Resolutions document and submit User Acceptance Test Results to the state for review and approval. The acceptance of these results by the state means that the implementation effort can begin.

Implement Enhancements

Having established that the enhancements satisfy state expectations, we begin the implementation process. To control this critical step, we develop a Detailed Implementation Plan (DIP). This plan details each step of the implementation process. The state reviews and approves this plan.

We then develop a Training Plan for users and state personnel. The plan is reviewed and approved by the state. We then conduct the training.

Also in this step, we develop an outline and sample contents of system documentation and deliver it to the state for review and approval. Once we receive sign-off on the approach, we complete the system documentation. We do not consider the work done until the documentation is completed.

With these tasks behind us, we perform the final file conversion. We submit a report on this effort, and then all system enhancements are operational.

Contact Provider Community

We will be proactive in communicating with the provider community well before changes that affect providers go into effect. This is particularly true for enhancements such as ClaimCheck and ClaimReview, which will affect payment to providers. We will include information about upcoming changes and their implementation dates in provider newsletters and workshops.

a.2 Project Management Tools

In addition to the deliverables and reports mentioned in the previous narrative, the EDS team will rely on some key tools to support project management and control. We discuss these tools in the following subsections:

- Automated Software Tools
- Meetings
- Reports and Documentation
- Change Control Board

Automated Software Tools

In the following table, we introduce key automated software tools we will use to support project management:

Automated Software Tools

Tool	Description	Purpose
Project Workbook	Web-based repository for all project documentation and communication	• Provides easy access to updated work plans, status reports, requirements documents, and other key deliverables
TLOG System	Automated tracking system for Plogs and CSRs	• Tracks authorized CSRs and Plogs • Tracks systems engineer and business analyst hours against projects • Produces project status reports
Microsoft Outlook	Software that supports the development of task lists, calendars, and automated support for scheduling meetings	• Lets users track items they need to complete • Supports project managers in determining people's availability and scheduling meetings • Supports the creation of calendars
Process Sourcerer	Process management tool developed by EDS that provides powerful means for capturing and leveraging process knowledge	• Helps organize large projects • Provides process flow capabilities • Lets users link documents within the process flows

Tool	Description	Purpose
CHAMP	EDS-designed application that provides automated support for change control management	• Ensures version control and that no two people are working on the same piece of code • Maintains past iterations of code in case a user needs to go back to a previous version • Supports quality by promoting a common approach for promoting source code • Promotes efficiency
Microsoft Word	Word processing package	• Contains templates for most recommended project management tools
Microsoft Excel	Spreadsheet application	• Contains templates for other recommended project management tools
Microsoft Project	Project planning application	• Supports the creation of project plans • Lets users organize a series of tasks for a project

Meetings

The following types of meetings are key in promoting communication between the state and EDS. These meetings support the work effort, requirements validation, and project oversight.

Standard Meeting Formats

Meeting	Purpose	Attendees
Kickoff meeting	• Review change to determine scope of work • Gather input on approach	• Person requesting change • EDS managers of affected departments • Any other person knowledgeable on the subject matter
Planning meetings	• Plan changes • Examine process flows, if appropriate	• State representatives • EDS managers of affected departments • EDS SME for the affected subsystem • EDS systems engineer for the affected subsystem
Process flow meetings	• Develop or review a pictorial view of the process changes • Gain consensus on the new process	• Facilitator Perry Melvin • State representatives • EDS managers of affected departments • EDS SME for the affected subsystem • EDS systems engineer for the affected subsystem
Status meetings	• Share status information regarding the project • Consider issues as a team	• State representatives, as appropriate • EDS managers of affected departments • EDS SME for the affected subsystem • EDS systems engineer for the affected subsystem

Reports and Documentation

The following list of reports and deliverables encompasses not only standard and familiar reports in use today but also special deliverables designed to support large-scale implementations.

Report/Documentation	Purpose/Description
E-mail Notification	• Notifies the state or the EDS team of critical or urgent information, such as POS downtime, a new edit, a power outage, or process changes going in over the weekend • Ensures team members not directly involved in a project recognize its impact
Work Plan	• Tracks all tasks with time frames and assigned resources • Identifies milestones and deliverables • Enables state and EDS personnel to monitor project progress against the plan
Communication Plan	• Documents planned communication events, audiences, dates, and purposes • Provides the state and EDS the opportunity to agree on a mutually agreeable approach to communication
Resource Plan	• Documents time frames when human resources will come on board • Reflects required skills and qualifications for resources
Weekly Status Reports	• Documents results from the previous week's activities • Reports plans for the next week • Identifies real or anticipated problems with suggested solutions or alternatives • Notifies of any significant deviation from previously agreed-upon work plans
Correspondence and Issue Tracking System Reports	• Identifies issues and their statuses
Requirements Specification Document	• Serves as the first-draft requirements document
Detailed System Design	• Serves as the final requirements document • Incorporates input from the RSD and requirements validation sessions with the state
System Test Plan	• Documents the comprehensive plan for testing the system

Report/Documentation	Purpose/Description
Comprehensive Test Plan Results	• Documents results of the test plan for state review
Operating Procedures	• Documents work procedures • Must be updated based on system modifications and enhancements
User Manuals	• Documents how to use the system • Must be updated based on system modifications and enhancements
Disaster Recovery Plan	• Captures a preplanned approach for recovery of services in case of a disaster • Documents the project's backup plan • Provides alternative solutions for processing, depending on the extent of the service disruption
Conversion Test Results	• Documents in detail for the state the conversion test results
Operational Readiness Report	• Documents in detail the results of operational readiness testing
User Acceptance Results	• Documents in detail the results of user acceptance testing
Detailed Implementation Plan	• Documents in detail exactly how the system will be implemented
Training Plan	• Provides a comprehensive plan for training all program stakeholders affected by the enhancements and modifications
Systems Documentation	• Documents for a technical audience how the system was developed • Must be updated based on system modifications and enhancements
Final File Conversion Results	• Captures the results of the final file conversion for the state's review
CSRs/Plogs	• Documents changes to fix system errors (Plog) • Documents a request for additional functionality (CSR)

Change Control Board

We propose the formation of a joint Change Control Board to concentrate on all change control requests; to approve, modify, or reject requests; and to prioritize requests. The Board would consist of managers from both your organization and ours with the authority to make change request decisions.

We recommend that this Board meet semimonthly, monthly, or as needed, depending on the agenda items to be resolved. We can prepare or contribute to the agenda for these meetings according to your preference.

The Board monitors project progress and resolves implementation issues at an operational level. The Change Control Board uses the status reports to determine whether a requested change is within scope of the approved project scope at that point in time, whether that be the Detailed Systems Design, the Requirements System Design, or the RFP, proposal, and contract. Board members use status report information to determine the need for changes, the program risks associated with implementing or not implementing a change, and the priorities for changes. The Board approves changes occurring outside of the agreed-upon scope of work or requests additional research before making a decision on a requested change. The Board might also decide to designate a change as a CSR for the post-implementation period or remove other items from scope to accommodate the new item. Minutes to the Change Control Board meetings are published to the Project Workbook.

As the Enhancements/Modifications Phase progresses, the Change Control Board will serve as a clearinghouse for recommended and required changes to the MMIS. The Board will review proposed changes against the RFP, proposal, Requirements Specification Document, and Detailed System Design and weigh change criticality against the risk of implementing a change in the base system. The Board can take any of several steps:

- Deny the change based on lack of need, high risk, or out-of-scope request.
- Approve the change as within the scope, to be implemented as part of the base enhancements and modifications, and to be operational on the operations start date. The Board will prioritize, schedule change implementation, and assign resources to accomplish this change in the required time frame.
- Approve the change as outside of the project scope, to be implemented as part of the base enhancements and modifications, and to be operational on the operations start date. The Board will mutually agree on the cost to state for the change, prioritize, schedule change implementation, and assign resources to accomplish this change in the required time frame.
- Approve the change as within the project scope, but to be implemented as part of ongoing system operations after the operations start date. The Board will prioritize, schedule change implementation, and assign resources to accomplish the change by the scheduled release date.

- Approve the change as outside of the project scope, but to be implemented as part of the ongoing system operations after the operations start date. The Board will mutually agree on the cost to the state to change, prioritize, schedule change implementation, and assign resources to accomplish this change in the required time frame.
- Request additional information upon which to make an informed decision. The additional information may include number of beneficiaries affected, number of claims affected, number of providers affected, additional description of the change or the process, or the cost to make the change. The Board may set a date for the information to be furnished.
- Reprioritize a change request based on other change requests. Just like you, we have a finite amount of resources assigned to the MMIS project. Situations may occur where more change requests than resources (either us to implement or you to test and approve) are available to implement the changes. In these cases, the Board will be responsible for reprioritizing a change in relation to other changes that may have higher or lower importance, risk, cost, or resource requirements.

The Change Control Board will meet according to a mutually agreed-upon schedule. We propose that the Board initially meet twice per month. After the implementation, we propose that this schedule change to once per month.

a.3 Project Management and Control Procedures

Throughout the Enhancements/Modifications Phase, the EDS team will rely on several key procedures to support project control. Each of these procedures is essential to managing a successful project. We describe them briefly in the following subsections:

- Communication Planning
- Issue Identification, Tracking, and Reporting
- Quality Process

Communication Planning

Early in the start-up phase of the project, we will work with you to establish mutually agreeable communication standards. This effort is the communication planning process. Once the plan is complete, we will document it in a communication plan similar to the one that follows.

Communication Plan

Event	Audiences	Dates	Purpose
Face-to-Face Meetings			
Change Control Board	• State managers with delegated authority for decision-making • EDS managers with delegated authority for decision-making	Semi-monthly	Receive, evaluate, and prioritize change and modification requests
Weekly fiscal agent meeting	• State leaders • EDS leaders • EDS subcontractors, if needed	Weekly	Discuss project progress and resolve issues
Deliverable walkthrough	• State reviewer • EDS deliverable owner • EDS subcontractors, if needed	Per work plan schedule	• Review content • Answer questions
Daily status calls/meetings	• EDS leaders • EDS team • EDS subcontractors, if needed	Daily	• Provide project update • Create awareness of project status with staff
Kickoff meeting (leadership)	• State leaders • EDS leaders • EDS subcontractor representatives	Start of design subtask	• Review design • Establish relationships • Set direction

Event	Audiences	Dates	Purpose
Reports (Paper/Electronic)			
Weekly report on current status of development tasks and issues	• State leaders • Senior EDS delivery leaders	Weekly during develop-ment and implement-ation subtasks	Update project status and identify issues
Letter (Paper/Electronic)			
Change in team members	• State leaders • EDS delivery leaders • EDS delivery operations • EDS subcontractors, if affected	As occurs	Report change and identify action plan
General correspondence	All	Periodically as needed	• Document issues and actions • Request information

The following table is an example of the detailed descriptions of each communication event indicated in the communication plan.

Communication Events Descriptions

Event	Description	Frequency
Provider service plan	Addresses aspects of provider service, such as telephone inquiry controls, provider training, correspondence inquiries, and documentation. The plan also addresses provider satisfaction surveys.	Annually
Change in team members	Provides a structure for making team member changes. A project leader identifies a need for change. This could be the addition or removal of team members or a change in a team member's area of responsibility.	As needed
Status report	Provides a project status summary for senior leadership and project leadership.	Weekly

Project management tools and a communication plan approved by you accompany our open approach to communicating with you. Our systematic approach to status meetings and written status reports will help us produce quality deliverables for consistently updating you about the project status.

Issue Identification, Tracking, and Reporting

We will establish a process to identify issues, communicate them to you, and resolve them. Our approach to corrective action is direct and logical. We use proven methodologies to identify, track, and report issues. We use the management tool TLOG to track and maintain control of identified issues. The issue resolution process includes problem definition, root cause analysis, and error severity classification solutions. This process also includes ongoing written and verbal communication with you until the issue or problem is resolved.

When we identify a system deficiency, we will inform you no later than the close of the business day during which we identified the problem. We provide verbal notice to you of our discovery of any delays in report distribution or MMIS access, or as soon as your offices are open. We then follow up with written notification.

After identifying and reporting the problem or issue, we develop and present a corrective action plan for approval within five business days of discovery, unless otherwise specified by you. For more detail on the issue identification, tracking, and reporting process, see our response to RFP requirement 6.2.2.9(f), "Approach to Problem Identification and Resolution."

Quality Process

To assure quality in the implementation of enhancements and modifications, the EDS team supports open communication and state approval of enhancements. In addition, we employ a rigorous testing approach. We will perform detailed unit, system, and operational readiness tests that comprehensively test all aspects of the enhancements and modifications to VermontAIM.

We will engage you in acceptance testing to verify appropriate operations. In addition, we have had great success in including provider focus groups among testers. This is especially appropriate for enhancements such as the Internet that will be designed to meet provider needs.

Testing enables us to work with stakeholders to communicate issues and accept input before a change is operational.

For more information about our commitment to quality in Vermont, see our response to RFP requirement 6.2.2.9(g), "Internal Quality Control Monitoring of Relations With the State, Providers, and Other Stakeholders."

a.4 Project Management Methodologies

Supporting and undergirding the best practices for project management and control established by the Vermont team is EDS' deep corporate commitment to maintaining and continually improving a methodology architecture that supports all EDS projects. Many of the templates, tools, and practices adopted as best practices for Vermont were selected from the larger body of EDS' project management and system development methodology architecture, which is incorporated in EDS' Global Solutions Management System (GSMS). **In the second year of operations, EDS will enhance established practices by adopting additional GSMS best practices applied to the Enhancements/Modifications Phase in support of the Operations Phase.**

GSMS takes the best of EDS' corporate methodologies and combines them into a single proven, documented, and repeatable project management approach. GSMS is a common global solution process set for application/information engineering and operations work. GSMS is a system of global processes, based on existing corporate methods and tools and incorporating the in-use best practices EDS uses around the world. The scope of GSMS is operational and software application development, implementation, and support. GSMS comprises corporate methods that are integrated into one process set:

- Project Management Version 2.3
- Systems Life Cycle Version 3
- Production Support Method
- Enterprise Testing Method
- Requirements Determination Process
- Estimating

Our GSMS approach is structured to help our solution centers meet Capability Maturity Model (CMM) criteria. The CMM is a benchmark developed by the SEI of Carnegie Mellon University to help organizations improve their software processes. It provides a framework for improving the management and development of software products in a disciplined and consistent way. The CMM consists of five maturity levels that are indicators of process maturity and capability:

- Level 1—Initial
- Level 2—Repeatable
- Level 3—Defined
- Level 4—Managed
- Level 5—Optimizing

GSMS Release 1 satisfies Level 2 and Level 3 key process areas of the SEI CMM and will help position EDS organizations to move towards SEI CMM Levels 4 and 5, as appropriate. The investment in CMM-based software process improvement will help our customers in many ways, including:

- Improved project predictability, with on-time, on-schedule, and on-budget delivery
- Reduced and more predictable development times

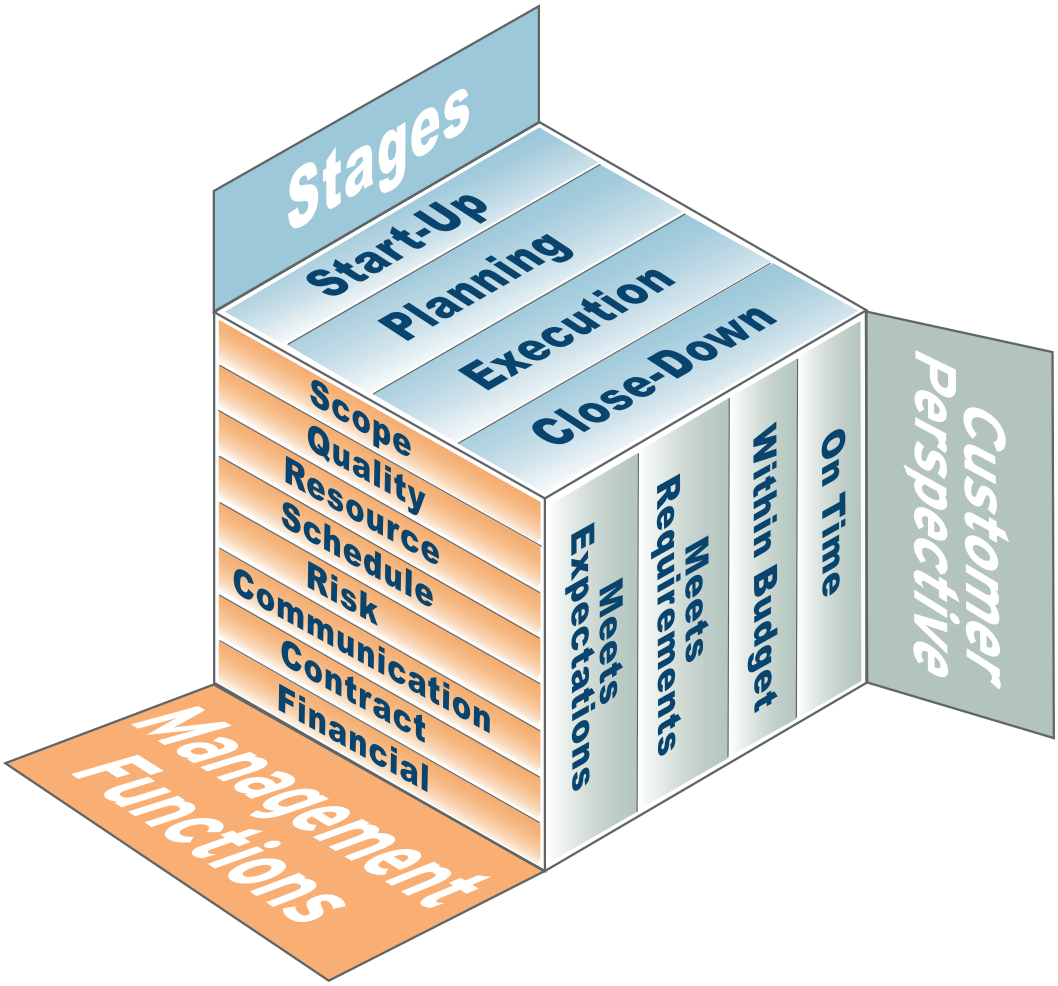
- Improved quality and lower defect rates
- Increased customer satisfaction
- Increased employee satisfaction and lower employee attrition
- Ability to work seamlessly from multiple sites
- Effective use of the engineering workforce
- Increased effectiveness through reduced learning curves
- Enhanced competitive advantage and company reputation
- Increased organizational capacity for change

GSMS enables EDS to increase its technical delivery capability, resulting in global competitive advantage and elevating EDS to a leading-edge market position. We will use GSMS to globally and consistently increase our process and organizational maturity to ensure that we have sustained superior execution in our delivery to our customers. **We look forward to applying the best of project management and control methodologies to support the reliable, timely operations that meet the state's expectations.**

Project Management Version 2.3

Project Management Version 2 (PM 2) is based on Carnegie-Mellon University's SEI practices and PMI fundamentals. This methodology complements our SLC 3 discussed later in this section and establishes a standard approach for implementing projects. As illustrated in the following graphic, PM 2 provides a solid foundation that enables project managers to create project plans and manage change effectively.

Project Management Version 2.3



The industry-recognized principles in PM2 provide for consistent, successful project outcomes.

PM 2 defines management of systems development projects, systems maintenance releases, systems integration, consulting engagements, proposal development, or other project-based activities. The methodology defines a project as any effort that has a plan and deliverables; that is constrained by schedule commitments, resource requirements, and budget limitations; and that can be delineated from other concurrent activities.

The project management methodology encompasses the following eight functions:

- Scope management
- Quality management
- Resource management
- Schedule management

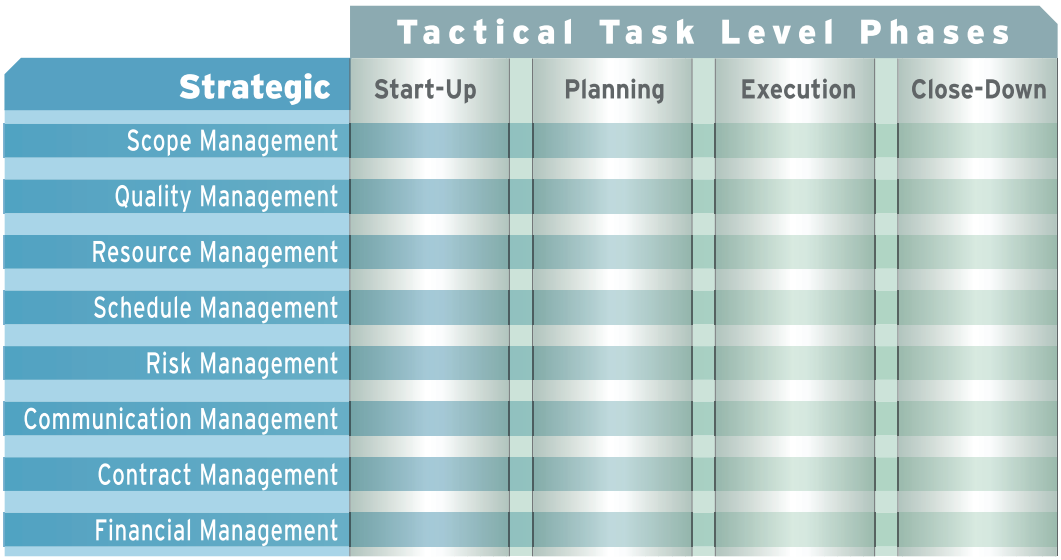
- Risk management
- Communication management
- Contract management
- Financial management

These functions are interwoven as activities into the following stages:

- Start-up
- Planning
- Execution
- Close-down

The following graphic, EDS' PM 2 Methodology, depicts the integral relationship between the tactical and strategic components.

EDS' PM 2 Methodology



PM 2 provides comprehensive management to meet your key milestones and key dates.

For more detailed information about PM 2, see our Operations Phase response to 3.2.2.9(a), "Project Management and Control Methodology."

Systems Life Cycle Version 3

SLC3 is a systems engineering methodology that evolved from EDS' collective systems engineering experience, industry insight, and SEI-recommended development approaches. It applies technology to evolve solutions that meet rapidly changing customer business needs. SLC3 lets us deliver value to you by providing a strong combination of engineering discipline and flexibility. SLC3 decreases systems engineering risks by using your active involvement throughout the process and by using planned iterations to validate intermediate results.

We can tailor the SLC3 methodology to meet your unique needs and deliverables and to support maintenance, minor enhancement, development, systems integration, and other work. It offers the flexibility to support systems engineering on various platforms and tools, from mainframe to desktop.

Benefits

SLC3 offers many benefits that help EDS provide superior products and services to you:

- Aligns information technology with your business requirements
- Strengthens communication with you
- Delivers the best practices from all of EDS
- Reduces risk by applying iteration to verify and validate intermediate results
- Facilitates process customization to meet your unique needs
- Reinforces consistent, repeatable processes and therefore, allows continual improvement
- Facilitates continual improvement as EDS develops, field tests, and deploys new practices and technologies throughout company
- Establishes a common basis for communication with you and throughout EDS
- Assists the project team in blending its requirements with engineering discipline and proven best practices from across EDS
- Provides a foundation for increasing systems engineering process maturity
- Reduces time and effort expended on retraining personnel about processes when the personnel transfer from one team to another

SLC3 describes the system development activities to be performed and is tailored to the process level of detail according to the methodology architecture. SLC3 consists of the following six-phase spiral approach that blends planned iteration with management control:

- **Define**—Identify the business need and determine high-level requirements
- **Analyze**—Refine high-level requirements into detailed business requirements
- **Design**—Build design specifications

- **Produce**—Translate designs into executable components to satisfy the business need
- **Optimize**—Verify that the produced system is ready to implement
- **Implement**—Install the produced system

The first four phases will be repeated as a group to produce intermediate results for your verification, approval, and validation. This phased repetition, or iteration, helps focus on different areas and requirement levels as the system evolves.

Iterative solution development offers the following benefits:

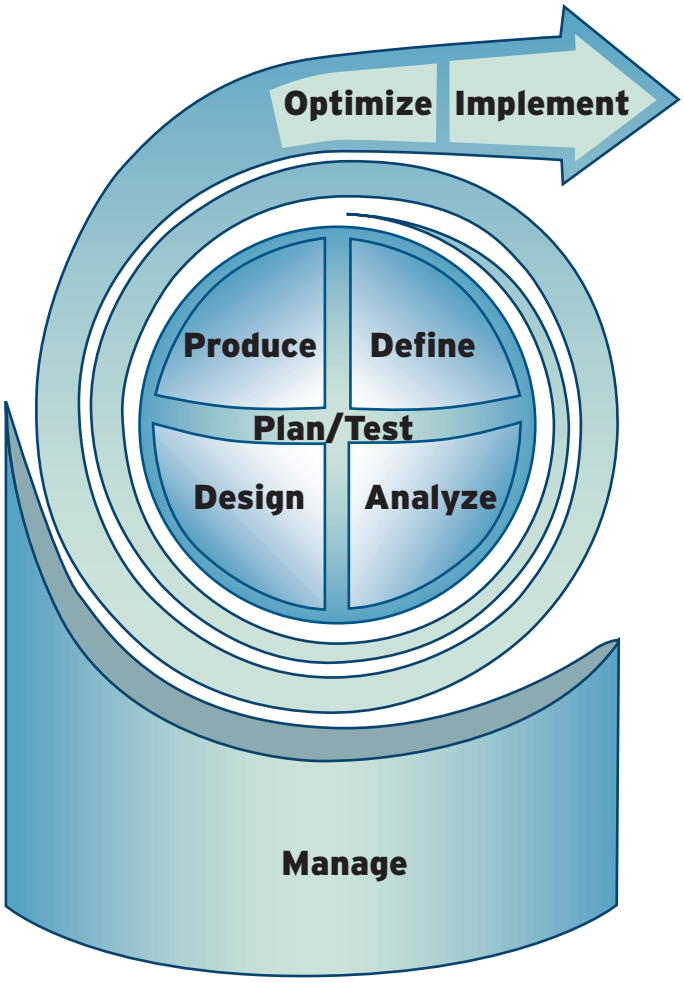
- **Provides a cycle of plan, do, learn, and improve—**Outputs of each iteration result in learning that can be applied in successive iterations to evolve the best overall solution.
- **Aids mutual understanding of requirements or solution ideas—**The completion of an iteration results in models, prototypes, or partially completed products that can be reviewed by you. These outputs provide a what-you-see-is-what-you-get medium for better communicating the intended solution, which results in better validation and feedback.
- **Tests the validity of critical or fundamental solution ideas before spending time and resources on development of contingent details—**Solutions usually consist of many interdependent decisions, some of which are critical and fundamental to the remaining decisions. Some of the most critical and fundamental decisions are based on major assumptions and understandings. By using preliminary iterations to deliver a proof of concept to validate these decisions, necessary adjustments can be made before spending a lot of time and resources on the remaining dependent decisions.
- **Enables you to see actual results earlier in the process—**This, in turn, gives you a higher level of confidence that EDS is meeting it commitments and schedules.
- **Allows you and users to feel involved in developing the solution—**State user involvement is essential to ensuring customer satisfaction and the effectiveness of the delivered solution. Continuous involvement of all affected persons, however, is not usually practical. Iterative development can involve user and your representatives throughout each iteration, and at the end of each iteration, we provide iteration results to a larger audience for a complete validation of the decisions made.
- **Focuses resources and management attention on a limited portion of the solution at one time—**Scattered across large projects, resources and management attention can become diluted and less effective. Using an iterative development approach can focus the resources and attention on one selected portion or cross-section of the problem at a time. This concentration of effort can improve both quality and productivity.

The last two phases are performed when the iterative portion is complete. Each phase includes individual plan and test components. Additionally, all phases have an underlying component, called manage, which enables continuous monitoring and control of process resources and results.

SLC3 complements other EDS methodologies, such as those that establish business direction, identify business process change opportunities, and set technology direction at the enterprise level.

As illustrated in the following figure, SLC3 balances iteration with management control to develop the business solution. Appropriate iteration evolves the business solution, providing you with early opportunities to clarify expectations and anticipate changing business needs.

Systems Life Cycle Version 3



SLC3 balances iteration with management control to develop the business solution.

The manage component defines work that cannot be scheduled because it recurs throughout the project. This includes management control functions critical to a successful project, such as scope management, issue management, software configuration management, and risk management.

Many of these components are integrated with EDS' PM2. Like other systems development life cycles (SDLCs), EDS' project management methodology is integrated throughout the SLC3.

The organization of each phase can be described as "plan-do-test." This cycle is repeated for each phase within each iteration and for each iteration.

- **Plan**—Preparation required to perform the phase effectively. Planning keeps the phase's work directed toward the objectives of that particular iteration.
- **Do**—Actual performance of the defined work within each phase.
- **Test**—Verifies that the work was performed as specified and validates that the work properly addresses the business need. Test also assesses results according to the phase's objectives to determine and report the project's progress and status.

SLC3's structure is logical rather than sequential. It provides the flexibility necessary for customization and continuous process improvement. The six SLC3 phases are documented in logical groupings; however, a sequential occurrence of events is not implied. The sequence of SLC3 work is determined during each project's customization process.

Production Support Method

The Production Support Method provides an integrated approach to help EDS provide better software maintenance and other production support services to customers. It offers greater productivity and quality for production support teams and greater recognition of the importance of production support to EDS business.

This method offers practical guidelines and procedures, proven techniques, and suggested templates and examples to help the systems engineering team successfully support a production system.

The Production Support Method provides the following value and benefits:

- Improved service excellence through an integrated approach for software maintenance and other production support activities
- Method support for GSMS production support work types
- Greater recognition of the importance of production support

Enterprise Testing Method

The Enterprise Testing Method is the EDS preferred methodology for enabling comprehensive testing. This methodology promotes productivity, quality, and comprehensiveness in our testing practices, providing a better deliverable for our customers with reduced risk of solution failure.

The methodology defines test-related activities from the initial stages of a project to the implementation of the final solution. The methodology also encompasses test activities across all deliverable components. From software to infrastructure to hardware, this method describes appropriate test activities.

Enterprise Testing Method has associations with other EDS methods, processes, and strategies. Enterprise Testing Method links, by direct reference, to other methods for cross-discipline functions such as project management and requirements determination.

Enterprise Testing Method enables greater consistency in the delivery of testing services, helping EDS and its customers achieve service excellence.

Requirements Determination Process

The Requirements Determination Process (RDP) provides a framework for communicating with customers and those who will receive and use requirements documentation to build a product or service.

The role of the RDP is to establish a set of requirements that describe the correct product or service to be delivered to the customer. The key benefits of RDP are:

- Reduced costs as a result of properly directed efforts and increased productivity
- Improved time to market
- Reduced risk due to clear understanding of customer requirements

The RDP is divided into five major activities:

- Plan/Manage
- Obtain
- Understand
- Validate
- Evaluation

The core of the RDP—Obtain, Understand, Validate—is executed multiple times, one for each set of requirements that the project team wants to obtain, understand, and validate.

Requirements must be reviewed by appropriate groups, including the project team, before they are incorporated into an overall project. Requirements become the basis for all project plans, work products, and activities.

Requirements determination identifies what is really wanted, needed, and expected—a familiar and necessary part of business and personal life.

Requirements determination in EDS is based on the following principles:

- Delivering the customer's full requirements and expectations into any EDS process used to produce a product or service
- Providing customers with EDS' leadership and expertise in using the RDP and the associated tools and techniques
- Adapting requirements determination to the unique needs of accounts and their particular customers or situations

Estimating

The EDS estimating process is a rigorous method that helps us develop valid estimates for programming projects. The estimating method is practical, adaptable, and scalable to cover a wide range of project/task sizes. Our estimating process is founded on the following three principles:

EDS' Estimating Process

Principle	Justification
Apply the correct resources to create and refine the estimate	The magnitude of a project, the risk of an inaccurate estimate, and the number of project uncertainties influence the level of detail and scope of the estimate created. The project team should invest in the estimate relative to these factors.
Do not arbitrarily change the resource estimate required for a given scenario	Unless a change occurs in the constraints, assumptions, or risks associated with a given scenario, an estimate should not be changed. The project team will develop alternate scenarios to provide the most effective mix of resources based on the existing constraints, assumptions, and risks.
Re-estimate often, even if the deadline cannot be changed	Even if commitments are made to a customer based on the original estimate, it is vital that the project manager create accurate estimates of remaining work. The project team should base decisions on the most current information available. Re-estimates are created when a constraint, assumption, or risk changes; when a scope change occurs; or when a major milestone occurs, such as the end of the design.

Estimating Process

The goal of the estimating process is to predict as accurately as possible the project's resource needs so that anyone having a vested interest in the initiation, execution, or outcome of a project can make informed decisions.

Realistic estimates, based on sound assumptions and historical information, assist in planning projects for the best use of resources, thereby avoiding:

- Depletion or waste of resources
- Excess effort within severe time constraints
- Last-minute project surprises
- Too many resources and not enough work

Realistic estimates are a key tool in completing the Vermont enhancements and modifications project on time and within budget. The estimating process described below has six basic steps, which are an integral part of the EDS project management process:

1. **Estimate Planning—**Identify required participants and their roles. Define the timing of the estimates and the details for each of the steps.

2. **Determine Project Size—**Identify high-level requirements, constraints, and assumptions. Use this information with historical data from similar projects/tasks to determine current project/task size. We accomplish this step through a variety of techniques, including function-point analysis, source-statement estimating, and component (window, report, and process) estimating.

3. **Develop Project/Task Estimates—**Estimate the project/task using two approaches: bottom-up and top-down. A bottom-up estimate involves separating the project into smaller parts, estimating them separately, and then aggregating the results. A top-down estimate involves looking at the project as a whole, using environmental characteristics, size, and historical information. We use automated tools to assist with each type of estimating. These tools are based on historical data from the information technology industry and previous EDS Medicaid implementations.

4. **Reconcile Differences—**Reconcile estimates from step 3, "Develop Project/Task Estimates," and historical data from similar projects/tasks into one solution set for each scenario. Portions of the process may be repeated to resolve differences as needed. The final estimate is not a single solution, but forms a set of possible solutions bounded by the associated risks.

5. **Assemble Estimating Documentation Package—**Create an estimating documentation package and a schedule and resource plan for the solution set. Consider the required resources available in the schedule and resource plan.

6. **Review Estimate With Stakeholders—**The review and approval process involves stakeholders such as the management team, the project team, and any other affected staff. We will use the estimating process output for the next steps, such as prioritizing decisions by the management team regarding which scenario best fits their needs, and the creation of a proposal package.

In conjunction with the estimating principles, we use metrics to measure progress toward the completion of a task or project. Each work plan task is represented by the amount of work hours required for completion. We use a standard systems engineering assessment that allows for the measurement of progress and provides accurate estimates for development and enhancement work efforts. Metrics examples include lines of code and the total number of reports, windows, and processes completed to date, as compared to the entire proposed system. Metrics from previous projects give us an accurate baseline from which to estimate realistic time frames and effort required for an activity, allowing us to adhere to the project schedule.

a.5 Proven, Customized Project Management and Control

Managing the extensive and critical enhancements and modifications to the MMIS requires stricter and more complex project management and control techniques than does the Operations Phase. As a result, EDS is bringing the best of its tools and resources to support the activities of the Enhancements/Modifications Phase.

We will bring a strong focus on requirements definition to ensure we acknowledge and meet the state's objectives for the project. We will enhance project communication by providing all project documentation to state and EDS personnel through our Web-based Project Workbook. And we will establish a formal Change Control Board that can clear hurdles for the Enhancements/Modifications team. These new initiatives, along with many others discussed in this section, will support the reliable, timely implementation of enhancements and modifications.

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b. Staff Resources and Time Estimating Methods

RFP Reference: 3.2.2.9(b), p. 3-14

To track staff resources and document staff hours, EDS uses two key tools:

- The Tracking Log (TLOG) System, a software application that tracks technical staff time against projects
- SAP, a standard corporate tool that tracks time use for all project team members

These two tools are the primary methods for tracking staff resources and documenting staff hours. We describe these tools and their applications in the following sections.

Tracking Time for Technical Personnel

Tracking time for technical personnel on key projects is essential for evaluating and improving our time estimation efforts and for overseeing staff productivity. To support this activity, we use the TLOG System. The TLOG System tracks systems engineer and business analyst hours against approved problem logs (Plogs) and customer service requests. The system also supports status reporting that helps project managers make informed decisions regarding project prioritization, resource management, and change management.

The TLOG System will support the communication of project information to all levels of the organization. Through the TLOG System, we can:

- Provide a view of all projects related to the Vermont MMIS
- View project status and summaries of project activities
- View resource utilization across projects
- Track corrective actions from discovery to resolution

Tracking Time for Nontechnical Project Personnel

To access information regarding nontechnical project personnel, managers can run reports from EDS' standard corporate time tracking system, the SAP. In fact, the TLOG System also interfaces to our corporate time tracking system, so reports from SAP can reflect all EDS staff.

Managers use this system to review and evaluate how both operational and technical employees use their time in support of client needs.

The information in these tools and our first-hand experience with the current environment and operational cycles guide us in staffing appropriately and efficiently.

Estimating

Realistic estimates are a key tool in completing the Vermont enhancements/modifications project on time and within budget. EDS describes our thorough process for estimating in the "Estimating" subsection of the "a. Project Management and Control Methodology (Enhancements/Modifications Phase)."

c. Procedures for Sign-off of Completed Milestones and Deliverables

RFP Reference: 3.2.2.9(c), p. 3-14

Formal sign-off of completed milestones and deliverables provides the state a checkpoint to ensure project progress is proceeding and to verify that our work is meeting state expectations.

Enhancements/Modifications Manager Sean Daly will be responsible for managing the sign-off process for completed milestones and deliverables. During communication planning, state personnel and Sean will jointly determine which milestones and deliverables will require formal walkthroughs and sign-off. These formal milestones are marked in the project plan for tracking purposes.

Walkthroughs and Joint Reviews of Deliverables

Walkthroughs and joint reviews of deliverables and test results are an integral part of our quality approach during the Enhancements/Modifications Phase. Walkthroughs of test results serve the state by:

- Providing an opportunity for the state to gain insight as to how our testing will verify operational readiness for implementation
- Facilitating understanding, answering questions, and expediting the deliverable approval process
- Determining the state's satisfaction or concern with the output

Our work plan details our approach to providing walkthroughs of the deliverables, as well as test data and systems to be tested. The work plan also details our communication with you for the review of contract deliverables and our communication with you for the review of operational readiness (demonstration) test results. Deliverable and test result walkthroughs occur in addition to the regularly scheduled status meetings with the state.

Formal Sign-off

When it is time to receive state sign-off, we will provide the deliverable in hard copy and/or electronic form with a cover memo attached for signature. As stated in the RFP, the state has 10 days for its review. Our project plan reflects this 10-day review period.

Should the state have an issue with the deliverable, we will revise it and return it to the state for another 10-day review period. We often work to avoid issues during the sign-off process by providing an outline or draft for state review prior to the deliverable due date to ensure the approach will meet state expectations.

Once the deliverable is satisfactorily revised and signed off, we record this successful milestone in the project plan. This standard approach assures an organized process for deliverable and milestone sign-off.

d. Management of Contractor Responsibilities, Milestones, and/or Deliverables

RFP Reference: 3.2.2.9(d), p. 3-14

Effective management of contractor responsibilities, milestones, and/or deliverables is central to our established approach to project management and control.

Contractor Responsibilities

Client Delivery Executive Barbara Davis and Enhancements/Modifications Manager Sean Daly will work together to ensure contractor responsibilities are fulfilled during the Enhancements/Modifications Phase. Key aids to this process include:

- **Completing the project teams—**Barbara Davis and Sean Daly will find the best technical and operations personnel to complete the team for each of the enhancements and modifications. EDS' central support centres will provide qualified technical personnel to support this effort.
- **Training and education—**We will provide training and education that gets each team member up to speed quickly on the requirements and work plan for each of the enhancements and modifications.
- **Reviewing the work plan with state personnel—**As we review the work plan with state personnel, we will educate state personnel on the milestones for each enhancement and modification, and then finalize the detailed implementation plan.
- **Working with provider representatives and state provider relations personnel—**Provider representatives and state provider relations personnel will play key roles in educating providers and other stakeholders about how they will be affected by changes. This education is particularly critical with the implementation of ClaimCheck and ClaimReview, which will affect provider payment for services.
- **Following systems life cycle methodology—**The team will monitor progress of the Enhancements/Modifications Phase by following the Systems Life Cycle, Version 3, methodology described in the "a. Project Management and Control Methodology" subsection of the "Project Management and Control (Enhancements/Modifications)" section.

- **Communicating often and with great frequency—**The Vermont team will communicate openly and frequently with the project team, the state, and other key stakeholders to ensure the project meets state and stakeholder expectations. Our means of communication will include formal status reports, status meetings, time tracking reports, and project plan metrics as well as informal communication between state and EDS staff.

Any issues are addressed aggressively and communicated as appropriate to the state. Some issues might warrant immediate conversations with state personnel. Most issues are reported and monitored through weekly fiscal agent meetings. For more information on our approach to resolving problems, see our response to RFP requirement 6.2.2.9(f), "Approach to Problem Identification and Resolution."

Milestones and Deliverables

Also during the Enhancements/Modifications Phase, we must meet the milestones and deliverables as delineated in the project plan for this phase. Enhancements/Modifications Manager Sean Daly will use the project management and control methodologies described in our response to RFP requirement 3.2.2.9(a) to monitor and manage the meeting of contractor responsibilities, milestones, and deliverables.

We provide a hard copy and/or electronic copy of the deliverable and a cover sheet for sign-off to appropriate state staff. State staff members have 10 days, according to RFP requirements, to review the deliverable and either request revisions or sign off on it. When appropriate, EDS will prepare an outline or draft of the deliverable in advance of the due date to validate our approach.

For a more detailed description of the sign-off process itself, see our response to RFP requirement 3.2.2.9(c), "Procedures for Sign-off of Completed Milestones and Deliverables."

e. Assessment of Project Risks and Approach to Monitoring and Managing Risks

RFP Reference: 3.2.2.9(e), p. 3-14

The risk management component of the project management methodology helps teams systematically assess, monitor, and manage the risk factors of a project. Effective risk management can significantly decrease project problems. In the following subsections, we identify our overall process for managing risk during the Enhancements/Modifications Phase and discuss the potential project risks we have identified and begun mitigating.

We recognize and use a risk management process consistent with the Project Management Institute (PMI) Body of Knowledge. Major risk management components include:

Risk Identification

Client Delivery Executive Barbara Davis and Enhancements/Modifications Manager Sean Daly will systematically assess project risk factors and identify specific risks. We will document the characteristics of each identified risk factor.

Risk Quantification

We work with the state to rank risks, determine risk interactions, and document possible project outcomes for each risk factor. We use standard project management tools, such as decision trees, to analyze the risk factors and determine possible outcomes.

Risk Response Development

We manage risk by accepting, transferring, or mitigating exposure and create contingency plans and responses to threats to reduce related uncertainties and consequences. Reducing or eliminating risk increases the probability of a project's success.

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Risk Response Control

Risk management is continual throughout a project. Because project risks increase or decrease their threat throughout the life of a project, EDS continually reviews risk factors and their priority. Working with the state, we will develop plans to reduce or eliminate risks. These risk plans will be posted and maintained on the Project Workbook.

EDS' methodology provides tools, templates, and processes that help identify risks. The process provides early identification of major obstacles to project success. It helps determine and communicate the degree of risk to the project and details plans to handle that risk.

The risk identification process and the resulting table also provide the state with the opportunity to discuss the consequences of doing or not doing specific project activities. Major obstacles to success are identified in a timely, objective manner. This identification provides the state and EDS with the opportunity to identify an action plan to resolve risk issues and increase the success of the project.

EDS plans a detailed review of all identified risks with the state so that we can resolve risk issues timely and effectively. In addition, we will post and maintain risk identification and risk handling plans in the Web-based Project Workbook for easy access by state and EDS personnel.

The risk identification table includes the following information:

- **Risk Item No.—**The identification number assigned to the risk
- **Responsible Team/Person—**The person ultimately responsible for resolving the risk
- **Risk Description—**Type of risk
- **Risk Status—**The current status of the risk; if the risk is open, an "O" will appear in this column; if closed, a "C"
- **Risk Level—**The magnitude of the impact of the risk; "L" is used to indicate a low level, "M" is used to indicate medium level, and "H" for high level
- **Probability—**The probability that the risk will occur; "L" indicates a low probability, "M" is a medium probability, and "H" is for a high probability that the event will occur
- **Potential Impact—**The impact to the project if the risk should occur
- **Approach—**The suggested approach to be taken; the state will review and approve all approaches before action is taken
  - "E" indicates eliminate: Act immediately on the risk, based on the cost of eliminating the risk compared to the cost of potential impact and the likelihood that it will occur
  - "A" indicates accept: Accept the consequences of the risk occurring; an appropriate strategy for risks with low possibilities of occurring or little impact if they do occur
  - "T" indicates transfer: Transfer the risk to the accountable entity that has the authority and accountability for resolution
  - "M" indicates mitigate: Reduce the impact of the risk and the likelihood that the risk will occur to an acceptable level should the risk occur
  - "S" indicates study: Further investigate the risk to acquire more information and better determine its characteristics to enable more knowledgeable decision making
- **Anticipated Mitigation—**Describes at a high level how EDS will reduce the probability or the impact of the risk

The following table lists potential technical obstacles and business issues associated with the Enhancements/Modifications Phase of the project.

Potential Risks for Vermont Medicaid and Other PATH Programs

Risk Item No.	Responsible Team/Person	Risk Description	Risk Status (O, C)	Risk Level (L, M, H)	Probability (L, M, H)	Potential Impact	Approach (E, A, T, M, S)	Anticipated Mitigation
R1	Client Delivery Executive and Enhancements/ Modifications Manager	Experienced EDS staff cannot be assigned according to project schedule	O	H	L	Work tasks are not assigned or scoped according to schedule and tasks begin to slip.	A	EDS has an experienced and successful team in place today. Additionally, EDS is the largest provider of services to Medicaid agencies across the country. We will draw upon corporate resources to identify and recruit the best possible staff to fill required positions as necessary.
R2	Enhancements/ Modifications Manager	Incomplete, vague, or unclear RFP requirements	O	M	L	Project scope is increased, which expands the demands on the state and EDS and jeopardizes our ability to deliver on schedule.	M	Our understanding of the existing system validates our assumption that the RFP is thorough and represents a good faith effort to fully document the requirements of the enhancements/ modifications. The requirement validation meetings will enable the state and EDS to finalize requirements and document results of our meetings. We will mitigate this risk by thoroughly mapping the RFP requirements to system objects to ensure that we are performing the right tasks and cooperating with the state to efficiently plan activities and resources to meet RFP requirements.

Risk Item No.	Responsible Team/Person	Risk Description	Risk Status (O, C)	Risk Level (L, M, H)	Probability (L, M, H)	Potential Impact	Approach (E, A, T, M, S)	Anticipated Mitigation
R3	Client Delivery Executive	The availability of full-time dedicated state staff with the necessary decision-making authority to provide thorough and timely review of all project deliverables and make decisions regarding project scope and requirements	O	H	M	Lack of state staff participation in the review of the schedule, work plans, project status reports, associated project records, and deliverables within the established time frames may negatively impact the overall project. Potential impacts include project task end-date slippage and cost overruns.	M	EDS will work with the state to meet requirements on time. We will use status meetings to review and identify potential threats to the work plan before they affect the dates, cost, and resources. To ensure timely completion of all deliverables and project goals within required time frames, We recommend that the state provide us written approval of deliverables within 10 calendar days of the submission of a deliverable. If written notification is not provided within the 10 calendar day period, EDS will assume the state has approved the deliverable.
R4	Client Delivery Executive	Unable to retain sufficient staff	O	M	L	EDS is unable to retain personnel with the necessary qualifications to operate the Vermont MMIS.	A	EDS has access to sufficient staff if this risk event occurs. EDS currently provides similar services to 26 Medicaid programs in 20 states and more than 150 health care clients. Moreover, we operate versions of the system in place for several clients and have more than 20 other health care system solutions.
		Insufficient program experience and system proficiency to address problems or questions	O	L	L	Inability to properly design and develop system components to meet requirements	T	Many of our staff who supplement Medicaid teams during enhancements/modification efforts have significant experience in Medicaid. Should we need to hire new staff, we will train them carefully and review their deliverables internally for quality and accuracy.

Risk Item No.	Responsible Team/Person	Risk Description	Risk Status (O, C)	Risk Level (L, M, H)	Probability (L, M, H)	Potential Impact	Approach (E, A, T, M, S)	Anticipated Mitigation
R5	Enhancements/ Modifications Manager	Equipment delivery delayed, causing delays in installation	O	M	L	The project scheduled is delayed.	M	The draft work plan allows for appropriate lead time to minimize the possibility of manufacturing, inventory, and transportation delays having a negative impact on the project schedule. We will work with the state to finalize schedules presented in the final work plan. Our work plan mitigates this risk.
R6	Enhancements/ Modifications Manager	Implementation schedule affected	O	L	L	The team could miss key implementation dates, possibly resulting in the project coming in late.	A	EDS' project plan incorporates methods to identify issues, risks, assumptions, and project constraints early in the project, allowing EDS to be proactive and work with the state to resolve and avoid problems that affect the schedule, therefore minimizing impact to scope.
R7	Enhancements/ Modifications Manager	Schedule delays in platform conversion	O	M	L	Delays in the schedule for the platform conversion could result in delays in implementing state changes to the base system.	A	EDS' project plan incorporates methods to identify issues, risks, assumptions, and project constraints early in the project, allowing EDS to be proactive and work with the state to resolve and avoid problems that affect the schedule, therefore minimizing impact to scope.
R8	Enhancements/ Modifications Manager	Serious defect prevents operation of the new platform	O	H	L	Defects could create implementation delays or force the team to revert to the previous system.	M	Our thorough approach to system testing will significantly mitigate the risk of an undetected defect. To address the unlikely chance that we might not identify a serious defect, our implementation plan will include a backout plan for getting the unconverted system back online.

Risk Item No.	Responsible Team/Person	Risk Description	Risk Status (O, C)	Risk Level (L, M, H)	Probability (L, M, H)	Potential Impact	Approach (E, A, T, M, S)	Anticipated Mitigation
R9	Enhancements/ Modifications Manager	Late implementation of ClaimCheck and Claim Review	O	M	L	Delays in the implementation schedule for ClaimCheck and ClaimReview could result in lost opportunity to reduce program dollar expenditures that ClaimCheck and ClaimReview would have provided.	A	EDS' project plan incorporates methods to identify issues, risks, assumptions, and project constraints early in the project, allowing EDS to be proactive and work with the state to resolve and avoid problems that affect the schedule, therefore minimizing impact to scope.
R10	Enhancements/ Modifications Manager	Mistake in programming ClaimCheck and Claim Review to reflect Vermont policy	O	M	M	A programming mistake could result in the inappropriate denial of claims.	M	Effective training with McKesson and the state will ensure the staff responsible for inputting policy has complete information regarding the policy and the McKesson system. Additionally, our own experience with Vermont's policy during the last 21 years will help us identify potential programming errors.
R11	Enhancements/ Modifications Manager	Staff violates HIPAA privacy regulations and erroneously sends confidential information that should go in a letter through e-mail	O	M	M	The state and EDS could face civil and criminal penalties for breaking the law.	M	EDS will provide extensive training to provider relations and communication staff on HIPAA privacy rules and regulations for e-mail communication.
R12	Enhancements/ Modifications Manager	Mistake in converting existing type and specialty taxonomy to HIPAA type and specialty taxonomy	O	M	M	A mistake in converting type and specialty taxonomies could result in errors in paying providers.	M	Thorough testing and design review processes mitigate the risk of a mistake in converting existing type and specialty taxonomy to HIPAA type and specialty taxonomy.
R13	Enhancements/ Modifications Manager	Untimely collection of additional provider information for the Provider Enrollment Data Integration enhancement	O	L	L	Late collection of data results in requiring additional requests for information to providers.	M	Appropriate planning and controlling of activities through proactive work plan management will mitigate this potential risk.

Risk Item No.	Responsible Team/Person	Risk Description	Risk Status (O, C)	Risk Level (L, M, H)	Probability (L, M, H)	Potential Impact	Approach (E, A, T, M, S)	Anticipated Mitigation
R14	Enhancements/ Modifications Manager	Late implementation of Internet enhancement	O	L	L	Providers lose the opportunity to benefit from the ease of access to information provided by the Internet.	M	Appropriate planning and controlling of activities through proactive work plan management will mitigate this potential risk.
R15	Enhancements/ Modifications Manager	Hacker accesses confidential information through the Internet	O	H	L	A hacker gains access to confidential health care information.	M	EDS is highly skilled at applying state-of-the-art technologies, system access restrictions, and security procedures that will fully address Vermont's concerns about unwarranted data access.
R16	Enhancements/ Modifications Manager	Erroneous publication of information to the Internet that violates HIPAA privacy regulations	O	H	M	Information protected by HIPAA privacy regulations is inappropriately available. For example, a provider inappropriately gains access to information about how other providers have treated his or her patient.	M	EDS mitigates this risk by providing extensive training regarding HIPAA privacy rules to the systems engineers programming the Internet functionality and to the provider relations and communication staff who will post information to the Internet.
R17	Enhancements/ Modifications Manager	Late implementation of third-party liability (TPL) subsystem upgrade	O	L	L	The state would lose the opportunity to recover some funds from third parties due to timely filing limitations.	M	Appropriate planning and controlling of activities through proactive work plan management will mitigate this potential risk.

Risk Item No.	Responsible Team/Person	Risk Description	Risk Status (O, C)	Risk Level (L, M, H)	Probability (L, M, H)	Potential Impact	Approach (E, A, T, M, S)	Anticipated Mitigation
R18	Enhancements/ Modifications Manager	Inadequate or late training for state personnel on new screens, procedures, and responsibilities for TPL	O	L	L	Inadequate or late training could result in errors in TPL processing, which could include the inability to recover dollars owed to the Medicaid program.	M	Appropriate planning and controlling of activities through proactive work plan management will mitigate this potential risk.
R19	Enhancements/ Modifications Manager	The state and EDS have different definitions of "acceptable performance" of contract requirements	O	M	L	There is variation in performance and deliverables because the state and EDS use different operational definitions for performance, deliverables, or sign-off.	A	As part of the quality management process, the state and EDS will jointly define performance requirements and methods for measuring and reporting results.
R20	Enhancements/ Modifications Manager	Hardware downtime	O	H	L	The impact of hardware downtime is a potential schedule impact if the team is unable to continue design, development, or testing due to the downtime.	M	To mitigate the risk of downtime during development, we will make backups and provide ongoing preventive maintenance. Should downtime occur, we will use additional server infrastructure available through other EDS facilities to support development.

Our proactive approach to project risk management helps us keep projects on track for implementation. Based on our knowledge of the Vermont Medicaid environment, we have allocated adequate time to respond to unanticipated risk situations that may arise or have developed a mitigation plan to address possible risk areas. In addition, our broad health care experience across numerous clients allows us to effectively handle risk issues specific to health care because we have worked with similar systems.

EDS carefully monitors the vital tasks on the critical path continuously throughout operations. Should a vital task appear at risk of slippage, the leadership team is prepared to act quickly to shift resources as needed to ensure all critical tasks are completed on schedule.

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f. Approach to Problem Identification and Resolution

RFP Reference: 3.2.2.9(f), p. 3-15

During the Enhancements/Modifications Phase, early problem identification is critical. Multiple enhancement and modification projects will occur simultaneously during this phase. All projects are on aggressive schedules, and some have state-mandated completion dates.

To quickly identify and correct any issues, we will use proven processes. Our approach to corrective action is direct and logical. We use proven methodologies to identify, track, and report issues. The issue resolution process includes problem definition, root cause analysis, and error severity classification solutions. This process also includes ongoing communication in fiscal agent meetings and other regular work group meetings until the issue or problem is resolved.

In addition, Client Delivery Executive Barbara Davis has a plan in place for identifying the personnel required for an efficient start up. Enhancements/Modifications Manager Sean Daly will rely on his extensive network of EDS technical personnel in both central support centres and other Medicaid project teams to staff the project and to replace technical personnel should the need arise.

We provide additional information about our approach to problem identification and resolution in the following sections:

- Resolving System Issues
- Replacing Key or Technical Personnel
- Proven Processes for Resolving Issues

Resolving System Issues

The EDS Vermont team is responsible for monitoring and identifying problems and resolutions during the Enhancements/Modifications Phase. We do this by through comprehensive requirements gathering and testing during system development. During testing, we follow testing progress, reviewing test reports regularly and intervening when trends indicate a potential issue. When we do identify defects, we track them through to resolution.

As enhancements/modifications manager, Sean works with a project planning specialist to track progress of each enhancement against documented milestones and time frames. Frequent written and oral status reports give Sean the opportunity to identify and explore any issues.

After identifying and reporting the problem or issue, Sean and his team use the process described below to develop and present a corrective action plan. The following table highlights the steps included in the process.

Corrective Action

Area/Function	Quality Checks	Frequency
Corrective Action	When issues or problems occur during any task, we have an established process for correcting them. The approach includes the following steps: • Document the issue or problem • Use temporary interventions to stop incorrect outcomes if possible • Communicate by written and verbal means with other staff and the state, then solicit input on cause and solution • Research and analyze the issue or problem to identify its root cause • Develop alternative solutions • Choose best solution • Develop a corrective action plan • Evaluate the time necessary to correct • Prioritize tasks in relationship to the work plan • Evaluate the impact on any existing project schedules and adjust as needed • Implement the corrective action • Update or correct corresponding documentation and/or perform training • Communicate action to other areas	As needed

Once the team has identified the issue or problem, we track the progress in status reports and project meetings.

System issues, including defects identified during system testing, are tracked through the Tracking Log (TLOG) system according to the customer service request /problem log (Plog) process until we make the correction, change, or modification. Briefly, this process involves:

- Tracking corrections and changes
- Prioritizing modifications
- Implementing corrections, changes, and modifications
- Supporting continual improvement

For a more detailed description of the change management and change control process, see the description in our Enhancements/Modifications Phase response to RFP requirement 3.2.2.9(a), "Project Management and Control Methodology." As a result of our established processes for identifying and resolving system issues, we promote good communication regarding issues and fast resolution.

Replacing Key or Technical Personnel

People are EDS' most valuable asset, so we take proactive steps to retain them. We offer excellent health benefits; an employee assistance program; company stock options; performance bonuses; training and tuition programs through EDS University; and significant discounts for personal insurance, retail services and merchandise, and new car purchases. Client Delivery Executive Barbara Davis and her key leadership team make every effort to retain employees and prepare them for career advancement opportunities; however, the team prepares for turnover situations by identifying and designating primary backup personnel for key positions and cross-training staff to handle multiple account responsibilities.

The Vermont team has been very successful in retaining technical personnel. In a time when the turnover of technical personnel averages 24 percent, we have had no turnover of technical staff for the last five years. This high retention record speaks to the team's sincere commitment to making EDS a great place to work.

Leveraging Experience Technical Personnel From the Central Support Centres

To augment staff **during the Enhancements/Modifications Phase, we will use people from our central support centres who have experience implementing similar enhancements.** Our central support centres employ hundreds of systems engineers with Medicaid experience who regularly support our Medicaid clients on implementations and special projects. They are located in Richmond, Virginia.; Vancouver, Washington.; Plano, Texas; and Little Rock, Arkansas. Central support centres offer cost-effective and reliable expert support when needed.

The state has witnessed the advantage of using central support centre staff recently during the HIPAA remediation project. Experienced staff members from central support centres have seamlessly backfilled for on-site staff in their regular positions so staff members who are thoroughly familiar with the system can support the HIPAA remediation. Central support centre staff members have also brought specific expertise to augment the account team's skill set in supporting the HIPAA remediation project.

Using central support centre personnel will provide excellent service to the state during the Enhancements/Modifications Phase.

Transferring Experienced EDS Personnel

When we must fill a permanent position that requires technical or medical experience, we can draw on more than 4,450 employees working in the 20 states where we support 26 state Medicaid-related programs. No other contractor has the same depth of experience and knowledge to fill critical needs for a client. If a qualified EDS employee is identified as the best person for a position and needs to relocate to Vermont, we can initiate this process. Providing the state with the best candidates to do the job is a top priority for EDS, and we will use our vast network of qualified and talented employees to select the best people for the job.

Hiring Local Talent

In addition, if necessary, we will look locally for qualified candidates throughout the Burlington area. Our hiring and retention methods include a comprehensive process that ensures our employees are forthright citizens. To support the ongoing security of our customers' information, we mandate drug testing and background investigations of all prospective employees.

To initiate new staff, we conduct new employee orientations. We want new members of our team to fully understand their company, customer expectations, job responsibilities, and performance criteria.

EDS complies with Affirmative Action and Equal Employment Opportunity regulations. EDS is an EEO employer and does not discriminate in employment practices with regard to race, color, religion, age (except as provided by law), gender, marital status, developmental disability, political affiliation, national origin, or handicap. We comply with all applicable provisions of the Americans with Disabilities Act.

Through our long-term involvement with Medicaid programs across the country and our more than 21-year relationship with Vermont, we can anticipate how changing circumstances in the dynamic Medicaid environment influence day-to-day operations. EDS is uniquely positioned to offer a low-risk Enhancements/Modifications Phase with a staff that possesses the skills to meet stringent deadlines.

Proven Processes for Resolving Issues

Any effort to enhance or modify a system of the size and complexity of the Vermont MMIS will face issues from time to time. **What differentiates EDS is a record of addressing those issues quickly and competently—before they disrupt system development.** As a result of our experience and superior people care, we avoid potential issues every day. In the Enhancements/Modifications Phase, we will continue to use proven processes for preventing issues and for communicating, tracking, and resolving issues to the satisfaction of the state.

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g. Internal Quality Control Monitoring of Relations With the State, Providers, and Other Stakeholders

RFP Reference: 3.2.2.9(g), p. 3-15

EDS fully understands the fundamental significance of internal quality control monitoring of relations with the state, providers, and other stakeholders as we proceed with the Enhancements/Modifications Phase.

Open Communication and State Approval of Enhancements

As we evaluate the scope of work for all enhancements and modifications, the full involvement of the Department of PATH will be necessary to move toward a new MMIS model that supports Vermont's business needs. We will seek and gain the approval of the Department of PATH as we begin to work on the enhancements and modifications. By defining points of input and specifying contacts during this process, we will continue the open communication we currently have with the state through e-mail and phone calls. We will also continue to use the S-Log system.

This system was developed in 1993 as a tracking mechanism for nonelectronic, written correspondence received from the state that requires our action. When we receive such correspondence, we enter it into the S-Log system and assign a sequential number. The document is photocopied and the original filed with the S-Log documentation. The S-log sign-in sheet lists to whom the document was sent, the date it was received at our facility in Williston, the date on the document itself, the name of the individual sender, a brief description of the documents (such as rate changes or procedure code additions/deletions), and a section to enter a response date if required. We then distribute copies of the document to the appropriate manager or team member required to complete the request.

Each week during our regularly scheduled fiscal agent meeting, we will inform the state of our progress, any testing that has occurred, and the results of this testing as the enhancements are implemented.

Provider Focus Groups

As we move into the testing phase of the enhancements, the provider community will play an important role. We have had great success in the past using provider focus groups for testing new functionality and updates. We expect this process to continue, with providers supplying candid, useful feedback regarding the effect of changes. One example of using provider focus groups was during the implementation of the Provider Electronic Solutions software. Providers representing each individual billing claim form were contacted to submit test claims. This allowed the providers a complete walkthrough of the new software prior to its release and helped us test each phase of the electronic claim submission process. We will communicate information to providers through the advisory newsletter, remittance advice banner pages, e-mail, and special mailings when necessary. As the Web enhancement progresses, providers will be able to view progress and information online.

Consistent Points of Contact for Other Stakeholders

In our experience in dealing with other stakeholders, appointing a specific contact person allows a relationship to evolve based on communication, efficiency, and trust. In the following table, we provide some examples of these contact people.

Points of Contact/Descriptions

Area Description	Point of Contact
Contract compliance—overall	Barbara Davis
HIPAA compliance—overall	Chrissie Racicot
Pharmacy Benefits Management contractor	Cindy Littlefield
Recipient benefit counselor	Chris Haskins
Global clinical record contractor, technical	Bob Randall
Centers for Medicare and Medicaid Services (CMS)	Louise Brooks
BusinessObjects support for the OVHA and DDMHS	Louise Brooks
BusinessObjects support for other state entities and the EDS staff	Ann Markle
Drug manufacturers	Chris Dapkiewicz
Banks	Cherie Benoit
Office of Investigations, Office of Inspector General	Cherie Bergeron
Medicaid Fraud Unit	Judy Isham
Vermont Program for Quality in Health Care	Cindy Littlefield
Anthem Health Care (state audit reports)	Ann Markle

Area Description	Point of Contact
Legislature regarding changes and impacts upon MMIS	Cherie Bergeron
Ombudsman's office	Niki Holton
Vermont Patient Accounts Managers	Jessica Monturo
Healthcare Finance Managers Association	Chris Haskins
Bi-State Primary Care Health Partners	Barbara Jackson
Community Mental Health Centers	Jessica Monturo
New Hampshire/Vermont Strategic HIPAA Implementation Plan (NHVSHIP)	Sarah Johnson
New England Medical Equipment Dealers (NEMED)	Chris Haskins

EDS maintains open communication with all stakeholders through phone calls, individual meetings, and e-mail. We intend to maintain these relationships to ensure uninterrupted service for all programs.

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h. Project Status Reporting

RFP Reference: 3.2.2.9(h), p. 3-15

Throughout the Enhancements/Modifications Phase, we produce a variety of status reports to provide project updates and document progress, including issues requiring action and attention. In preparing the reports, Enhancements/Modifications Manager Sean Daly and his team observes, evaluates, and appropriately incorporates verbal and written briefs from other EDS project team members. We combine this information with the output from automated project tracking tools, such as Microsoft Project and the Tracking Log (TLOG) system.

We will significantly enhance our approach to status reporting in the Enhancements/Modifications Phase by providing all key status reporting documents in the Web-based Project Workbook. After the Enhancements/Modifications Phase ends, we also plan to apply these improved reporting procedures to Operations Phase status reporting as appropriate.

We describe our approach to project status reporting in the following subsections:

- Weekly Status Reports
- Weekly Status Meetings
- Web-Based Project Workbook
- Sample Project Workbook Status Reports

Weekly Status Reports

Weekly status reports communicate to state and EDS management the status of the project. These reports provide an overview of the project's status in comparison to the detailed work plan schedule, change requests, and issues that may impact the project. The status report is the primary working document used in the joint state and EDS status meetings.

Weekly status reports provide project updates and document progress for the archive records, including issues requiring action and attention from the state or EDS. Our managers will prepare a written status for each major enhancement project. These reports document progress on work plan tasks, key decisions made or needed, key personnel additions or changes, and key project measurement statistics. Each report documents actions and progress from the prior week and identifies planned actions and issues for the current week. The status report serves as the discussion tool during the weekly status meeting. All status reports are also published to the Project Workbook.

EDS will extract the status of initiatives in process to meet the state's progress reporting objectives. We will consolidate and publish status reports to the Project Workbook and send copies to the state one day before the fiscal agent meeting. We will update work plans and schedules biweekly, publish them to the Project Workbook, and send copies to the state before the fiscal agent meeting. For more information on the Web-based Project Workbook, see the "Web-Based Project Workbook" section that follows.

Weekly Status Meetings

At 9:30 a.m. every Friday at the EDS offices, key state managers meet with EDS managers to review the week's activities and look ahead to upcoming events in the fiscal agent meeting. During the Enhancements/Modifications Phase, we will use this meeting as a forum to discuss status and issues related to the Enhancements/Modifications Phase projects as well.

Discussion items in this meeting include:

- Past events
- Upcoming events
- Program changes
- CSR/Plog status
- Problem resolution status

Each week, the EDS administrative assistant takes meeting minutes and distributes them to all attendees. **This established meeting provides an efficient means of communication and idea exchange for key state and EDS managers.**

Web-Based Project Workbook

EDS will implement a Web-based version of our Project Workbook during the contract's Enhancements/Modifications Phase. EDS' Project Workbook is a unique approach to providing comprehensive project-related communication. It provides a comprehensive journal of all project documentation and includes status reports, work plans, change orders, deliverable specifications, test data, test results, and even sign-off documents. Through the linking features included in the Project Workbook, state and EDS personnel can gain an understanding of the current status of virtually any aspect of the project and of the meetings and decisions that have affected the project's current state.

We have used the Web-based Project Workbook to support our two most recent and on-time client/server MMIS implementations in Oklahoma and Delaware. We are also using this innovative communication tool to support MMIS implementations in Kansas, Tennessee, and Pennsylvania and to support HIPAA remediation in Idaho.

The Web-based Project Workbook provides the following significant advantages:

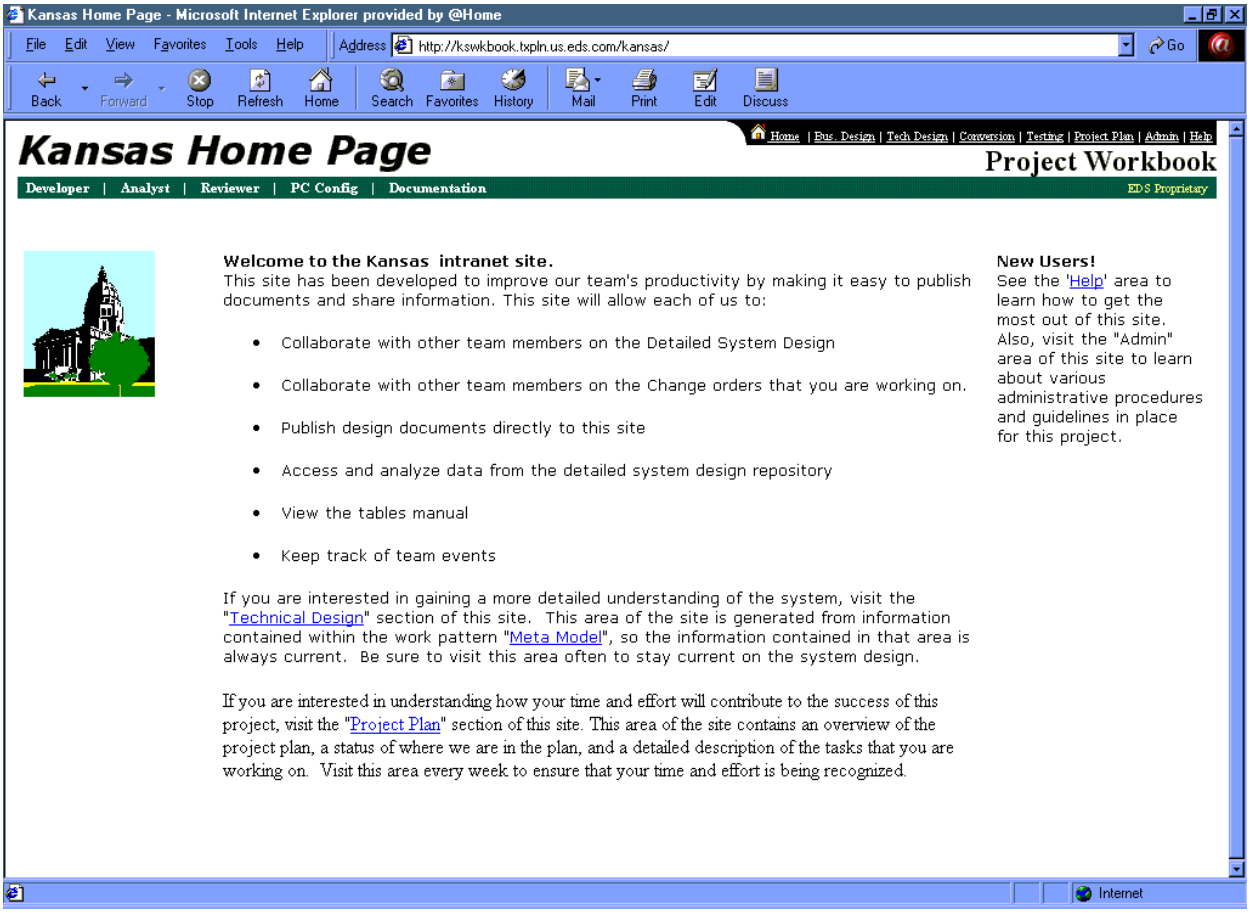
- Timely access to project-related information for the state and EDS
- Rapid access to status reports, schedules, and documentation for authorized personnel when published
- Hypertext links from status reports to related documents such as sign-off sheets, specifications documents, and test criteria, thereby providing a comprehensive picture of the status with only the click of a mouse
- The complete Microsoft Project work plan published as a Web page for viewing by authorized personnel, thereby providing an additional level of status reporting
- Intuitive design and easy-to-use search features
- Complete training from EDS on all aspects of navigating and reading Project Workbook

During the Enhancements/Modifications Phase, we will maintain the Project Workbook as an interactive Web-based tool. EDS has found in other large-scale implementations that the Web-based Project Workbook is the most effective, efficient, and timely way to communicate key information. No other bidder offers this access to project information at the level EDS provides in the Project Workbook.

Sample Project Workbook Status Reports

The following sections provide an overview of the content and format of the various status reporting documents available through the Web-based Project Workbook. These examples are from the Project Workbook currently in use on the Kansas MMIS implementation. Due to the different nature of the Kansas project, we expect to use the Project Workbook in a slightly different way for Vermont. Nevertheless, these sample windows provide insight into how the online tool works.

Project Workbook: Home Page Example

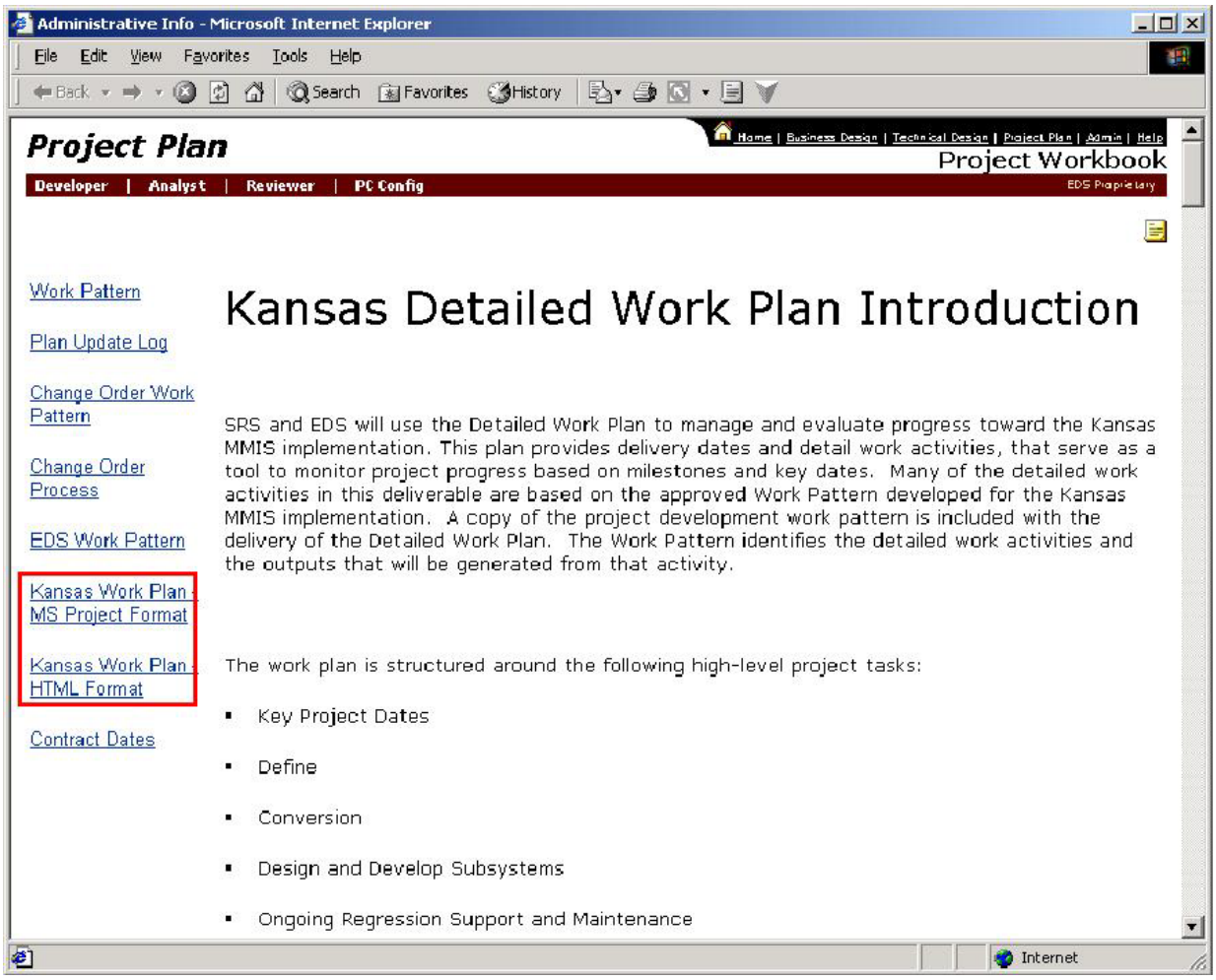


The Project Workbook provides easy, online access to all project documentation.

Detailed Work Plan Windows

The Project Workbook operates as a comprehensive Web site that offers access to important information. In the following example, the detailed work plan main page provides access to the detailed work plan in Microsoft Project 2000 format and HyperText Markup Language (HTML) format. These formats provide a comprehensive status by each phase, task, and subtask. The links to the work plan from the introduction page are highlighted in a red box.

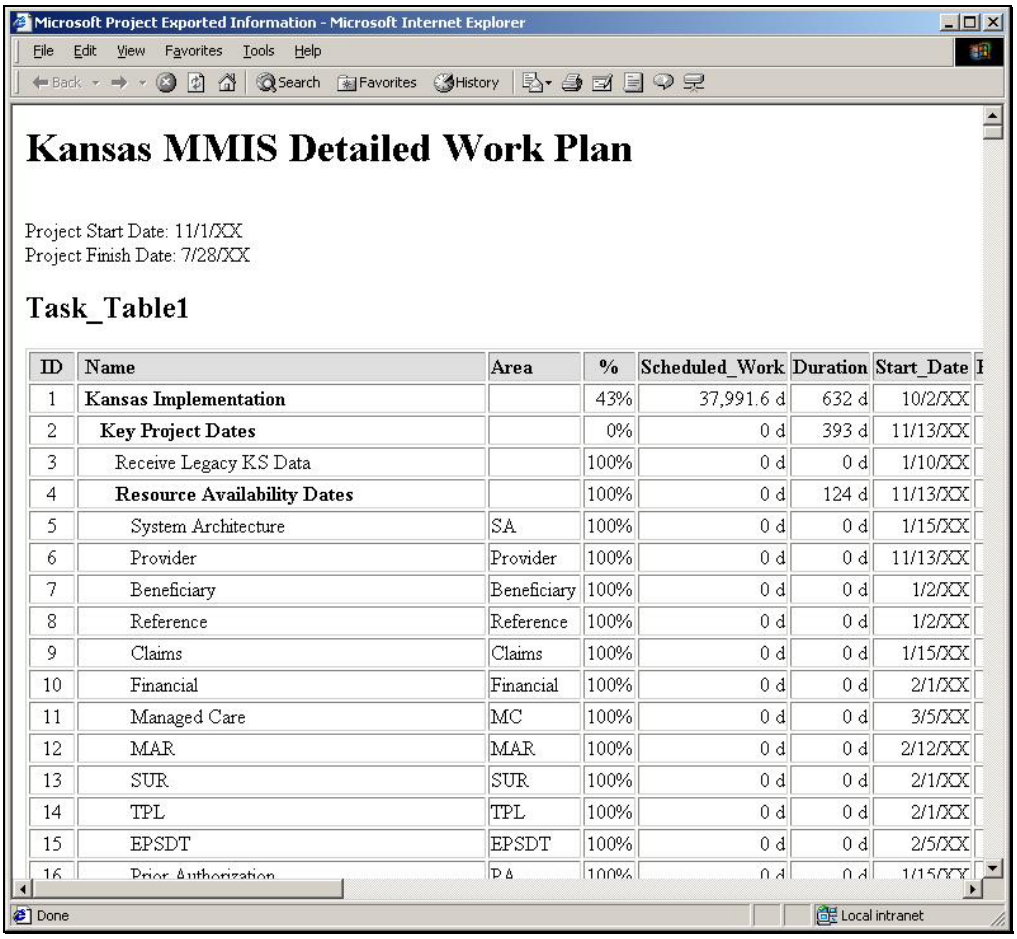
Project Workbook: Detailed Work Plan Introduction



The Project Workbook provides easy, online access to the detailed work plan.

When the user clicks on the link for the work plan in HTML format, the Project Workbook displays the following window with detailed work plan information. With this window, the user can easily determine the status of any phase, task, or subtask in the work plan.

HTML (Browser-Readable) Detailed Work Plan



Microsoft Project Exported Information - Microsoft Internet Explorer

File Edit View Favorites Tools Help

Back Search Favorites History

Kansas MMIS Detailed Work Plan

Project Start Date: 11/1/XX
Project Finish Date: 7/28/XX

Task_Table1

ID	Name	Area	%	Scheduled_Work	Duration	Start_Date
1	**Kansas Implementation**		43%	37,991.6 d	632 d	10/2/XX
2	**Key Project Dates**		0%	0 d	393 d	11/13/XX
3	Receive Legacy KS Data		100%	0 d	0 d	1/10/XX
4	**Resource Availability Dates**		100%	0 d	124 d	11/13/XX
5	System Architecture	SA	100%	0 d	0 d	1/15/XX
6	Provider	Provider	100%	0 d	0 d	11/13/XX
7	Beneficiary	Beneficiary	100%	0 d	0 d	1/2/XX
8	Reference	Reference	100%	0 d	0 d	1/2/XX
9	Claims	Claims	100%	0 d	0 d	1/15/XX
10	Financial	Financial	100%	0 d	0 d	2/1/XX
11	Managed Care	MC	100%	0 d	0 d	3/5/XX
12	MAR	MAR	100%	0 d	0 d	2/12/XX
13	SUR	SUR	100%	0 d	0 d	2/1/XX
14	TPL	TPL	100%	0 d	0 d	2/1/XX
15	EPSDT	EPSDT	100%	0 d	0 d	2/5/XX
16	Prior Authorization	PA	100%	0 d	0 d	1/15/XX

Done Local intranet

State users can review work plan status online in HTML.

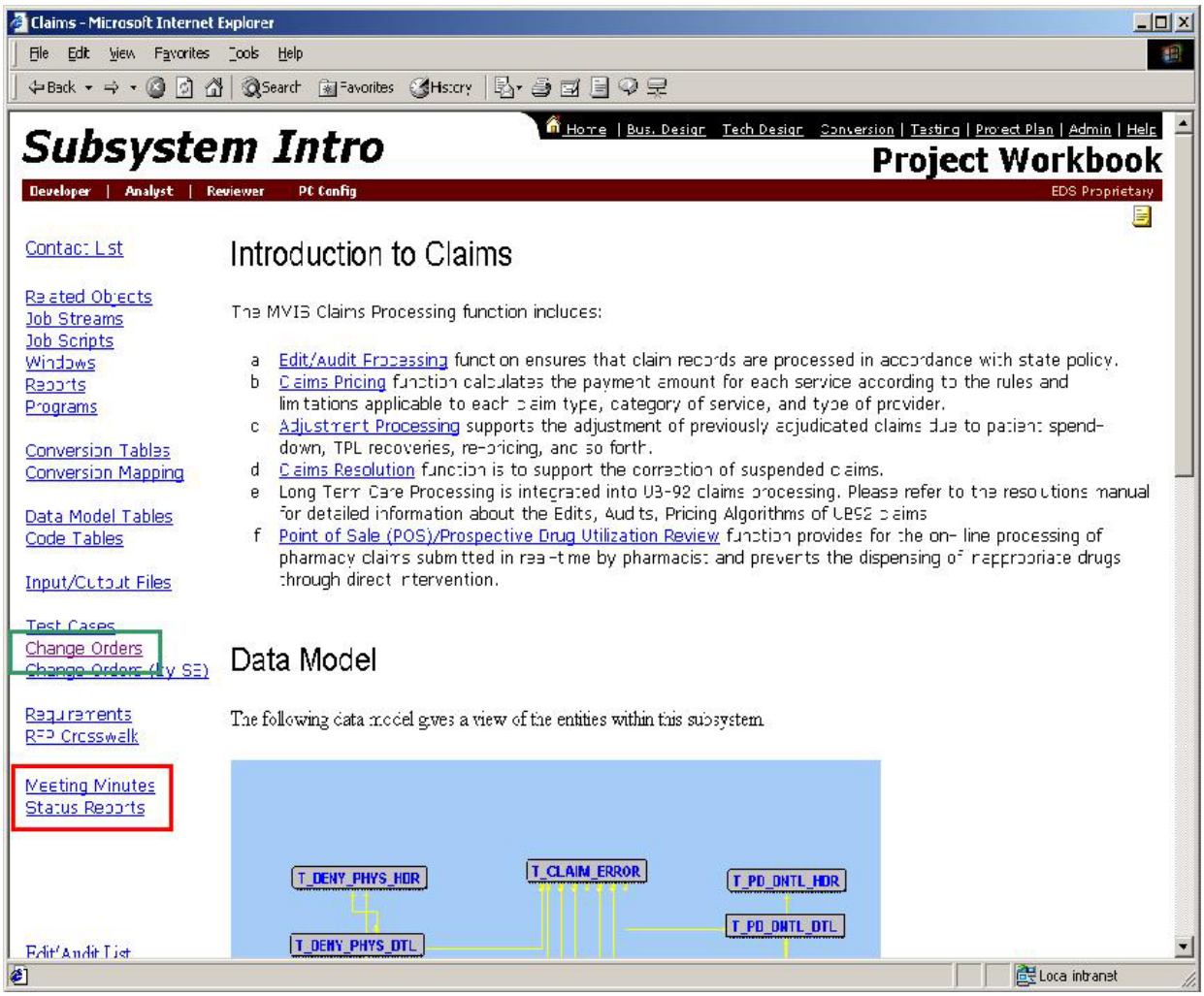
Subsystem Windows

The Project Workbook provides for the capture of status and meeting notes for each portion of the project. In the Kansas implementation, the project is segmented by subsystems, so the windows presented reflect that organization. In Vermont, teams will be organized by enhancement, so the Project Workbook will report status information by enhancement. While the Kansas structure is slightly different from the enhancement-by-enhancement approach we anticipate using for Vermont, we believe the sample windows are helpful in presenting the concepts of how the Project Workbook functions.

The following three windows provide examples of the format and information available in the Kansas MMIS Project Workbook for subsystems: the Subsystem Introduction window, the Meeting Minutes window, and the Subsystem Status Report window.

The Subsystem Intro window shows how Project Workbook conveniently links related information together, thereby providing the user with a more comprehensive understanding of the requirements, modifications, testing, and current status of each subsystem. The links highlighted in a red box provide for quick access to meeting minutes and status reports related to this subsystem.

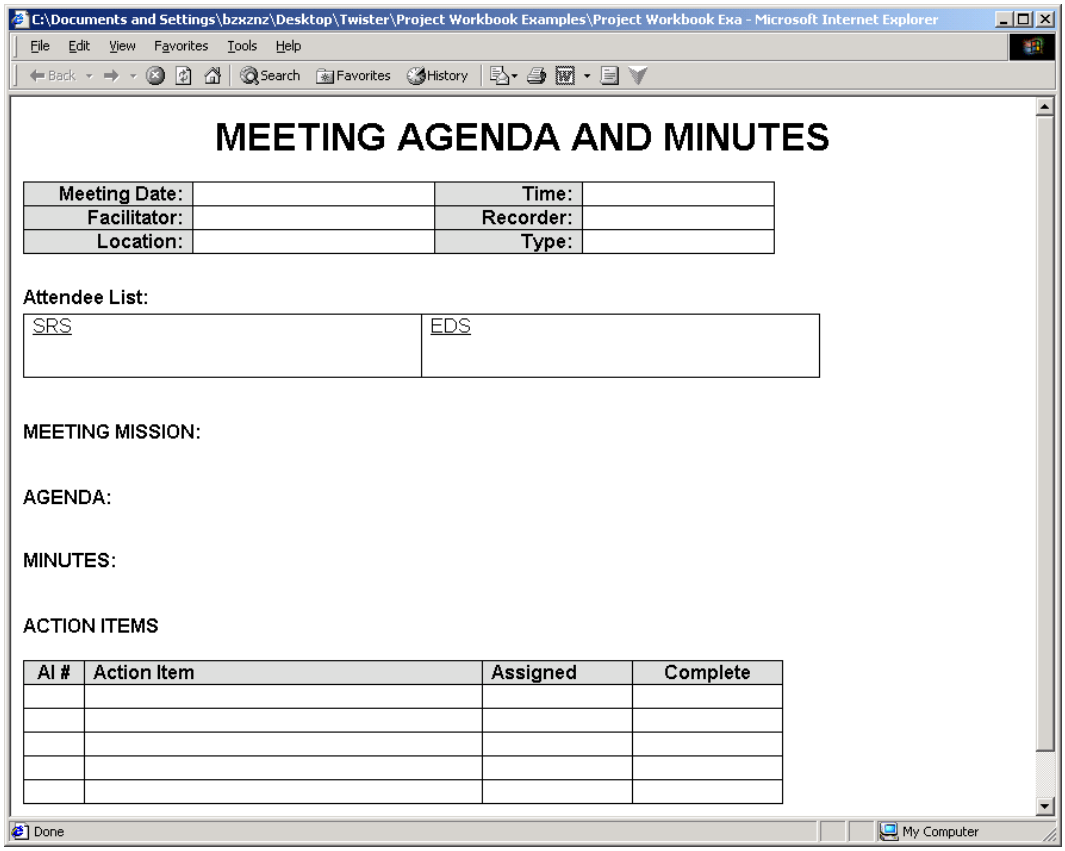
Subsystem Intro Window



Users can review information about each subsystem in the Subsystem Intro window.

When users click on the Meeting Minutes link on the preceding window, they are presented with the following online report. The Meeting Agenda and Minutes window provides access to each meeting related to the subsystem, attendees from the state and EDS, detailed minutes, and specific action items with the person(s) assigned and expected or actual completion date.

Meeting Agenda and Minutes Window



MEETING AGENDA AND MINUTES

Meeting Date:		Time:	
Facilitator:		Recorder:	
Location:		Type:	

Attendee List:

SRS	EDS

MEETING MISSION:

AGENDA:

MINUTES:

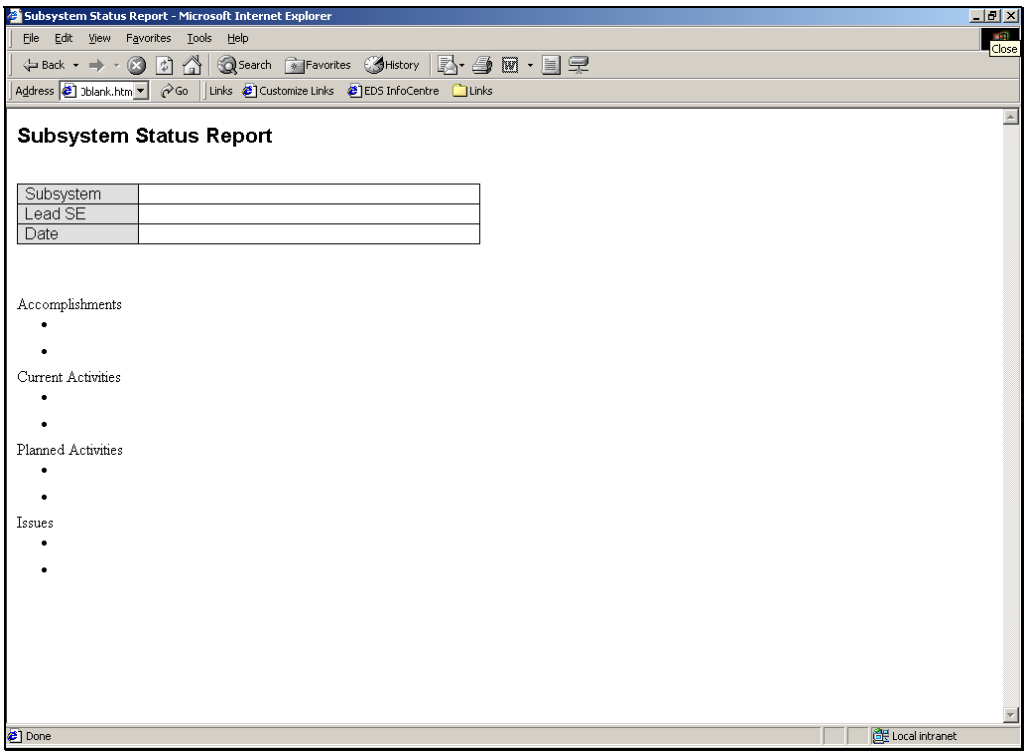
ACTION ITEMS

AI #	Action Item	Assigned	Complete

Users can quickly determine enhancement team status by reviewing meeting agendas and minutes online.

When users click on the Status Reports link on the Subsystem Intro window, they are presented with the following online report. The Subsystem Status Report window provides current information for each subproject, including the EDS person responsible for the subproject, accomplishments to date, activities currently in progress, future activities, and any issues related to the subproject. Through these windows, the user can quickly determine the status and activities related to a specific subproject.

Subsystem Status Report Window



Online subsystem status reports provide a quick review of activities planned and accomplished for each subsystem.

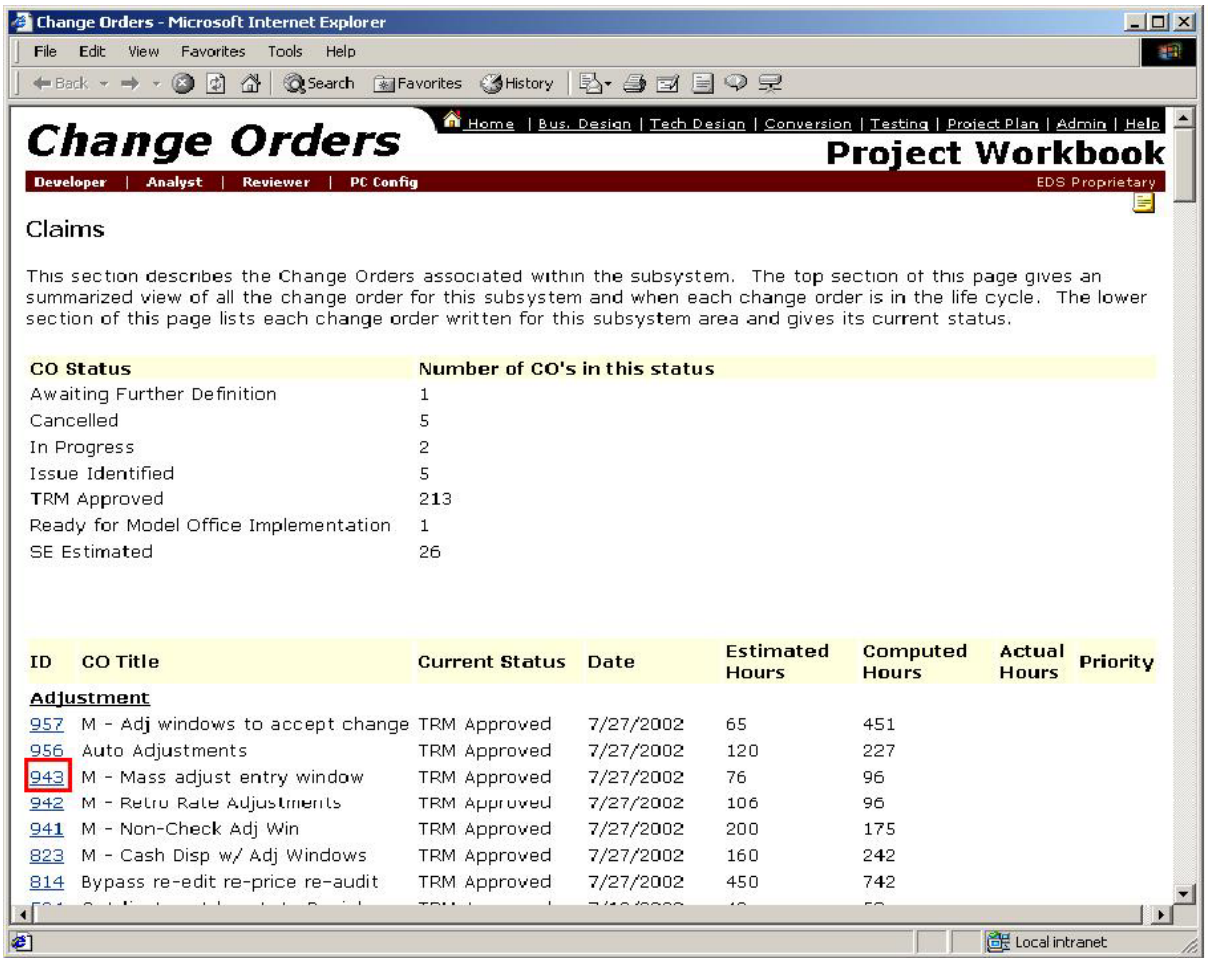
Change Management Windows

The Project Workbook also provides detailed information on change orders as well as the specific details of what we need to do to implement the enhancements that the customer has requested in the RFP and subsequent discussions. The Change Management windows reflect these sorts of change requests and their status. These types of changes are different from proposed changes to project scope that will be taken to the Change Control Board as addressed in the "a. Project Management and Control Methodology" subsection of "Project Management and Control (Enhancements/Modifications)."

Users access information on change orders from the link in the preceding Subsystem Introduction window. The following three illustrations show the Change Request Overview window and an Individual Change Order window.

When users click on the Change Orders link on the Subsystem Introduction window, they are presented with the following Change Request Overview window. This window provides a status of each change order submitted for the subsystem. In addition, the top of the window provides a summary of the total number of change orders, change orders that have been documented or the issues identified, and the number of change orders that have been approved through the transfer review meetings. In addition, each change order number is a link to further detail for that change request. The change order link is highlighted in a red box in the following graphic.

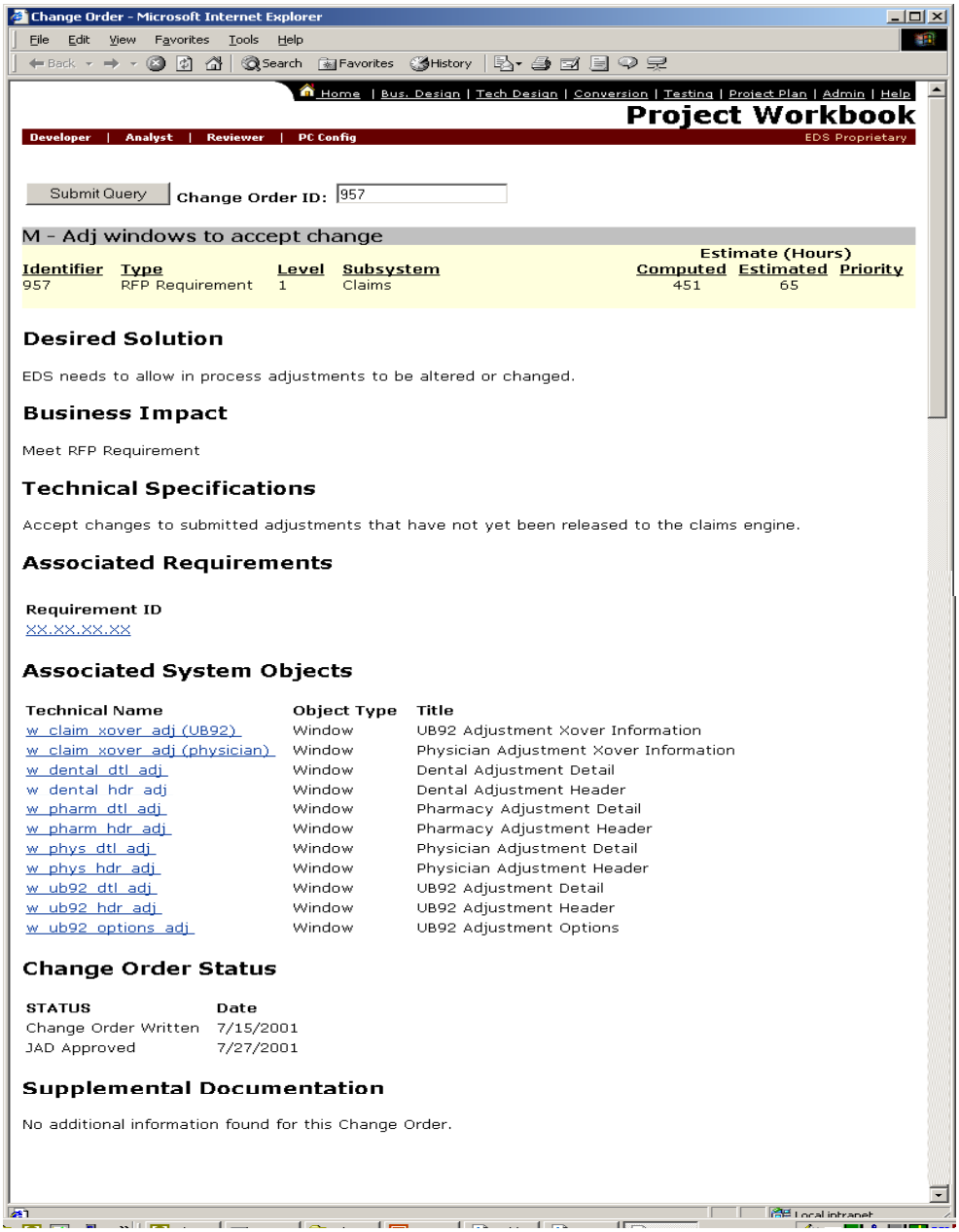
Change Request Overview Window



Users can view at a glance the status of all change requests.

When users click on the change order number link, the Individual Change Order window appears. This window also presents status information combined with significant related information, such as a description of the desired solution, a business impact justification narrative, links to related system requirements, links to the actual RFP citation and EDS proposal citation, change order status, and a narrative of any additional documentation relevant to the change order.

Individual Change Order Window



Users can rapidly access and review details regarding individual change orders online.

As these illustrations indicate, the Project Workbook is a powerful status reporting, documentation, and management tool.

We will work with the state during our initial Enhancements/Modifications Phase project meetings to refine and mutually agree on the exact content, titles, and update frequency for all Project Workbook status documents. Our approach to status reporting and the format and content of our reports will quickly provide the state and the EDS team with an accurate, thorough understanding of project status.

WORK PLAN AND SCHEDULE (ENHANCEMENTS/MODIFICATIONS)

RFP Reference: 3.2.2.10, p. 3-15

The Department of PATH and EDS have worked side by side in a partnership implementing enhancements to the VermontAIM for more than two decades, and we look forward to providing your required modifications for improved health care services. Because of our understanding of the state's vision for future MMIS functionality and our in-depth system and program knowledge, we are the vendor most qualified to implement your enhancements on time, within budget, and with minimal disruption. We will leverage the continued operations and support for the existing base system as well as the existing equipment for enhancements, a separate server for testing, and a seasoned leader dedicated to making the implementation transparent to the state, providers, beneficiaries, and users.

To provide a logical sequence of events, sufficient detail for review, tasks, contractor responsibilities, milestones, and deliverables, our Enhancements/Modifications Work Plan and Schedule are defined in both Gantt chart and narrative description, addressing the following requirements:

a. Understanding of, Response, and Approach to Completing the Enhancements/Modifications Scope of Work
   - Response to Mandatory Enhancements and Modifications Described in RFP Requirement 2.8.2
b. Acquisition and Utilization of Staff
c. Utilization of Staff Resources
d. Approach to Infrastructure
e. Approach to Facilities and Infrastructure Acquisition and Installation
f. Approach to System Security, Backup, and Disaster Preparedness
g. Design and Development Approach
h. Implementation Approach
i. Testing Approach
j. Operations Approach
k. Approach to Relations with State Personnel, Providers, and Other Stakeholders
l. Use of Subcontractors
m. Cost Containment Mechanisms

n. Assumptions or Constraints in Developing and Completing the Work Plan and Schedule

o. Critical Path Diagram

p. Gantt Chart

q. How the Work Plan Provides for the Handling of Potential and Actual Problems

r. How the EDS Approach to the Enhancements/Modifications Scope of Work Clearly and Unambiguously Accommodates Existing Technology and Meets Stated Technical Requirements

a. Understanding of, Response and Approach to Completing the Enhancements/Modifications Scope of Work

RFP Reference: 3.2.2.10(a), p. 3-15
2.8, p. 2-159

By choosing the right vendor for the new fiscal agent contract, the state can achieve its goal of minimizing disruptions in ongoing operations while implementing enhancements and modifications. The best vendor for Vermont is the one that brings comprehensive knowledge of the VermontAIM, its components, the Vermont Medicaid Program, and the state's providers and users. EDS is the right choice for implementing the enhancements requested by the state of Vermont.

As stated in the RFP, we will complete the specified enhancements and modifications to the current MMIS between January 1, 2004, and December 31, 2004. Through detailed planning and adherence to proven project management and system development methods, we will make the implementation of the RFP-specified enhancements and modifications as transparent as possible to Vermont providers, beneficiaries, and users.

We have reviewed the Global Clinical Record (GCR) application of the MMIS and Coverage and Services Management Enhancement (CSME) application of the MMIS RFPs and corresponding selected proposals to gain a comprehensive understanding of the state's vision for future MMIS functions. By combining our understanding of the state's goals, our in-depth system and program knowledge, and our experience in implementing similar enhancements and modifications for other states, we have developed a detailed work plan that depicts our approach to successfully completing these projects on time and within budget.

Enhancements/Modifications Work Plan

To give the state a straightforward view of the activities involved in implementing the Enhancements/Modifications scope of work, we chose to develop a consolidated work plan for all enhancements and modifications specified in Section 2.8 of the RFP. This consolidated work plan shows all enhancement and modification activities in a single plan, allowing the state to have one view that depicts the scope of work required to implement the enhancements and modifications. To develop this work plan, we determined the detailed tasks, resources, and level of effort required for each enhancement and modification project. Then, we consolidated the individual tasks into the Enhancements/Modification Phase Work Plan, which can be found in our response to RFP requirements 3.2.2.10, subsections (n) through (q). For more information, see our work plan in the "Work Plan and Schedule (Enhancements/Modifications)" section of our proposal.

As the developer of the current MMIS and its components, we will have fewer tasks and shorter durations in our work plans than any other vendor will require to accomplish the RFP-specified enhancements and modifications. Before beginning any system or process changes, a new vendor would require time to learn the intricacies of the VermontAIM and to gain an understanding of the Vermont Medicaid environment. Without this depth of knowledge, making changes to the MMIS and associated processes would greatly increase risk for the state, its providers, and Medicaid beneficiaries.

During the same time that a new vendor would get up-to-speed, we can be well on the way to completing the RFP-specified enhancements and modifications. Our VermontAIM knowledge—combined with previous experience in other states implementing similar types of enhancements and modifications—uniquely qualifies us to successfully complete each of the mandatory and optional enhancements and modifications specified in Section 2.8 of the RFP.

We have modularized work plan tasks for each enhancement and modification to enable the state to more easily view project-specific activities. From a resource perspective, we will provide one team to complete the mandatory activities. Then, if the state chooses to implement one or all of the optional projects, we will assign separate, highly qualified subteams to complete each of the selected optional projects.

Following contract award, if the state desires, we will divide the Enhancements/Modifications Work Plan into separate plans for each mandatory and optional project.

Enhancements/Modifications Team

To successfully complete each of these activities, the Enhancements/Modifications team will work under the direction of Enhancements/Modifications Manager Sean Daly. Sean's team will include current on-site systems engineers and technical staff, in addition to technical staff from EDS' Vancouver and Provost Support Centres.

Sean's 10 years of experience designing and implementing client/server systems for EDS and seven years of Medicaid-specific system experience give him the technical and industry knowledge to manage a smooth implementation of the mandatory and optional enhancements and modifications. In addition to his technical expertise, the state will benefit from Sean's project management and leadership experience gained through leading EDS' Delaware Medicaid team. This team was responsible for the recent on-time implementation of the Delaware Medicaid Program's new MMIS.

Sean performed key technical roles in the Idaho and Delaware MMIS implementations. Both of these systems are based on the VermontAIM. This experience gave Sean vital experience with the AIM systems. In Idaho, Sean served as the technical lead for implementing the eligibility verification system (EVS), electronic claims system (ECS), and claims administration components of the Idaho MMIS. EDS brought the IdahoAIM to Delaware, incorporated HIPAA standards, and converted the system from Ingres to Data Base/2 (DB2). For the recent Delaware implementation, Sean was the system architect, responsible for overall system design decisions. He also led a staff of 30 employees that performed key implementation activities. For additional

information about Sean and his team, please refer to the "Project Organization and Staffing (Enhancements/Modifications)" subsection in the "J. Enhancements/Modifications Narrative" section of this proposal.

In the following subsections, we present our approach to implementing each of the mandatory and optional enhancements and modifications.

- Mandatory Enhancements and Modifications
  - MMIS System Modifications
  - Platform Conversion
  - ClaimCheck® and ClaimReview™
  - Provider Enrollment Data Integration

- Optional Enhancements and Modifications
  - Internet
  - Recipient Eligibility Verification System Upgrade
  - Third-Party Liability Subsystem Upgrade
  - Fiscal and Budget Application

In our response to each of the mandatory and optional enhancements and modifications, we address the following topics:

- Understanding of the Enhancements/Modifications
- Approach to the Enhancements/Modifications

Mandatory Enhancements and Modifications

RFP Reference: 2.8.2, p. 2-161

Through the successful implementation of the mandatory enhancements and modifications requested in the RFP, the state will gain the following benefits:

- Efficient core MMIS, supporting claims processing, financial management, standard reporting, reference file maintenance, and provider enrollment and related services
- Increased access to financial reporting and financial analysis through enhancements to the Enhanced Vermont Ad Hoc (EVAH)
- Improved drug rebate processing by tying it to specific programs
- Enhanced claim edit and audit capabilities through the integration of McKesson's ClaimCheck and ClaimReview software with the MMIS to reduce unnecessary program expenditures
- Upgraded provider subsystem, including increased data collection and tracking to improve communication with the provider community and conversion to HIPAA type and specialty taxonomy
- Conversion to a DB2 production database platform from the existing Ingres. By using a DB2 platform, we will leverage the state's investment in existing EVAH equipment, expand possibilities for using third-party software applications, and deliver reliability, performance, and scalability.

Development and testing for mandatory enhancements and modifications to the base system will be performed on an existing server at the EDS Vermont location. This server is separate from the one supporting the base system. Using separate servers for development and the base system provides the state with the following key benefits:

- Continued operation of and support for the existing base system, including making necessary changes, while also performing development for the RFP-specified enhancements and modifications
- Leverage of existing equipment for mandatory enhancements and modifications to reduce costs
- Complete testing and resolution of issues for all mandatory enhancements and modifications on a separate server before the changes are released into the operations environment

We present our understanding and our approach to completing each of the mandatory enhancements and modifications in the following subsections:

- MMIS System Modifications
- Platform Conversion
- ClaimCheck and ClaimReview
- Provider Enrollment Data Integration

MMIS System Modifications

RFP Reference: 2.8.2.1.a-b, p. 2-161
Amendment 1, 2.8.2.1.c-d

As the state and EDS implement the enhancements and modifications included in the RFP, certain components of the current MMIS will require modifications. These modifications will result in a core MMIS that includes those functions inherently central to an MMIS:

- Claims processing
- Financial management
- Standard reporting
- Reference file maintenance
- Provider enrollment and related services

To provide the efficiencies of a core MMIS, EDS will complete the following modifications:

- Completely disable the following:
  - Early and periodic screening, diagnosis, and treatment program (EPSDT) subsystem (notification and reports, but not pricing logic) as described in the RFP
  - Prior authorization (PA) functions (but not pricing logic) as described in the RFP
- Partially disable the following:
  - Surveillance and utilization review subsystem (SURS) functions
  - Management and administrative reporting subsystem (MARS) functions

To update financial reports, we will complete modifications to the MMIS database and query/reporting tools. This enhancement is considered an optional enhancement that the state may choose to implement.

We also will enhance drug rebate accounting and query functions. These functions include drug rebate amounts tied to specific claims with amounts invoiced and collected and data collected. At a minimum, drug rebates will be attributable to specific population groups.

The following subsections describe our understanding of the need for modifying the MMIS and the impact of the changes, in addition to describing our approach to completing the MMIS modifications specified in the RFP.

- Understanding of the MMIS System Enhancements and Modifications
- Approach to Completing the MMIS System Enhancements and Modifications

Understanding of the MMIS System Enhancements/Modifications

Throughout the implementation of any enhancement or modification to the MMIS, the system must continue processing claims, authorizing services, and performing required audit and reporting activities. The state's desire for a seamless takeover of the MMIS and a smooth implementation of the enhancements and modifications will be achieved by selecting a proven and experienced vendor. EDS brings the necessary technical expertise and knowledge of the Vermont Medicaid Program to enable the state to achieve its implementation goals.

In the following paragraphs, we present our understanding of each of the RFP-required mandatory MMIS system enhancements and modifications:

- **EPSDT, PA, SUR, and MAR Disablements—**The complete or partial disablement of these RFP-specified components will result in an efficient core MMIS and eliminate any duplication of process or functions. We will work with the state to determine the appropriate elements to disable to ensure continued CMS certification of the VermontAIM and to ensure that the state retains critical subsystem functions, such as notification, reporting, and pricing.
- **MMIS Database and Query/Reporting Tools Modifications—**The state's amendment requesting modifications to the MMIS database and query/reporting tools will result in the automation and streamlining of many of the state's current query and reporting processes. The enhanced financial analysis capabilities and minimized manual processes will save the state time and money, while giving state-authorized users access to more targeted information to meet their unique query and reporting needs. We acknowledge that this is an optional enhancement, although it is included on a mandatory enhancement and modification worksheet.
- **Drug Rebate Accounting and Query Enhancements—**The RFP-requested enhancements to the drug rebate subsystem will enable the state to track more closely the actual dollars spent in support of each Vermont Medicaid population (or program). In addition, we will implement random sampling capabilities to accommodate the state's response to bidder's questions about this function.

Approach to Completing the MMIS System Enhancements/Modifications

Upon successful completion of the RFP-requested MMIS system modifications, the state will have an efficient core MMIS and enhanced capabilities for financial and drug rebate query and reporting. EDS' skilled and experienced staff will perform the modifications in the most efficient manner possible to minimize risk for the state, protect the integrity of the MMIS' data, and provide for continued operation of the MMIS.

In the following paragraphs, we present our approach to completing each of the RFP-required mandatory MMIS system enhancements and modifications:

- **EPSDT and PA Disablement—**To be sure that the state retains the ability to price and pay claims for EPSDT services and claims requiring PA, we will disable the notification and reporting aspects of the EPSDT and the PA functions. However, we will not disable the pricing logic or the function of claims edits that require a valid PA. Thus, the MMIS will continue to correctly process, price, and pay EPSDT and PA claims.
- **SUR and MAR Partial Disablement—**CMS requires SUR and MAR functions in all certified Medicaid systems; therefore, we will work with the state to determine the appropriate SUR and MAR functions to disable to avoid duplication, while making sure that Vermont retains its CMS certification. Before disabling any functions, we will verify that required SUR and MAR activities/outputs are achieved through other components or means, ensuring that Vermont continues to meet CMS standards.

  For example, today some of the SUR and MAR functions can be accomplished through the current EVAH system that EDS implemented in 1998. We will work with the state to determine if additional functions should be added to the ad hoc system, or we will validate that the required functions are met in other ways.
- **MMIS Database and Query/Reporting Tools Modifications—**We will complete modifications to the MMIS database and query/reporting tools, such as EVAH and BusinessObjects, to result in updated financial reports. We will perform the requested modifications to existing financial reports referenced in Appendix T of the RFP. We will also purchase additional BusinessObjects licenses to support the staff required to make these modifications.

  While the state estimates 8,800 staff hours to perform the requested changes, we estimate a much lower number of staff hours. Based on our knowledge of the MMIS, EVAH, and BusinessObjects, in addition to our understanding of the state's data and reports, we estimate only 3,000 staff hours to accomplish the requested changes, which will give the state an excess of approximately 5,800 hours to apply to other BusinessObjects projects.
- **Drug Rebate Accounting and Query Functions—**We will modify the drug rebate subsystem to reflect drug rebate invoices and payments at the program level. EDS' comprehensive knowledge of the drug rebate system, the Vermont Medicaid Program and its data, and the state's desires surrounding the requested enhancements will provide for a smooth implementation of these changes.

To successfully make modifications or enhancements to a complex system, such as an MMIS, without negatively impacting ongoing operations, the vendor must have in-depth knowledge of the MMIS and all associated components. Any vendor other than EDS will require significant time and resources to develop a thorough understanding of the core MMIS and its components before it could attempt such a modification. In addition, a new vendor must become familiar with the various system and operations areas with which these components interact. An error in the disablement or modification process could cause the MMIS not to pay claims properly and a disruption in health care service, resulting in dissatisfied beneficiaries and providers. Because EDS developed and implemented, and continues to operate the MMIS, our staff thoroughly understands how to efficiently and effectively make all types of modifications without disrupting other areas of operation.

Platform Conversion

RFP Reference: 2.8.2.2, p. 2-162

To deliver the most benefit to the state and to meet the state's platform conversion requirement, we selected the IBM DB2 Universal Database (DB2). In this section, we will provide our rationale for this selection and describe the enhanced functions the state will receive from the conversion to DB2.

The state desires to convert the production MMIS and its supporting databases from the existing Ingres database to an industry standard relational platform. We will accomplish this platform conversion by August 31, 2004, as specified in the RFP. In addition to the core MMIS conversion, we will convert the supporting databases, including the backup eligibility server, model office, and test databases.

We will convert the production database by successfully accomplishing the following major tasks:

- Purchasing licenses and support
- Providing adequate technical resources to perform migration and ongoing operation
- Making any and all programming changes required for the database conversion. The resulting system will perform all functions that existed prior to conversion, including internal and external processes that interact with the production database, unless they have become obsolete.
- Developing a plan, to be approved by the state, that outlines the process for transitioning to the new system. This plan will include consideration of the potential problems with proposed solutions and a contingency plan to ensure support for ongoing business operations. The transition plan also will include benchmark and milestones at decision points.

Our proposed approach to completing the platform conversion, as well as our pricing that we include in the "Price Proposal," includes the following RFP-specified elements:

- Production database requirements
  - Purchasing of licenses for production migration for 200 concurrent users
  - An annual maintenance agreement for full support, 24 hours a day, 7 days a week
  - Full-time on-site database administrator (DBA)
  - Programming modifications of approximately 1,440 hours
  - Backup production database
- Interface support—Full- and real-time testing of internal (for example, Viking) and external (for example, PBM) interfaces

- Model office database
  - Purchasing of licenses for model office migration for 85 concurrent users
  - Annual maintenance for business hour support, eight hours a day, five days a week
  - DBA resource time of at least 376 hours
  - Full-time on-site model office business analyst for testing and reporting results

We present our understanding and approach to completing the platform conversion in the following subsections:

- Understanding of the Platform Conversion Enhancements/Modifications
- Approach to Completing the Platform Conversion Enhancements/Modifications

Understanding of the Platform Conversion Enhancements/Modifications

Converting the MMIS from the CA Ingres relational database management system (RDBMS) platform to IBM DB2 Universal Database will provide the state with an efficient MMIS that includes enhanced information management capabilities.

The platform conversion is a significant task that we believe will require many more programming hours than the 1,440 specified in the RFP. We estimate that the platform conversion will demand approximately 136 staff months—more than 20,000 programmer hours—to perform all aspects of the conversion. In addition to the 136 staff months for programmers, this effort will require 2.5 DBAs to be assigned to the project for 12 months. Included in this estimate of effort are the following major tasks:

- Requirements definition
- Construction
- Testing
- Implementation support

We base this estimate on the amount of work required to convert the IdahoAIM platform to DB2, during our Delaware MMIS implementation. [Note: The IdahoAIM was the base system from which we developed the Delaware MMIS.]

Although IBM's DB2 software is the most widely used database platform in the world, EDS felt it necessary to analyze the functions and the fit for DB2 and other industry-leading database platforms. Our assessment is that DB2 will best meet the needs of the Vermont Medicaid Program, based on the following characteristics and benefits to be achieved:

- **Best fit—**Although both Oracle and DB2 are industry-leading products, EDS' assessment is that IBM's DB2 is a better fit with the existing Vermont MMIS infrastructure, which will minimize risk and improve efficiency of the conversion.

- **Leveraged investment—**Using DB2 as the new MMIS database platform will enable the state to leverage its investment in the existing EVAH subsystem, which runs on the DB2 platform, thus eliminating the time and resources required to convert EVAH to another database platform.
- **Best value—**When comparing these products, the state's overall procurement objectives remained at the forefront of our decision process. DB2 supports the state's fundamental commitment to contract for results and "best value" (defined as the optimum combination of economy and quality).Our selection of DB2 meets both of these strategic objectives.
- **Expanded functions—**Using DB2 will enable the state to take advantage of a wider variety of third-party software than Ingres would provide. For example, EDS recently converted EVAH from Ingres to DB2 to enable the state to continue its use of the BusinessObjects reporting tool, which no longer supports the Ingres database.

To perform a smooth conversion for Vermont, we will leverage experience gained through another Vermont project that also used DB2 and similar conversions in other states. In Vermont, we recently employed DB2 for the Department of PATH and successfully converted the EVAH system from Ingres to DB2. Again in 2002, we demonstrated our capability to effectively work with the DB2 platform through our smooth implementation of the Delaware MMIS, which runs on the DB2 platform.

Approach to Completing the Platform Conversion Enhancements/Modifications

The proposed platform conversion is a labor-intensive effort that impacts almost all of the components of the MMIS. A successful conversion means that the state's providers and beneficiaries can continue to rely on the MMIS performing properly—verifying eligibility, issuing prior authorizations, accepting and processing claims, and generating accurate and timely payments. Accomplishing this major effort effectively and efficiently requires a team that is knowledgeable, skillful, and dedicated to achieving success.

Sean Daly, the proposed enhancements/modifications manager for Vermont, led the Delaware MMIS implementation. He brings his leadership skills, along with his DB2 and AIM experience, to Vermont. Sean and his team's combined MMIS conversion and implementation expertise, DB2 knowledge, and comprehensive understanding of the Vermont program will provide a smooth and successful conversion from Ingres to DB2.

The broad scope of programming changes required to convert the VermontAIM to a new database platform is illustrated by the following statistics:

- The MMIS has 1,320 batch source code modules, which include:
  - 540 Cobol programs
  - 541 C programs
  - 142 Ingres Report Writer programs
  - 97 Ingres SQL scripts

- Of these 1,320 source code modules, the following require programming changes to accommodate the new database:
  - 336 Cobol programs
  - 309 C programs
  - 97 Ingres SQL scripts
- All 142 of the Ingres Report Writer programs must be recoded in another language

We will start the conversion process by providing DB2 training to the conversion team. This training will focus on the differences between Ingres and DB2 and how to make the necessary programming changes. We will then divide the team into specialty areas, such as C, Cobol, SQL scripts, and database administration. Sean and his team leaders will oversee each group's activities as they make the necessary changes to each portion of the system.

As each module is converted, it will be compiled and unit tested. Other members of the conversion team will review and verify the code changes. Once all the modules are modified and verified, we will release them for systems testing. During the testing, we will use detailed test cases and automated testing tools to be sure that each converted system component, and ultimately the entire MMIS, works properly. Only after the system has passed all tests will we convert the production Ingres database to DB2 and then begin production on the DB2 platform. This approach provides assurance for the Department of PATH and the state's beneficiaries and providers that claims will continue to be processed and paid accurately and on time.

The following paragraphs describe our approach to completing RFP-specified tasks for converting the production and model office database for the Vermont MMIS.

Purchase of Licenses and Support

We will purchase necessary DB2 licenses for the production, model office, and testing environments. We will also procure 24-hours-a-day, 7-days-a-week maintenance support for the production environment as well as model office.

Adequate Technical Resources to Perform Migration and Ongoing Operation

To provide adequate technical resources to perform migration and ongoing operation, we will employ one full time, on-site enhancement DBA and 1.5 off-site DBAs to support the enhancements phase. These 2.5 DBAs are in addition to the DBA support for ongoing operations.

The operations DBA will continue to support the Ingres AIM databases and the EVAH DB2 database during the enhancement phase. Once the platform conversion is complete, our full-time, on-site DBA will support the ongoing operations for all DB2 databases for both the MMIS and EVAH, calling on additional off-site DBA support if necessary.

We will provide a system engineering staff capable of performing all database conversion tasks. Based on our experience and our understanding of the VermontAIM, we estimate that this conversion will require 136 staff months, which encompasses the entire effort from requirements validation through coding, testing, and post-implementation support. In addition, 2.5 DBAs will be required to support this conversion effort. EDS will staff the conversion team to meet requirements of 136 staff months and the 2.5 DBAs for 12 months.

Programming Changes Required for the Database Conversion

EDS' conversion team will complete programming changes required for a successful database conversion. The resulting system will perform all functions that existed prior to the conversion, including all internal and external processes that interact with the production database, unless they have become obsolete.

This type of conversion will affect a majority of the programs in the VermontAIM. To validate that all programs within the MMIS continue to provide the appropriate functions, we will perform comprehensive and thorough integrated system testing on each of these programs, with the exception of any that have become obsolete. To reduce impact to ongoing operations of the MMIS, we will initially deploy DB2 on the existing HOSTTEST server to prevent any degradation of the existing MMIS and to leverage existing equipment. In addition, all enhancement development and testing also will occur on this server. Once we have successfully completed the development and testing activities, we will implement the changes on the production server, using a carefully designed detailed implementation plan.

Plan for Transitioning to the New System

A smooth conversion and transition occurs when a well-developed and comprehensive plan is skillfully executed. EDS will use its conversion and transition experience to develop a plan that outlines the process for transitioning to the new system. We will submit the plan to the state for approval. The transition plan will address EDS' approach to resolving potential problems, in addition to including our contingency plan to ensure support for ongoing business operations. We also will include benchmark and milestones for key decision points and major tasks throughout the transition process. At a minimum, the transition plan will identify major tasks, subtasks, task duration, and associated resource requirements.

The following list identifies some of the major conversion tasks that we will include in the transition plan:

- Identify and modify existing batch code requiring modifications to support DB2
- Identify and make any changes required to the online windows
- Identify and modify programs and procedures performing data transfers from the MMIS to EVAH
- Convert data from Ingres to DB2
- Identify and recode modules (Ingres Report Writer) that must be replaced entirely

- Perform unit testing on all updated programs
- Perform integrated system testing
- Perform testing of internal interfaces, such as Viking and external interfaces, such as PBM

We will deliver a detailed implementation plan to the state for its approval. Upon state approval of the plan, we will begin preparations for the platform conversion to provide a smooth transition.

EVAH Platform Conversion

RFP Reference: 2.8.2.2.1, p. 2-163

EDS proposes to convert the MMIS to the IBM DB2 Universal Database platform. Therefore, the EVAH platform will not require a conversion. Keeping EVAH on the DB2 platform allows the state to leverage its existing investment in EVAH hardware and software, in addition to saving implementation dollars by not requiring the resources or the time for an EVAH conversion.

ClaimCheck and ClaimReview

RFP Reference: 2.8.2.3, p. 2-163

Integrating McKesson's ClaimCheck and ClaimReview products into the core MMIS offers Vermont the opportunity to reduce program costs without reducing benefits for beneficiaries. We will implement a fully automated prepayment and postpayment auditing system using McKesson software. This system will identify inappropriate coding that could lead to increased or incorrect reimbursement. This auditing process allows further review of claims meeting specified criteria and prevents incorrect or unnecessary payments.

EDS will integrate the ClaimCheck and ClaimReview software into the core MMIS by June 30, 2004. Following are some of the functions offered by this enhanced auditing system:

- Line-by-line auditing, both online and batch, to be sure the claim is being reimbursed in an accurate and consistent manner, allowing the core MMIS to allocate the correct reimbursement value for each claim line prior to payment
- Consistent application of payment guidelines across all claims processed
- Automation of parts of the clinical review process to reduce claims handling costs
- Customizable audit criteria and relational audits to monitor appropriateness and questionable claims and to assist with medical management issues
- Pricing and payment evaluations performed based on at least three data elements per relationship, such as procedure code, diagnosis code, and provider type. Creation of this custom audit will allow for more focused, consistent, and accurate auditing evaluations
- Customizable reporting that displays, at a minimum, daily activity, actual dollars, and accounts receivables from denials and suspended claims
- Security to limit access to only authorized users
- Access to clinical information for provider support staff through McKesson's Clinical Inquirer product

The ClaimCheck product provides standard reports that can be sorted by account, provider, or a user-populated field. These standard reports contain baseline information related to ClaimCheck's auditing recommendations. These standard ClaimCheck reports will include any pertinent financial data, such as the charged or paid amount, that is passed from the MMIS.

Through the security features of the MMIS and ClaimCheck, we will control access to the product. State-authorized users can be granted either full access privileges or limited access to specific product features, such as the customization utilities, administration utilities, and the code auditing windows. We will work with the state to ensure that access to information is compliant with HIPAA regulations.

Understanding of the ClaimCheck/ClaimReview Enhancements/Modifications

In early 2002, EDS recommended that the state look at McKesson's auditing program software: ClaimCheck and ClaimReview as a means of saving program dollars. With the state's permission and support, McKesson performed a test to determine the potential program savings for Vermont using the McKesson software. On April 8, 2002, we hosted a meeting where McKesson representatives presented the test results to the agency. These results presented clear evidence that the McKesson products could help save program dollars beyond the capabilities of an MMIS by itself. Based on the test, which used a sampling of two months of paid claims from the Vermont Medicaid Program, McKesson's software uncovered an additional $314,000 (4.1 percent) in potential savings. The test showed that the claims provided by EDS had a 99 percent acceptance rate through the current MMIS. However, due to the bundling/unbundling of claims from providers, the additional payments of $314,000 could not be identified by traditional MMIS edits and audits.

Based on the test results, McKesson presented estimates that the state of Vermont could achieve $1,885,362 million per year in program savings. These estimated savings are based on current medical claim expenditures of $45,476,472 million annually, the integration of McKesson software into the Vermont MMIS edit/audit criteria, and the implementation of certain payment policy rules made possible by the McKesson software.

The 99 percent acceptance rate of the paid claims that McKesson received for the test illustrates the effectiveness of the current MMIS' edits and audits. Software such as McKesson's provides additional capabilities for identifying savings because of the company's focus on continuously analyzing new payment codes and trending bundled and unbundled code combinations from many states and thousands of health care providers.

Before initiating the McKesson test, EDS also evaluated other well-known vendors' supplemental edit/audit software. Based on our evaluations, we felt that the McKesson software was a better match for the current Vermont program and MMIS infrastructure. In addition, McKesson's online medical compendia and user file update capabilities provide even more savings potential.

Implementing the McKesson software provides the state with a comprehensive auditing software system (ClaimCheck) that automatically edits and corrects billing errors to be sure that claims are paid appropriately. ClaimReview builds on ClaimCheck's core auditing capabilities with a customizable level of review for problem claims that are often overlooked or require manual processing. ClaimReview continues the data cleanup process started by ClaimCheck that is so important for accurate analysis activities such as provider profiling and regulatory reporting. These applications help target utilization management and profiling issues like diagnosis and treatment appropriateness, service frequency/intensity, and upcoding (bundling/unbundling for maximum payment).

Vermont's goal for increased flexibility is met with the design of the auditing criteria component of the software. This flexibility is inherent to the application and allows authorized users to apply edits selectively, as well as define the level of action desired (deny, suspend, replace, or monitor) when a potential problem claim is encountered. This flexibility will make it easier and quicker to adjust to policy changes and any unique requirements for the Vermont Medicaid Program.

Approach to Completing the ClaimCheck/ClaimReview Enhancements/Modifications

Successfully implementing the McKesson applications and integrating them into the core MMIS requires a thorough understanding of the many intricacies of the MMIS' edit and audit functions. Each edit and audit is specifically designed to meet the unique needs of the Vermont Medicaid Program. EDS will combine its in-depth knowledge of the Vermont program with the experience gained from integrating McKesson products for other Medicaid programs, including Oklahoma, Wisconsin, and Mississippi, to successfully integrate ClaimCheck and ClaimReview into the VermontAIM.

Installation, Integration, and Implementation

We will complete the ClaimCheck/ClaimReview enhancement task by conducting thorough testing to be sure that the software is correctly installed and integrated with the MMIS claims engine. EDS will complete the installation and testing by June 30, 2004, as specified in the RFP. Throughout the implementation and beyond, we will work with the state to customize the software by defining and incorporating Vermont policy into the software's edits and audits to achieve optimum program savings. The duration of this customization task is dependent upon the amount of resources and level of effort by the state's policy staff, in addition to the depth of policy customization that the state desires.

To effectively integrate the McKesson tools into the VermontAIM, we will use our comprehensive knowledge of the MMIS to make necessary programming changes to the claims engine. When fully implemented and integrated, the MMIS will automatically call on the edit/audit subsystem and the McKesson software during the adjudication process. This approach will facilitate an efficient and thorough application of the optimum level of edits/audits from both the MMIS and ClaimCheck/ClaimReview to each claim in a timely manner.

Provider Support

As the McKesson software begins finding savings for the state through denial of inaccurate or improper claims, we expect provider inquiries to increase at least temporarily. To address the providers' inquiries in a timely fashion, we recognize the need for quick and easy access to the clinical rationale supporting an edit type when responding to a provider appeal. To support this need, authorized users will have access to McKesson's Clinical Inquirer on the Internet. Clinical Inquirer will provide authorized state and EDS staff with immediate access to clinical rationale, newly released clinical documentation, and select McKesson product documentation.

Searching for an edit clarification using the Clinical Inquirer is as simple as entering up to three procedure codes or a keyword and selecting the Search option. Clinical Inquirer will search for applicable rationale related to these codes and quickly retrieve the pertinent information. Almost immediately, we will have access to the information necessary to understand and explain to the provider the nature of a ClaimCheck/ClaimReview edit. The rapid availability of Clinical Inquirer's comprehensive information will allow the state and EDS to quickly resolve inquires about claim payment status, thus minimizing the time and effort required to process appealed claims.

In addition to the inquiry support available through Clinical Inquirer, McKesson will provide additional support to help ensure Vermont's success with the ClaimCheck solution. Throughout the implementation process, a McKesson implementation consultant will work closely with us, providing installation advice and delivering detailed application training related to product functions, customization, and work flow issues. As part of implementation planning, we will work with the state and McKesson to determine the best strategy for communicating with providers about the incorporation of the McKesson edit/audit software into the claims review process.

Once we successfully complete the ClaimCheck/ClaimReview implementation, McKesson will provide a product support line from 8 a.m. to 8 p.m., Monday through Friday, to answer questions related to the McKesson software. This support line will be available to key state and EDS users. We also will have access to a McKesson operated medical director support line for instances when the Vermont medical director would like to speak with a McKesson physician about a particular edit. Other forms of support extended by McKesson include detailed application, technical, and clinical documentation.

Experienced Implementation Team

Sean Daly, our proposed Vermont enhancements/modifications manager, will lead the ClaimCheck/ClaimReview enhancement team in integrating the McKesson software by June 30, 2004. The ClaimCheck/ClaimReview Enhancement team will include an EDS medical policy analyst responsible for managing the MMIS edits/audits and their disposition. The EDS medical policy analyst will work closely with the state's clinical and medical policy staff and the rest of the EDS enhancement team to incorporate Vermont's billing policy, ensure continued compliance with existing MMIS edits/audits, and test and review functionality of the McKesson products to determine which processing components will provide the highest level of savings for the state.

Sean and his team bring to Vermont crucial knowledge of the claims engine (one of the most complicated parts of the MMIS) and EDS' experience gained by implementing McKesson software for other states. This experience base provides an infrastructure and approach that reinforces our commitment to achieving the state's goal of reduced benefit expenditures, while not cutting actual benefits received by Vermont's Medicaid population.

Provider Enrollment Data Integration

RFP Reference: 2.8.2.4, p. 2-164

The state has requested upgrades to the provider subsystem that will deliver the following benefits:

- Enhanced ability to communicate with targeted groups of providers
- Easier tracking and monitoring of provider enrollment and disenrollment
- Adherence to HIPAA requirements for conversion of the existing type and specialty to the HIPAA type and specialty taxonomy
- Enhanced enrollment information from providers

We will implement the enhancements and modifications to the provider subsystem as specified by the RFP. These upgrades will enable the following capabilities:

- Accommodate the following:
  - Collection and input of e-mail addresses for all providers who have them
  - Document merge and distribution using e-mail to the entire provider database or targeted segments
  - New and planned additional provider information
- Convert existing type and specialty taxonomy to the HIPAA type and specialty taxonomy
- Resolve other address issues such as capacity to send information to more than one provider address
- Capture updated information changes such as viewable windows-based history
- Require physicians to provide National Association of Boards of Pharmacy (NABP) identification numbers and pharmacies to provide DEA identification numbers prior to enrollment

Understanding of the Provider Enrollment Data Integration Enhancements/Modifications

While the Vermont provider subsystem currently operates effectively, the state-requested modifications will enable easier and quicker access to provider information, thereby increasing state user productivity and enhancing user access to provider information. We will efficiently and effectively complete the RFP-requested changes to the provider subsystem related to gathering additional provider information and expanding the system's address merge and distribution capabilities. We can confidently make this commitment because of our comprehensive knowledge of the programming and operation of the current MMIS.

Unlike the other less-labor intensive changes requested in the RFP, the conversion of the existing provider type and specialty taxonomy to the HIPAA type and specialty taxonomy will require a significant programming effort, even for EDS as the system's developer. This programming effort is due to the number of places within the system that display and store provider data and the claims processing changes necessary to allow for providers who may have more than one taxonomy on file.

Standardization throughout the industry of provider type and specialty taxonomy is being driven by HIPAA requirements and the expected implementation of the national provider ID.

National Provider Taxonomy

Taxonomy is the standardization of provider type and specialty. It also includes subspecialty. Examples of provider type include chiropractor, dentist, hospital, supplier, and optometrist. Provider specialty examples include psychologist-clinical, physician-allergy, and podiatrist-radiology. The provider taxonomy field is 10 characters comprising a two-character provider type; a two-character provider class field similar to Vermont's provider specialty ID; a five-character provider specialty, which is equivalent to a subspecialty; and finally a one-character training indicator, which is no longer used.

Another implication of the conversion to the HIPAA taxonomy is that one provider may have more than one taxonomy, and that provider would only have one provider ID number. In today's VermontAIM, a provider with two specialties has two provider ID numbers. When processing a claim for a provider such as this, the MMIS will need to determine which taxonomy the provider is billing on a specific claim. Knowing the taxonomy enables us to correctly process and price the claim.

By requesting the conversion to the national provider taxonomy, even before it is federally mandated, Vermont has once again shown its desire to stay at the forefront of the Medicaid industry. Once the conversion is complete, Vermont providers will be tracked by a single identification number and will be able to submit claims with their standard taxonomy (specialty) information through HIPAA-mandated 837 transactions, ensuring compliance with HIPAA transaction requirements.

The national provider taxonomy is more precise than the provider specialty currently used in Vermont. The national taxonomy will make it easier for providers to track their specializations because the same code set can be used for all carriers. Currently, providers have specialty codes that are assigned by each carrier, including the Vermont Medicaid Program. By using the national provider taxonomy, each provider will have only one set of specialty codes (taxonomies) to be used for all carriers. To date, the use of multiple identification numbers has made it easier to enforce billing policies and to track services in Vermont. However, once this conversion is complete and each provider has a single Vermont provider ID, providers will submit their taxonomy code on their electronic claims. Currently no field exists on the industry-standard HCFA 1500 or UB 92 claim form for taxonomy, which will enable us to determine under which specialty they are submitting. In addition, converting Vermont to the national provider taxonomy now will result in a smoother conversion to the National Provider Identifier (NPI) code set when the federal government mandates compliance.

The national provider taxonomy also provides a more specific way of identifying provider specialty information than what is currently used. By more narrowly defining the specialty, the MMIS, in conjunction with the McKesson software, can perform more detailed editing to reduce unnecessary program costs, and the state can more effectively manage benefits in terms of allowing specific services, depending on the type of provider who provided them.

Selecting a vendor that understands these intricacies and the magnitude of the potential impact is imperative for Vermont to achieve a successful implementation of the national taxonomies and NPIs. EDS has already implemented this type of change for Delaware, becoming the first vendor to achieve HIPAA compliance for an MMIS. Unlike other vendors, we understand the depth and breadth of the requirements and the solution. We will use this understanding and our Delaware experience to successfully convert to HIPAA-compliant provider IDs and taxonomies.

Approach to Completing the Provider Enrollment Data Integration Enhancements/Modifications

The following paragraphs provide our approach to successfully completing RFP-specified enhancements and modifications to the provider subsystem:

- **Collection and input of provider e-mail addresses—**We will modify the provider enrollment forms to collect the provider's e-mail address. We will update the MMIS to add the provider's e-mail addresses to appropriate existing windows of the current MMIS. This approach meets the state's requirement, using a window with which users are familiar, so no additional training is necessary.
- **Addition of document merge and distribution capability through e-mail—**We will integrate an off-the-shelf software package into the MMIS to cost-effectively incorporate the document merge and distribution capability through e-mail. Using readily available software is the most cost-effective and efficient way to provide the capability to easily and quickly communicate with targeted groups of providers.
- **Accommodation of additional provider information—**As the state or EDS identifies new or expanded provider information requirements, we will work with the state to determine the best manner possible to incorporate the new information into the provider subsystem, continuing to meet the needs of the Vermont Medicaid Program.
- **Conversion of existing type and specialty taxonomy—**Standardization of type and specialty taxonomy will allow for more specific edits and audits to be performed by the MMIS and McKesson software, in addition to improving the ability to more efficiently manage the Medicaid program. To make this conversion, we will work closely with the state and its providers to accomplish the following tasks in this conversion process:
  - Determine the mapping between the current Vermont types and specialties and the taxonomy codes, and validate this mapping with the state
  - Convert the existing Vermont provider file using the approved mapping from Vermont type and specialty to taxonomy

- — Inform the Vermont providers of their newly assigned taxonomies, and modify the billing instructions to require the use of these taxonomy codes when billing electronic claims; as approved by the state. We will contact the providers through methods such as informational letters, e-mails, and notification bulletins.
- — Perform programming changes to every location in the MMIS that contains, uses, or reports the provider specialty. One such change is to expand the size of the provider specialty field from the three bytes currently used to eight bytes, enabling the storage of taxonomy class, specialty, and training indicator.
- — Modify current processes that use provider type and specialty, such as category of service assignment, editing, and reporting. EVAH will also reflect these changes.

While we have presented these tasks at the highest level for this proposal, the successful performance of the tasks is far from basic. Based on our experience in other states, such as in the Delaware HIPAA implementation, EDS has a thorough understanding of the complexity of the conversion effort. We estimate that the taxonomy conversion alone will require almost 3,000 hours of programmer effort (not including testing and post-implementation support) to perform the conversion from local to national provider type and specialty taxonomy.

- **Resolution of other address issues—**We will incorporate the capacity to send information to more than one provider address into the provider subsystem through modifications to system code, changes to databases, and adjustments in operational process. In addition, we will work with the state to determine the priority and appropriate resolution process for other provider address issues as identified by the state.
- **Capture of updated information changes—**We will complete this requirement and expanded value through a global enhancement of adding window audit trails, which will enable users to view window-based history from most MMIS windows.
- **Provision of identification numbers prior to enrollment—**We already meet the requirement to obtain the NABP pharmacy identification number and the DEA physician/prescribing identification number in the following ways:
  - — The recertification and enrollment application forms we currently use request these identification numbers as part of the existing provider enrollment process.
  - — The Vermont pharmacy benefits manager (PBM) also uses the NABP and DEA identification numbers in processing pharmacy claims. Then, the PBM crosswalks the numbers to the Vermont Medicaid provider number used in the EDS-operated MMIS.

Once we successfully implement the RFP-specified upgrades to the provider subsystem, the state will benefit from easier and quicker access to additional provider information and enhanced communication capabilities. By using technology, such as e-mail and document merge/distribution, the state will be able to communicate with targeted groups of providers more quickly.

In addition, following the successful conversion of existing type and specialty taxonomy to the HIPAA type and specialty standard, providers will benefit from reduced administrative tracking of their provider codes and the more accurate payment for claims.

We will successfully complete these upgrades to the provider subsystem to deliver the expected benefits to the state and its providers. These upgrades will enhance communication with providers, while giving the state additional flexibility and more efficient processes.

Optional Enhancements and Modifications

RFP Reference: 2.8.3, p. 2-165

The optional enhancements and modifications specified by the state in the RFP will provide enhanced access to information and improved communication capabilities with the provider community. In addition, the third-party liability (TPL) enhancement will deliver improved ability to recover program dollars.

In addition, by implementing the enhancements requested in RFP Amendment 1, the state will gain the following benefits:

- Increased access to financial reporting and financial analysis through enhancements to the Enhanced Vermont Ad Hoc (EVAH)
- Enhanced drug rebate processing by tying it to specific claims
- Improved fiscal reporting and improved budgeting ability through a new fiscal and budget application that links budget and expenditure information

We acknowledge that the state has the option of selecting which of these projects, if any, to implement and the timing of such implementations.

For the development activities of any optional enhancements that the state may choose, we propose to leverage the existing server infrastructure. Our approach will protect the integrity of the base system, allowing for ongoing operation and maintenance. For additional details on the platform infrastructure, please refer to the "Infrastructure Requirements" subsection of the "G. Overall Approach" section.

EDS' approach provides the state with these key benefits:

- Continued operation of and support for the existing base system while making necessary changes to the MMIS
- Leverage of existing equipment for mandatory and optional enhancements and modifications to reduce enhancement costs
- Complete testing and resolution of issues for all enhancements and modifications on a separate server before the changes are released into the operations environment

In the following subsections, we present our understanding of the optional enhancements and modifications, in addition to presenting our approach to completing those enhancements and modifications, if the state chooses:

- Internet
- Recipient Eligibility Verification Upgrade
- Third-Party Liability Responsibility Reorganization and Subsystem Upgrade
- Fiscal and Budget Application

Internet

RFP Reference: 2.8.3.1, p. 2-165

To facilitate access to data and enhance recipient service and provider relations, EDS proposes to implement a flexible, reliable, scalable, and affordable solution for migrating internal and external business processes to the Web.

We will build a Web site linked to the Department of PATH site that is consistent with the look and feel of the Department of PATH site and the state portal, including page layout, menu, and formatting standards.

The EDS-developed Web site will meet federal, state, and HIPAA privacy, security, and confidentiality requirements.

The new Vermont MMIS Web-site will include the following RFP-specified classifications of content:

- Basic Requirements
- Static—Purely informational, can be viewed but not changed by users, including providers, drug manufacturers, and customer service contractors (for example, Maximus, and Ombudsman)
- Dynamic—Operational and interactive, requires design, development and implementation
- Authorized Access—Users have access (for example, standard reports) and can change parameters (for example, dates)

Understanding of the Internet Enhancements/Modifications

Through the implementation of this new Internet Web site, the state and its providers will gain improved access to data and enhanced beneficiary service and provider relations. As part of HIPAA compliance activities in the state of Vermont, we are already working on the development of a Northeast Regional Translator Web site, the first phase is schedule to go live in July 2003. Several of the capabilities requested in Section 2.8.3.1 of the RFP will already be available through the translator site by the beginning of the new contract term.

If the state chooses to have EDS implement the optional Internet Web site described in the RFP, we will be able to leverage the capabilities of the translator Web site, thus eliminating duplicate activities and providing the state with the desired capabilities as soon as possible. Upon request from the state to implement, we will begin developing the RFP-requested capabilities that do not already exist in the translator site and will build links to the existing translator site for the existing capabilities. This approach will prove to be efficient, timesaving, and cost-effective.

Selecting EDS to implement Web-based technology means selecting a team with the experience to build a secure, stable, effective Web site. We were the first Medicaid contractor to offer Web-enabled claims submission, prior authorization, eligibility inquiry, and other key claims transactions. We have recently implemented similar Web sites for the Delaware and Oklahoma Medicaid Programs. In addition, we are implementing eligibility verification and claims status inquiry in other states in the Northeast.

As part of the recently completed Delaware MMIS implementation, we developed a Web site for the state's Medicaid providers. The benefits gained through this site are reflected in the following comment from a state official:

> "Offering medical providers Web-based access to information reduces telephone call back and waiting time, extends the hours provider staff can access information and frees program support staff to address claims and file maintenance tasks with less distraction. Provider usage of our Web-based system grew immediately after it was implemented."
>
> *—Norman Clendaniel,*
> *Delaware Social Service Senior Administrator Development & Maintenance*

In November 2000, we implemented a pilot program in California that allowed large provider groups to test EDS' Web-based solution. The program resulted in huge productivity gains for providers, as demonstrated in the comments of two of California's primary providers:

> "By giving us the opportunity to go out to the Web site and review our total claims submitted and accepted in the inquiry/upload, we have saved a tremendous amount of time. We were calling your help desk on a daily basis to get a verbal status report of our data. Now we can go out there the next day and review it, print it, and file it. As part of an operations procedure, this is a big help. Again I want to say thank you."
>
> *—Rafael Felix*
> *Billing Operations, Unilab Corporation*

> "I think that the Internet billing system is great! While before it would take me almost all day to manage and send all the claims by modem, now I can be done in a few hours or less."
>
> *—Brenda Lim,*
> *Business Officer, Paradigm HealthCare Services*

Medicaid providers in several other states that EDS supports have increased their daily productivity by using Web-enabled claims status inquiry and eligibility verification functions. The secure Web sites implemented by EDS conform to CMS and HIPAA-proposed security rules.

Our Web-based success in other states will enable us to successfully deliver the functions requested by the state. We will bring to the state of Vermont our Web development experience, in addition to our knowledge of the Vermont environment, to deliver enhanced Web-based access to information for the Department of PATH and other Medicaid stakeholders in Vermont.

Approach to Completing the Internet Enhancements/Modifications

EDS is proficient in designing intuitive, easy-to-use Web sites. We will include features such as user-friendly navigation, help text, search capability, and site maps. We will also have an online help feature. If a Web user is filling out a form and has a question, the user can send a message to the EDS provider relations support team and describe their problem or question. This request will be formed as an e-mail and will be routed to the appropriate call center clerk. In turn, the clerk will receive the message to access the Web form to assist the user. In addition, we will use the latest security techniques and practices.

The Optional Enhancement/Modification team, led by Sean Daly, will include a Webmaster to provide developmental guidance and ongoing support for the site, experienced Web developers from our Vancouver Support Center, and select members of EDS' Vermont support team. This well-rounded and experienced team combines both Web-development expertise and Vermont Medicaid understanding to deliver an impressive and functional Web site to meet the needs of state and its Medicaid providers.

We present our approach to completing each of the requirements in the following subsections:

- Basic Requirements
- Static Content
- Dynamic Content
- Authorized Access

Basic Requirements

RFP Reference: 2.8.3.1.a, p. 2-165

The basic requirements listed in the RFP will allow Web users to employ commonly used, familiar navigation methods that meet the accessibility requirements of Section 508 of the Rehabilitation Act. At a minimum, the site will include the following functions and features:

- **Instructions on using site—**The site will include a site map informing the user of all key pages on the site. In addition, the home page of the site will provide basic instructions to new users on how to navigate the site and how to access desired information. If needed, the user will be able to get more individual assistance or send e-mails through the contact information provided on the main home page.
- **User-friendly navigation—**We will work with the state to determine the most user-friendly navigation techniques that allow users to move freely throughout the Web site without having to enter data multiple times, while still adhering to the accessibility rules of Section 508 of the Rehabilitation Act. Navigation tools to be discussed include drop-down menus, graphical user interface, and point-and-click functions.
- **Links to applicable state and federal Web sites—**We will work with the state to determine the applicable links to place on the Web site. Examples of appropriate links include the Department of PATH site, other state agencies, and provider associations.

- **Contact mechanisms—**The Web site will include contact information, including applicable mailing addresses and telephone numbers, for both state and EDS staff. Listings for state and EDS staff, such as provider representatives, will include an e-mail address. Users may click on an e-mail address to open a message form. E-mail messages will be sent directly to the appropriate personnel. We will include this option on all appropriate windows as approved by the state.

  As specified in the "Provider Enrollment Data Integration" subsection of the "Mandatory Enhancements and Modifications" section, we will collect and store applicable contact information in our provider subsystem, in addition to adding contact mechanisms through the document merge and distribution capability.

- **Online audit trail for Internet data updates—**We will establish audit trail triggers to track a user's Internet transactions that update data. The system will automatically store the audit trail information in a database, allowing for retrieval and report generation by authorized state and EDS personnel.

- **Password control—**Authorized users can establish unique passwords the first time they access the Web site. However, the EDS Webmaster will have the capability to reset passwords for users that forget their passwords or disable user accounts when necessary.

- **Help capability—**Users will be able to access online help in numerous ways.

  — Static help: We will develop an overall help page for the static part of the site, which the user can access from any of the static windows by clicking on a Help link

  — Dynamic help: For the dynamic areas of the site, users will have a "mouse-over-field" capability, which will display a simple description of the item. Users also will be able to click on a link that takes them to a Help window for the dynamic functions of the site.

  — Other help: By clicking on the Contact link, users will be able to e-mail more complicated questions to the Webmaster. A toll-free telephone number will also be accessible from most windows, enabling users to call an EDS representative and ask questions.

- **Standard reports—**We will work with the state to determine the type, format, and accessibility requirements for reports to be accessed from the Web site. Authorized users will be able to print reports or download them in PDF format using Adobe Acrobat®. A free downloadable Adobe PDF reader will be available to those users who do not already have that capability on their systems.

- **Document posting—**Authorized users will be able to submit documents to the Webmaster for posting to the site. We will work with the state to determine the appropriate timing of postings and the authorization procedures.

Static Requirements

RFP Reference: 2.8.3.1.b, p. 2-166

The static content on the Web site will provide information that can be viewed but not changed by users. The audience for this static information includes state and EDS personnel, providers, drug manufacturers, customer service, and contractors, such as Maximus and Ombudsman. In the following paragraphs, we describe our approach to completing each of the static content requirements.

- **Reference data—**We will provide commonly available information, which all authorized providers will have access to through the Web site. Provider listings that currently are mailed to pharmacies also will be available. We will make available reference data that is typically available to providers through documentation or telephone lines, such as National Drug Code (NDC), procedure codes, revenue codes, and C schedules. Providers will be able to enter procedure information, such as reference code, and have the system display the payment policy. Thus, saving the providers time and minimizing their need to call a support line.
- **Contractor's organization chart—**We will post an organization chart, showing the names of EDS personnel in key positions.
- **Provider information and publications—**The Web site will include information of interest to providers. This information will include state-approved training programs, bi-monthly provider advisory bulletins, and publications, such as provider manuals and supplements and HIPAA transaction companion guides. Providers will be able to print or download this information with prior state approval. The most recent Provider Electronics Solution software version will also be available for download by providers at their convenience.
- **Standard reports—**EDS will work with the state to determine the type of reports to be included on the Web site and the appropriate approval process.
- **CMS-required audit reports—**We will include an area on the Web site for posting CMS-required audit reports for downloading or printing through PDF format. We will work with the state to determine which reports will be posted.

Dynamic Requirements

RFP Reference: 2.8.3.1.c, p. 2-166

By implementing the dynamic requirements for the new Web site, the state and its providers will gain improved access to information, as well as enhanced ability to submit claims and verify beneficiary eligibility. Below, we describe the EDS approach to completing each of the dynamic requirements listed in the RFP.

- **Provider enrollment—**We will enhance the provider enrollment process by taking it from the current paper-based process to the Internet. To do so, we will change the current process that calls for a provider to send for a package of provider enrollment forms, fill them out, sign them in ink, mail them to us for review, and eventually be informed that they are now activated with an entirely online process that will decrease the amount of time required in half.
  - Providers will complete forms online through the new Web site.
  - Data the providers enter into online forms will automatically be stored in the provider database, eliminating the current need for double-entry of data. Today we rekey the forms in the VermontAIM.
  - Providers will answer a series of questions to validate their identity; then they will be issued a secure digital certificate. Providers will be presented with their provider agreement online and will be able to electronically sign the agreement using their digital certificate. This process allows us to verify the provider's identify, thus validating the digital signature.
  - Through the digital certificate process, we can prove that person actually signed the agreement because we validated the identity prior to issuing the certificate. We can prove that the agreement that was signed was not altered after it was signed because the agreement is signed by the provider using their unique private digital key (part of the digital certificate), and is then countersigned by us using our private digital key.

    When providers have digitally signed their provider agreement, we will automatically generate their provider ID, pending their enrollment to a clerk for final review. Once this review takes place (usually within a few days), the provider is considered fully active. For providers who do not wish to make full use of the digital signature process for provider enrollment, we will still allow them to perform all of the other enrollment steps online. However, the provider would print the enrollment forms, sign them, and mail them. Once we receive the forms with an ink signature, we will make them active.
- **Online form submission—**Once providers have authenticated themselves to the Web site through their user ID and password, they will be able to submit forms online. We will work with the state to determine the forms to be provided and accepted online. Examples of forms that could be submitted online include provider survey, history inquiry requests, and address changes.
- **Electronic claims and data submission—**Following the implementation of the Northeast Regional Translator, which will be in place by the start of the new contract, the capability for providers to submit claims and data from their PC through the Provider Electronics Solution software, or their own software, will be in place through the Translator Web site. Trading partners will be able to upload claims through the Web also. The MMIS will communicate with the Translator site to collect the submitted claims and process them through the MMIS as appropriate. Other data transaction types to be included are online and batch submissions, remittance advices, rosters, and claim adjustment requests. In addition, we will use the Web site as a secure way to interface with other entities.

- **Interactive beneficiary eligibility verification inquiry and response—**The new Web site will include an interactive capability for providers to verify beneficiary eligibility. Through this function, providers will be able to submit online inquiries and receive the online response quickly. At the time of this proposal, we are implementing this Web-based capability for the Connecticut and Rhode Island Medicaid Programs. We have also successfully completed similar implementations for other states, including Delaware and Oklahoma. The Optional Enhancements/Modifications team will draw on the experience gained from other states to provide a smooth implementation of interactive beneficiary eligibility verification for the state of Vermont.
- **Provider Electronic Solution software updates—**As part of HIPAA remediation for Vermont, EDS has already modified the Provider Electronic Solution software to allow providers to download new version updates from the Web site when they are released. The Provider Electronic Solution software is fully integrated with the Web functions. It allows data to be uploaded and downloaded through the Internet.

Authorized Access Requirements

RFP Reference: 2.8.3.1.d, p. 2-167

Some transactions on the Internet site will be available to the general public. Other transactions, such as claims inquiry and submission, require higher security and will be restricted to those with approved user IDs and passwords. Users with a valid ID and password may access the secured transactions. User IDs are set up with role-based security, which means users can be limited to the functions they are allowed to perform. For example, some providers may have only inquiry access, while others will have the update capability necessary to submit claims.

The state will identify and approve who has a specific level and type of access to a specific portion of the Web site. We will work closely with the state to develop and document profiles for users and their access rights. Web-site users that the state deems appropriate will have access to state-specified standard reports and be able to change state-specified parameters, such as dates, procedure codes, and beneficiary IDs.

The state will have access to all of the information through the Citrix-enabled PowerBuilder window. Additionally, we will make data in these areas available through the Internet Web site to authorized users. We will work with the state during the requirements validation sessions to determine what data will be made available to whom over the Internet. The following paragraphs present our approach to completing each of the authorized access requirements stated in the RFP.

- **Beneficiary data—**The new Web site will contain beneficiary data, such as beneficiary profiles and beneficiary reports, which can be accessed by authorized users. Our Enhancements/Modifications team will work with the state to determine the type of data and reports to be added to the site, and the state will approve the format of any data or reports available through the Web site.

- **Remittance advices—**The Web site will provide electronic remittance advices (RAs) that active authorized providers can download. We will retain providers' RAs for download on the translator site for at least 90 days after the RA was been generated. The electronic RA files will be stored in HIPAA-compliant format (ASC X.12N 835 standard) on the Internet Web site.
- **Claims data—**Through the Northeast Regional Translator Web site, authorized Vermont providers will have access to claims data that includes status, payment, and history. The Internet Web site will maintain claims and eligibility verification transactions in extensible markup language (XML), the most interoperable data standard today. The content of our XML format will match directly to the content specifications for HIPAA.

  When receiving HIPAA-compliant transactions from providers or billing groups, we will have a translator convert those transactions into XML format. The same translator will be used to convert from XML to HIPAA-compliant format when we send our transaction through the Internet. In addition, HIPAA may support an XML format in the future. With our solution, we will already have this transaction format implemented and be ready to accept the XML format.
- **Claims history distribution—**Providers will be able to complete and submit an online form containing the criteria for the history request. In an overnight batch job, the MMIS will process the request and generate the claims history report. The day following the request, providers can download their claims history information in a PDF format.
- **Receipt of provider requests for history and eligibility inquiries—**Providers will be able to request historical listings of eligibility verification inquiries and responses by submitting an online form. As with the claims history process described in the previous paragraph, the online request will be processed by the MMIS in an overnight batch job and will generate the eligibility verification history report. The day following the report, providers can download their eligibility inquiry history information in a PDF format.
- **Inquiry to edit disposition information—**We will support the state in posting the edit disposition to the site. We will work with the state to determine the appropriate format and the access requirements. Authorized state users will have full access to the edit disposition information, over and above what will be available to the general provider community.

If the state chooses to implement the Internet enhancement, EDS will use its experience and technical expertise to establish a new Web site that meets the basic requirements defined in the RFP, including incorporating the requested static and dynamic content. We will work with the state to ensure that access to the Web site is appropriately controlled to protect the integrity of the site and any confidential information. Through our successful implementation of a flexible, reliable, scalable, and affordable solution for migrating internal and external business processes to the Web, the state will gain improved access to data and enhanced recipient service and provider relations.

Recipient Eligibility Verification System Upgrade

RFP Reference: 2.8.3.2, p. 2-167

The ability to quickly and easily verify a beneficiary's eligibility for Medicaid services is a critical activity for beneficiaries and their health care providers. Each eligibility submission type requires providers to communicate with the MMIS. Therefore, a comprehensive solution requires both the back-end processing capability managed through the MMIS and the front-end processing capability in the provider office. EDS will continue to support both the front-end and back-end processing capabilities.

Understanding of the REVS Enhancements/Modifications

The variation of provider equipment, technical environments, and business requirements makes it necessary to provide a wide variety of eligibility verification options to Vermont providers. We will support all claims submission types allowed under HIPAA, as well as the automated voice response system (AVRS).

The HIPAA-mandated changeover to the X12 270/271 eligibility transaction standard will require a change in the swipe-card point-of-sale (POS) devices currently in use at provider offices and hospitals. Therefore, we propose to work with vendors, such as Verifone, to make a new HIPAA-compliant swipe-card POS device available to the provider community at the provider's cost. The flexibility of the VermontAIM and the completeness of our HIPAA project coding efforts results in no additional programming changes being required to the MMIS to work with the new POS devices.

By supporting a wide variety of eligibility verification options, we offer providers the ability to submit large numbers of eligibility requests simultaneously through a batch request, or they can receive real-time eligibility information through a POS application, a Web application, or the AVRS. The robust set of verification choices shown in the following table will enable providers to fulfill their business and operational needs by being able to reliably obtain approval of beneficiaries for Medicaid benefits.

Eligibility Submission Type Options

Eligibility Submission Type	Supported by EDS
270/271 X12N Batch file	Yes
270/271 X12N Interactive file	Yes
WEB (Using X12N data content requirements)	Yes
Automated Voice Response System (AVRS)	Yes

Approach to Completing the REVS Enhancements/Modifications

In addition to supporting the full range of submission types, we currently give providers options to exercise each submission type without incurring additional expense. Providers also can choose to integrate the functions into their proprietary applications. Provider submission choices are listed in the following table.

Provider Options for Submitting Eligibility Requests by Submission Type

Submission Type	Provider Option(s)	Description
270/271 X12N Batch file	Provider Electronic Solutions software	Software provided by EDS free of charge to providers
	Third-party application	Software acquired by the provider and developed using the companion guide and technical specifications provided by EDS
270/271 X12N Interactive submission	Provider Electronic Solutions software	Software provided by EDS free of charge to providers
	Third-party application	Software acquired by the provider and developed using the companion guide and technical specifications provided by EDS
	POS device*	POS device acquired by the provider using software developed by a sponsored third-party vendor, such as Verifone, based on EDS specifications
WEB	Internet Explorer, Netscape or other compatible browser	Browser interaction through the provider portal.
AVRS	Toll-free in-state call	Touch-tone telephone system using toll-free number for in-state calls
Note: Shading indicates that the new POS device is the only change required. All other options are currently in place.		

For the Web- and X12N-based transactions, providers can communicate with the MMIS using their own Internet service provider (ISP) or through EDS, using a remote access server (RAS). With RAS, EDS functions as the ISP, enabling providers to connect to the MMIS without having their own Internet access account. Providers use a toll-free telephone number so they have no long-distance expense.

Under HIPAA, the minimum requirement for responding to an eligibility request is for the MMIS to respond with "Yes/No, the patient is/is not eligible." To better serve provider needs, we will return a more specific response, such as the following:

- Eligibility status
- Maximum benefits (benefit limitation status)
  - Office visits
  - Vision
  - Adult dental
  - Chiropractic
- Co-Pay Required (Y/N)
- Third-party liability (TPL)

With the proposed REVS enhancement, the state will continue to benefit from the comprehensive eligibility verification solution that we provide and manage through the VermontAIM and the front-end processing capabilities at providers' offices.

Third-Party Liability Responsibility Reorganization and Subsystem Upgrade

RFP Reference: 2.8.3.3, p. 2-167

By having a successfully reorganized and upgraded third-party liability (TPL) subsystem, the state can achieve its goals of receiving optimum savings from TPL operations, while ensuring that program funds are expended for eligible services based on coverage classifications. We have developed an effective TPL solution as requested in the RFP. This approach encompasses these three key goals:

- Enhancing the current TPL subsystem as appropriate
- Incorporating new system capabilities when needed
- Teaming with Health Management Systems (HMS)

The existing TPL subsystem already meets many of the processing requirements defined in the RFP. Therefore, upgrading the current subsystem, rather than starting over with a new system, will help leverage the state's investment in the AIM MMIS.

Where new system capabilities (such as case tracking) are required, EDS may leverage work that has already been done for the TPL subsystem we implemented for Delaware, or we may customize the existing TPL system to add these capabilities, whichever is most efficient in meeting requirements. For example, to meet the state's requirement to replace the FoxPro™ Case Tracking system, we will transfer the Delaware TPL case-tracking component to meet Vermont's requirements. This approach will enable us to implement this capability more quickly, so you can begin to take advantage of the benefits sooner.

We also will partner with HMS to bring proven data matching and electronic billing capabilities to the state. We successfully partner with HMS in other states, including Delaware, to efficiently and effectively provide these capabilities.

In developing a TPL solution for this proposal, we considered the differences between the requirements in the Coverage and Services Management Enhancement application (CSME) of the MMIS RFP and the state's current one. We describe our proposed TPL solution in detailed responses to each requirement of RFP Section 2.8.3.3.6. However, our solution also considers and addresses the information and requirements provided in each of the following TPL-related RFP sections:

- FoxPro
- Microsoft Word and Excel
- Identified Limitations
- Proposed Solutions
- TPL Recovery Types
- Upgrade Inputs

We present our understanding of and approach to completing the TPL enhancements and modifications in the following subsections:

- Understanding of the Third-Party Liability Enhancements/Modifications
- Approach to Completing the Third-Party Liability Enhancements/Modifications
- Upgrade Processing Functions
- Outputs
- Interfaces

Understanding of the Third-Party Liability Enhancements/Modifications

The OVHA is interested in reorganizing TPL responsibilities and upgrading existing TPL processes to maximize TPL recoveries and save program funds. Currently, the state and EDS share recovery responsibilities. Collections have increased each year, but the OVHA believes that upgrading existing TPL processes can further increase collections.

Today, the MMIS and various off-the-shelf software packages are used to support various aspects of TPL processing and recovery. The state's FoxPro database tracks total payments recovered on behalf of a client and total statewide TPL collections. The state also uses Microsoft Word to create TPL correspondence and Excel spreadsheets to track the status of some casualty claims. ACCESS is used for entering and maintaining beneficiary insurance information; then a daily recipient eligibility file is used to give that insurance information to the MMIS. The MMIS currently performs the following functions:

- Identifying paid claims that can be recovered
- Supporting creation of claim facsimiles, claim summaries, and account receivables
- Providing for the disposition of recoveries against those accounts
- Using TPL coverage type and threshold information during claims adjudication

To refine and streamline the TPL processes, EDS will upgrade and enhance the TPL subsystem, thus integrating automated TPL functions into a single system. This approach will eliminate the state's need for the FoxPro database.

The state has significantly invested in developing in-house expertise, and our TPL solution will help preserve that investment. We will reorganize responsibilities to transfer contractor staff's TPL responsibilities to the OVHA TPL unit. We will work with the state to enhance the tracking of recovery status and to improve communication capabilities with various entities.

We will enhance the TPL subsystem by implementing case management and tracking capabilities. This enhancement will help improve recoveries through more effective management of TPL-related case data.

EDS will comply with Act 75, Title 3 of Vermont Statutes Anointed, Chapter 14, and will not contract or subcontract with another unit that provides services similar to the Department of PATH's TPL unit.

Approach to Completing the Third-Party Liability Enhancements/Modifications

The TPL optional enhancement, if selected by the state, will help Vermont increase cost recoveries and cost savings, yielding significant benefits immediately after implementation. Our proposed TPL solution will help the state meet its goal for saving Medicaid program funds, while ensuring that program funds are expended for eligible services based on coverage classification. We will continue to build on our strong working relationship with the state's knowledgeable TPL staff, providing them with enhanced capabilities to improve their effectiveness.

Enhancing the TPL Subsystem and Incorporating New Features

Our approach begins with upgrading and enhancing the existing Vermont TPL subsystem to meet many of the new requirements. Some of the changes will require modifying certain features of the subsystem, and some will call for adding features that are new to the subsystem in Vermont, such as integrated case tracking.

For new system functions, we will first look to the TPL subsystem that we recently implemented for the state of Delaware (whose overall MMIS is based on the Vermont AIM). By taking advantage of EDS' work in Delaware, we save time and money by using the Delaware code as the starting point. We will then customize the Delaware code to meet Vermont's unique TPL requirements. This upgrade and enhancement approach leverages the state's investment in the existing Vermont TPL subsystem.

Teaming with HMS

EDS and HMS work together in many states to implement file transfers between the MMIS, HMS' system, and other insurance carrier systems. These file transfers allow HMS to use its highly successful TPL data-matching process, which is a complex series of electronic data matches, using selected multiple match keys performed with a wide network of third-party carrier files. HMS performs these matches with a level of technical sophistication unequaled in most state Medicaid TPL data match operations. HMS currently has cross-matching agreements with 110 health insurance entities, which represents more than 85 percent of the private carriers in most areas of the United States. HMS already has data sharing agreements in place with 17 of the top 25 health care insurers in Vermont (based on Year 2000 premiums paid as reported to the Vermont Department of Insurance).

Upgrade Processing Functions

RFP Reference: 2.8.3.3.6, p. 2-173

By bringing a proven TPL subcontractor to the solution, we can enhance the state's data matching and electronic billing capabilities, making the state's benefit recovery process more effective. We propose partnering with HMS because of its strong data matching and electronic billing capabilities. EDS, as prime contractor, will team with HMS to provide the state with specified TPL services. We will provide oversight to ensure HMS' continued contract compliance and provision of high quality services. The approach described in this section acknowledges and is compliant with the requirements listed in the preceding subsections of 2.8.3.3 (2.8.3.3.1 through 2.8.3.3.5).

We provide a brief description of our approach to completing each requirement in the remainder of this section. We also include examples of windows that represent the TPL-related functions requested by the state.

Please note, some of the windows shown in this section are Vermont PowerBuilder windows designed for the HIPAA project, and others are PowerBuilder windows from the Delaware MMIS, as some window functionality needed to meet the RFP requirements will be met by the Vermont windows to be provided by the HIPAA project, and other requirements will be met using windows transferred from Delaware.

a. Maintain Third-Party Resources by Recipient on a TPL Resource File

The proposed solution will maintain third-party resource information by client, including all of the elements listed in the RFP. The system will maintain this information through manual updates and electronic data exchanges. Authorized users will have the ability to update TPL information through various online windows. Each field that is updated by an online window will have appropriate edits for validity and data integrity (such as checks for valid dates). The system will notify users immediately if the update being entered cannot be accepted. An error message box will prompt the user to the necessary corrective action. This approach will help us be sure that only valid information is used in claims processing and third-party recoveries.

Additionally, TPL resource information will be updated systematically through data exchanges with outside entities, such as Vermont's ACCESS system. All systematic updates will undergo validity and data integrity edits. The system will generate reports of non-accepted information (such as ACCESS Update Transaction Report). This information can be reviewed by the submitting entity.

The online windows are used to update information specific to TPL processing. The following window allows authorized users to view, update, and inquire on TPL field data to maintain a beneficiary's insurance coverage information.

Vermont Medicaid Management Information System

File Edit View MMIS System Tools Window Help

QUERY Other Insurance - TPOI

Carrier Information
MID
Name
TP Unique ID
Birth Date
Death Date
HIC #

Recipient Identification
Carrier Code
Carrier Name

Recipient's Policy Information
Client Begin Date
Client End Date
Status
Relationship
Origin
Subrogation
Prem
Assignment
Insurance Type

Recipient's Employer Information
Employer Code
Address Line - 1
Address Line - 2
City
State
Zip

Policy Information
Policy #
Group #
Policy Holder Name
Coverage Code
Policy Holder SSN
Provider #
HMO Level

Policy
Changed
Clerk

Recipient Policy
Changed
Clerk

Retrieve Add Save Exit

Ready | Row 1 of 24 | Clerk: 019 | 02/27/2003 09:36:07 | PRODUCTION | Ver: 20030220T1

Third-Party Other Insurance - TPOI window

The MMIS captures an audit trail of any changes made to data through online screens. The audit trail—including user ID, the data that was changed, and the date and time of the change—is viewable through the Audit Trail - GNAT window, which follows.

Delaware Medicaid Management Information System

File Edit View MMIS MAR SUR DCIS II Favorites System Tools Window Help

VIEW Audit Trail - GNAT

Audit Table A_T_AID_CTG_LIST

Cde Action	Dte Time	Nam User	List Number	Aid Ctg Cde	Dte Add	Tme Add	Dtl Status	Eff Start Dte	Eff End Dte	Lst
I	12/17/2002 09:57:45	XXX	502	12	20021217	95744				
U	12/17/2002 10:03:37	XXX	502	12	20021217	95744	A			

Show Updates | Show Inserts | Show All | Exit

Ready | Row 1 of 2 | Clerk: YYY | 03/17/2003 13:38:44 | MODEL | Ver. 20030314M2

Audit Trail - GNAT window

A summary of all policies for a client is accessed from the Other Insurance Summary - TPIS window. This window enables authorized users to display insurance information for clients.

Vermont Medicaid Management Information System

File Edit View MMIS System Tools Window Help

QUERY Other Insurance Summary - TPIS

Recipient Information

MID Last Name First MI

Insurance Policy Information

Carrier Code Coverage Code

Policy # Group #

Policy Begin Date

Policy Holder Name Policy Holder SSN

Summary Detail

MID	First	MI	Last	Carrier Code	Coverage Code	Status	Policy Begin Date	Policy End Date	Prem	HM Lev

Retrieve Add Save Exit

Ready Row 1 of 1 Clerk: 019 02/27/2003 09:37:58 PRODUCTION Ver: 20030220T1

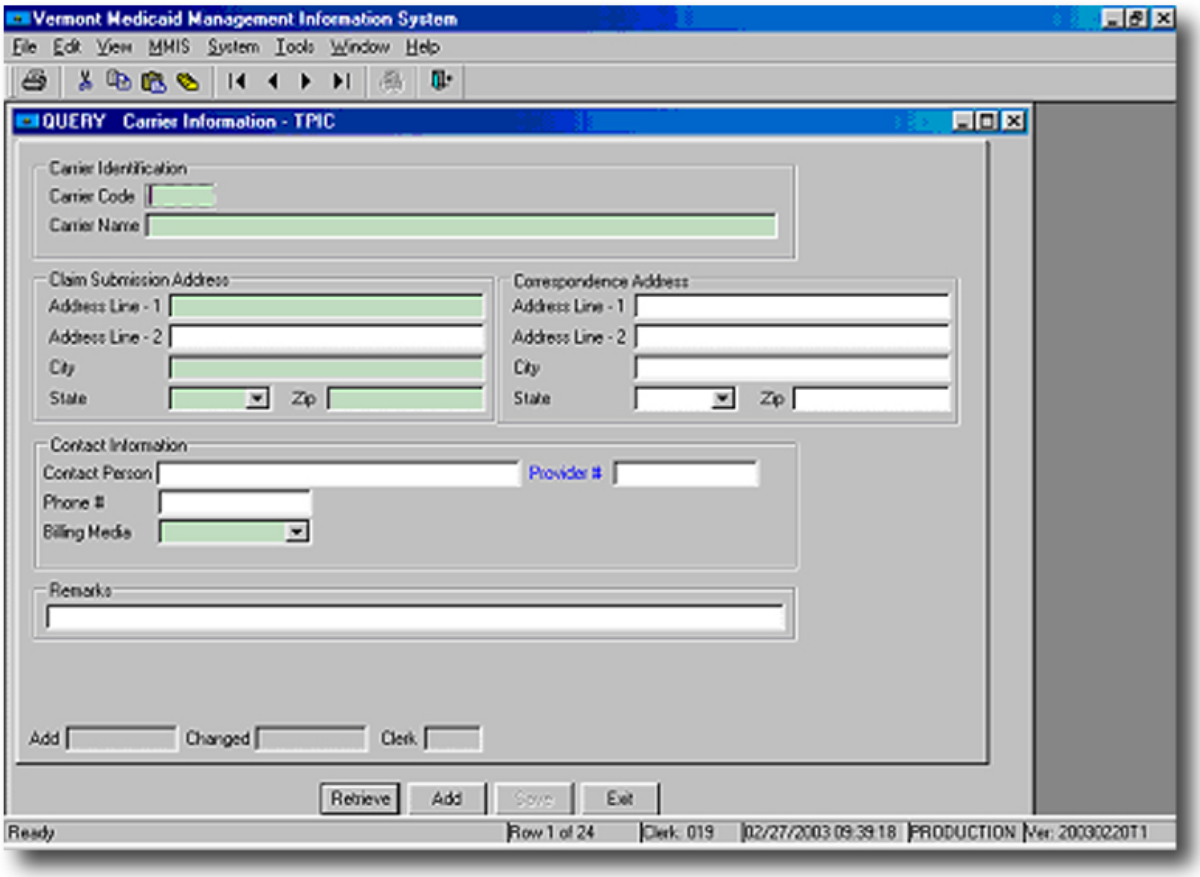
Third-Party Other Insurance Summary - TPIS window

All fields displayed on this window are from the TPL and client functional area. When the user enters a Medicaid ID, this window displays the beneficiary assigned to that ID. It also displays all active, inactive, and policies in error.

The Status field indicates if the policy is active, inactive, or in error. A policy is inactive when the current date becomes equal to the Policy End Date. The status is updated to “I” (inactive) when the beneficiary or the insurance carrier cancels the policy before the Policy End Date. The premium indicator is set to “Y” (yes) when the beneficiary has an insurance premium amount greater than zero.

b. Maintain Third-Party Carrier Information on a TPL Carrier File

Our TPL solution provides users with the ability to maintain required fields on the following Carrier Information - TPIC window. Authorized users employ this window to maintain information about carriers and other entities paid or billed by the MMIS.



Third-Party Carrier Information - TPIC window

This window displays information about carriers, including carrier name, carrier city, contact person, and billing media. The claim filing limit will be added to the TPIC window, as described later, in our response to "r. Create Tables to Edit for Timely Filing Limits" in this subsection.

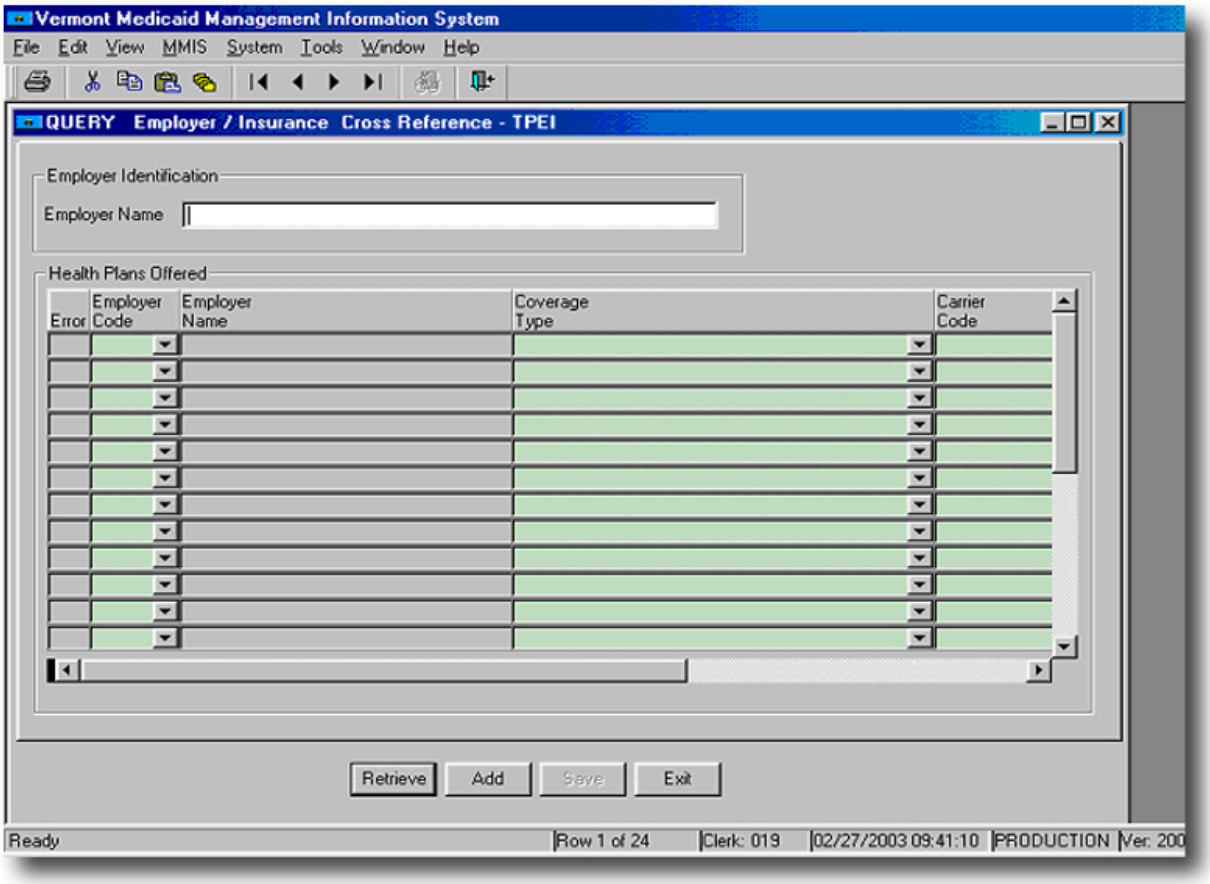
c. Maintain Historical Information on Third-Party Resources for Each Recipient

The proposed solution provides users with the ability to maintain historical third-party information on the Other Insurance Summary window, shown previously in our response to "a. Maintain Third-Party Resources by Recipient on a TPL Resource File" in this subsection. The Other Insurance Summary window allows users to display insurance information for beneficiaries.

All fields displayed on the Other Insurance Summary window are from the TPL and beneficiary functional areas. When the user enters a Medicaid ID, this window displays the beneficiary assigned to the specified ID. The window also displays all active, inactive, and policies in error.

d. Cross-Reference Carrier and Employer Data

EDS' TPL solution will enable the user to cross-reference carrier and employer data on the following Employer/Insurance Cross Reference - TPEI window. Through the TPEI window, authorized users can maintain a cross-reference of employers to insurance carriers and their insurance plans.



Employer/Insurance Cross Reference - TPEI window

The user adds insurance policy information to the list for an individual employer. After the user enters the employer name and the system finds the employer, the window displays a list of insurance policies and carriers associated with the employer.

If the employer is not in the system, the user can add the employer by accessing the Employer Information - TPEM window that follows. The system generates an employer code when a new employer is added.

Vermont Medicaid Management Information System

File Edit View MMIS System Tools Window Help

QUERY Employer Information - TPEM

Employer Identification

Employer Code

Employer Name

Employer Address

Address Line - 1

Address Line - 2

City State Zip Code

Contact Information

Phone#

Contact Person

Changed Clerk

Retrieve Add Save Exit

Ready | Row 1 of 24 | Clerk: 019 | 02/27/2003 09:42:20 | PRODUCTION | Ver: 20030220T1

Employer Information - TPEM window

The TPEM window also allows authorized users to maintain employer information. They can perform queries on existing employer information through the TPEM by entering either the employer name or the employer code.

e. Display, Online, Coverage Data for Current and Previous Recipient IDs When Either is Specified

The proposed TPL solution provides the ability for the user to look up Medicaid beneficiary information based on either the current or past Medicaid ID on the window. A beneficiary's insurance coverage information is maintained through the Other Insurance Information - TPOI window shown earlier in our response to "a. Maintain Third-Party Resources by Recipient on a TPL Resource File" of this subsection.

f. Accept Updates of Medicare HIC Numbers and Batch Updates to TPL Resource File

We will accept batch updates to the TPL resource file with data from ACCESS. Health insurance claim (HIC) numbers are currently stored in the TPL subsystem. If we anticipate updates to the

Medicare HIC numbers from systems other than ACCESS, we will send this updated information back to the ACCESS system.

g. Maintain Online Inquiry to TPL

Our TPL solution provides authorized users with online access to information needed to manage and operate the TPL program effectively, with a variety of possible options for organizing recipient data. By using the Other Insurance Summary -TPIS window—shown earlier in our response to "a. Maintain Third-Party Resources by Recipient on a TPL Resource File" of this subsection—users can search and view the most up-to-date information in real time, limiting searches according to a variety of possible variables, including the following:

- Recipient name, identification number, and Social Security number (SSN)
- Policy number and policy type
- Group number including Medicare HIC Number
- Coverage codes
- Carrier code
- Name of policyholder

Users also can view TPL carrier information through the Carrier Information -TPIC window shown earlier in our response to "b. Maintain Third-Party Carrier Information on a TPL Carrier File" of this subsection. This window permits information retrieval based on carrier name and carrier code. Authorized users can maintain information about carriers and other entities paid or billed by the MMIS through the TPIC window. The TPIC window displays information about carriers, such as carrier name, contact person, and billing media. As part of the TPL subsystem upgrade, we will add a field for the claim-filing limit to this window.

h. Expand the TPL Claim Selection Window

EDS will expand the TPL claim selection window to include the following capabilities:

- Filter selection based on diagnosis code, drug class, and so forth
- Display English translation of codes
- Select and deselect claims
- Navigate to claims detail information
- Duplicate carrier code and reason code for highlighted claims to reduce keystroke repetition
- Total the amount of claims selected for recovery.

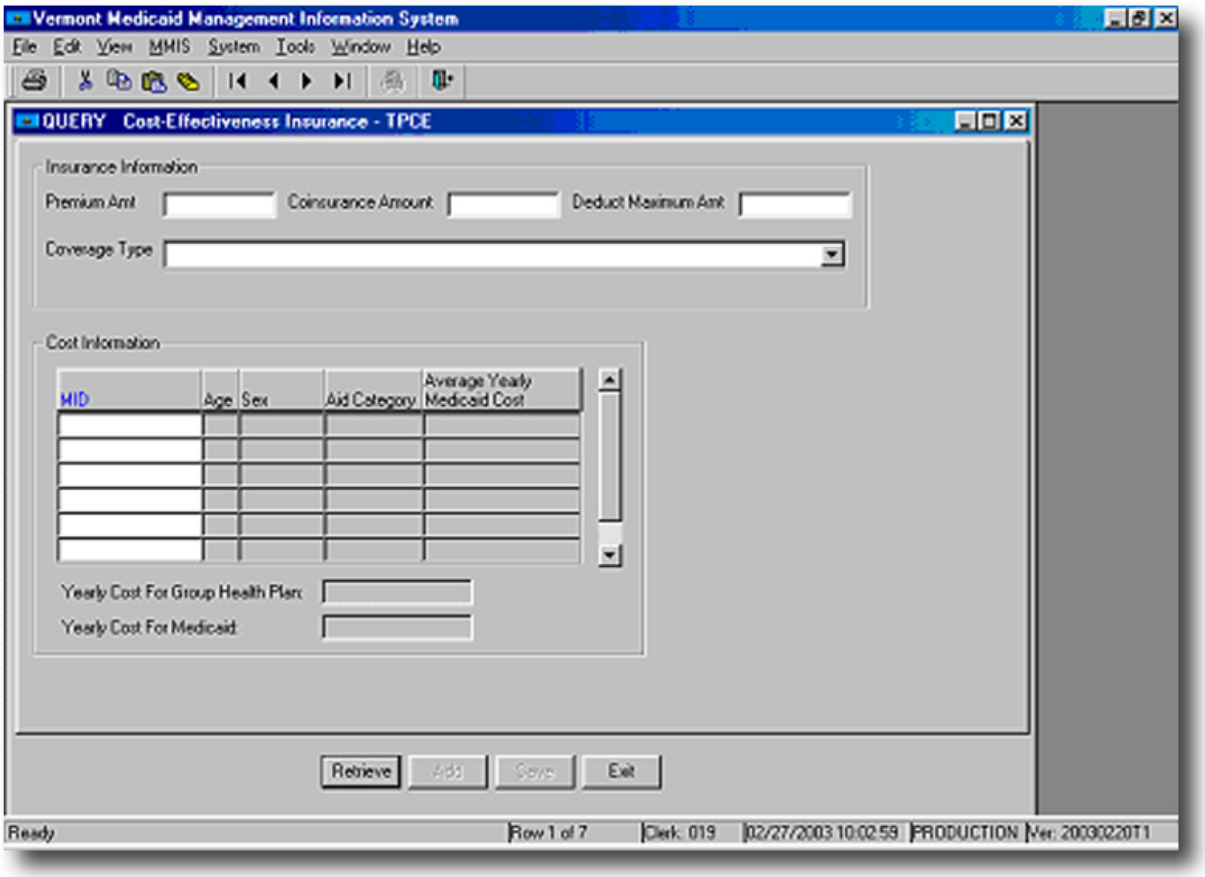
i. Adjust Multiple Claims From a Single TPL Recovery

Because TPL recoveries may encompass payment for multiple claims, we will include in our TPL solution the ability to adjust multiple claims from a single TPL recovery to apply a payment

to any number of claims. We will discuss various ways to meet this requirement with the state during our requirements validation sessions and will implement the agreed upon approach.

j. Support the TPL Private Insurance Carrier Payment Program

Our TPL solution will create cost-of-service (COS) profiles based on age, gender, and program code by using the Update Yearly Medicaid Cost quarterly transaction. This quarterly transaction currently runs in the TPL cost-effectiveness business function and calculates the cost-effectiveness data used by the Cost-Effectiveness Insurance -TPCE window shown below.



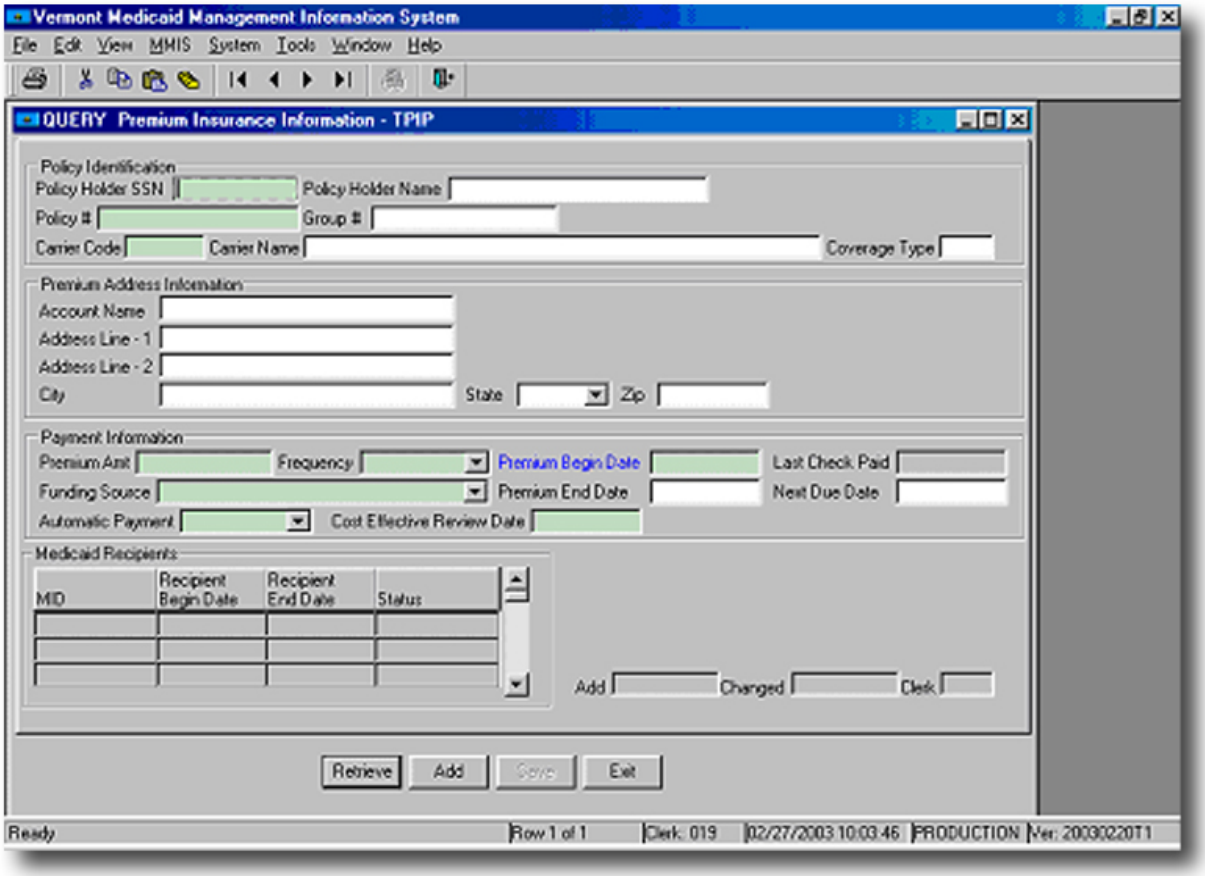
Cost-Effectiveness Insurance - TPCE window

The COS process retrieves all clients eligible for Medicaid in the last year; totals their Medicaid costs in each category, and divides the costs by the unduplicated beneficiary count in each category. The TPCE window retrieves a Medicaid cost per covered member for each of the coverage codes entered. It also produces demographic information for each covered client. We will work with the state to create cost-of-service profiles based on diagnosis code.

Through the TPCE window, authorized users can provide information that compares yearly cost totals of paying insurance premiums for certain clients to the yearly cost totals of paying the

providers with Medicaid funds. This window is also used as a worksheet to compare the yearly cost of Medicaid and the cost of paying premiums for beneficiaries.

To automate premium payments to individual beneficiaries, authorized users can access the Premium Insurance Information -TPIP window shown here. This window allows users to maintain insurance premium information for a beneficiary, identify beneficiary premium information, and establish payment.



Premium Insurance Information - TPIP window

A value of Review "R" in the Automatic Payment field indicates that the coverage must be reviewed. If the user decides that the premium should be paid, the field is changed from Review "R" to Verified "V." Once the premium is paid, the system resets the value to Review "R" for the next period.

The premium check process runs on a weekly basis. Based on the next due date and automatic payment indicator, the TPL functional area reviews client premium information and creates premium MMIS financial transactions for payments due within the next week. The MMIS financial functional area then creates the premium payment information for all premium financial transactions with an open status and, after a check is generated, updates the last check paid date.

Account IDs entered in Add Payee mode must either be a valid carrier with a billing address or a valid client with a mailing address. To report estimated savings for the private payment insurance program, we will create a report that will accumulate the premium payments generated for the quarter. It also will compare the result against the estimated Yearly Medicaid Cost table, which is refreshed quarterly.

To automatically discontinue premium payments when an individual is no longer a Medicaid beneficiary, we will modify the weekly premium payment process to verify beneficiary eligibility prior to the creation of payments. If the beneficiary is no longer eligible, we will update the Premium Insurance Information window so that the premium end date equals the beneficiary eligibility closure date.

k. Alert TPL Staff When Private Insurance Information Changes

We currently produce, and will continue to produce, reports that alert the TPL staff when private insurance information changes. Following are two reports that meet this requirement:

- TPLR020V—Insurance Premium Review Report
- TPLR021V—Insurance Premium Txn Report

l. Streamline Payment Disbursement to Accounts Receivables

We will offer the state an automated way to disburse payment to account receivables. We will work with the state during the requirements validation sessions to determine the most effective and efficient solution to accomplish this function.

m. Automate Identification of Abnormal TPL Payments and Creation of Accounts Receivables for Drug Claims

On January 15, 2002, we implemented a modification to the Vermont MMIS that automates identification of abnormal TPL payments. The policy sets an edit for any claim that has a TPL payment of less than $5 when the beneficiary has other insurance on file. Front-end claims editing enforces this policy, reducing the need for back-end reporting and research for all claim types other than pharmacy. Since we implemented this edit, we have identified and denied 870 claims.

Because another vendor processes pharmacy claims, front-end editing cannot be performed on pharmacy claims in the MMIS. EDS uses BusinessObjects to provide a report that identifies all pharmacy claims with other insurance payments of less than $3. The state can use this report to open accounts receivable and recover money we have paid on a pharmacy claim where the other insurance amount appears to be invalid.

The following window shows a sample of the BusinessObjects report we developed to show pharmacy claims with abnormal TPL payments.

BusinessObjects - [OI Payment - Pharmacy Claims.rep]

Print | Next Page | Prev Page | Last Page | Zoom In | Zoom Out | Close

Office of Vermont Health Access

Pharmacy Claims with Abnormal TPL Payments

Run Date: Wednesday February 13, 2002

Run Time: 01:25:36 PM

Billing Provider Full Name	Recipient First Name	Recipient Last Name	ICN	Paid Amount	Other Insurance Amount
XXXXXXXXXXX	XXXXXXXXXXX	XXXXXXXXXX	432002038331386	$7.34	$0.01
XXXXXXXXXXX	XXXXXXXXXXX	XXXXXXXXXX	432002036327251	$7.94	$0.01
XXXXXXXXXXX	XXXXXXXXXXX	XXXXXXXXXX	432002025335092	$68.66	$0.01
XXXXXXXXXXX	XXXXXXXXXXX	XXXXXXXXXX	432002028326432	$6.09	$0.01
XXXXXXXXXXX	XXXXXXXXXXX	XXXXXXXXXX	432002024332247	$12.32	$0.01
XXXXXXXXXXX	XXXXXXXXXXX	XXXXXXXXXX	432002035340750	$5.47	$0.01
XXXXXXXXXXX	XXXXXXXXXXX	XXXXXXXXXX	432002025334838	$65.36	$0.01
XXXXXXXXXXX	XXXXXXXXXXX	XXXXXXXXXX	432002025334988	$71.97	$0.01
XXXXXXXXXXX	XXXXXXXXXXX	XXXXXXXXXX	432002029337529	$7.94	$0.01
XXXXXXXXXXX	XXXXXXXXXXX	XXXXXXXXXX	432002009337369	$14.62	$0.20
			Sum:	$267.71	

Page 1 / 1 | Last Exec: 2/13/02 01:25 PM | NUM

Pharmacy Claims with Abnormal TPL Payments report

We request that the state have the pharmacy benefits manager (PBM) vendor supply us with a file of drug claims that could not be cost-avoided. Once we have the file, we will add the claims to the current TPL subsystem so that post-payment recovery can be initiated, if appropriate.

n. Track Individual Claims and Multiple Claims That Reach a State-Defined Threshold

Our TPL solution will track individual claims and multiple claims that reach a state-defined threshold for post-payment recovery on trauma cases. We will provide the following Accident/Trauma Threshold Report to the state to assist in accident and trauma tracking. This report includes accumulated paid claims with an accident indicator (auto, employment, or other type of accident) or accident- and trauma-related diagnosis codes that meet or exceed the threshold amount. An indicator on the diagnosis file determines whether or not a diagnosis code is related to TPL.

```
TPLR310V                                   MEDICAID MANAGEMENT INFORMATION SYSTEM                          PAGE  99,999
RUN DATE:  MM/DD/CCYY  HH.MM                ACCIDENT/TRAUMA THRESHOLD REPORT                   PERIOD: FOR MONTH OF  MM/CCYY

    MID            LAST NAME            ACC CD            ICN            PROV #       TAXONOMY     DIAGNOSIS 1   DIAGNOSIS 2
                    BLO AMT             AMT PAID          PD DT          ACC DT                      OI AMT
 XXXXXXXXXX        XXXXX                 XXXX        999999999999999    XXXXXXXXX   XXXXXXXXX      XXXXX         XXXXX
                   $$$$,$$9.99          $$$$,$$9.99      MM/DD/CCYY     MM/DD/CCYY                 $$$$,$$9.99

 ** DETAIL **     DIAGNOSIS        FROM        TOOS      PROC    MOD MOD 2 MOD 3     PD AMT
                  XXXXX          MM/DD/CCYY  MM/DD/CCYY  XXXXXXX  XX   XX   XX     ZZZZ,ZZ9.99
                  XXXXX          MM/DD/CCYY  MM/DD/CCYY  XXXXXXX  XX   XX   XX     $$$$,$$9.99
 ** CLAIM DETAIL TOTAL **                                                           ZZZZ,ZZ9.99
 ** CLIENT THRESHOLD **                                                             $$$$,$$9.99


                                          *** END OF REPORT ***
```

Accident/Trauma Threshold Report

Our accident and trauma tracking process will use the diagnosis code to determine if the claim was the result of an accident. If this cannot be determined by the diagnosis code, the accident indicator will be checked. For hospice or professional crossover claim types, the employer, auto, and other accident indicators are checked to determine whether or not they are set on the claim. If they are set, the claim is included on the report.

For other claim types—such as inpatient, outpatient, home health, institutional Part A crossover, and institutional Part B crossover—the system examines the diagnosis code. If it is one of the accident- or trauma-related diagnosis codes, the claim is included on the report. A claim detail total is listed at the end of each claim.

o. Electronically Bill Insurance Carriers and Liable Third Parties

The extraordinary volume of insurance claims makes electronic submission of claims preferable whenever possible. We propose using HMS' proven electronic billing capabilities to meet this requirement. The HMS billing solution will also verify that claim facsimiles used to bill third-party insurers are created with accurate information. With the EDS/HMS solution, the state can maximize electronic billing technology.

For those carriers that do not accept electronic billings, the state can request paper claim facsimiles as it does today. Currently, the state requests HCFA-1500, UB-92, and ADA claims that are produced and delivered to the state TPL unit weekly. We will continue to provide these claims, verifying that they contain accurate information.

The following paragraphs present several of the advantages of using HMS to meet the state's electronic billing needs:

- **HMS uses electronic billing 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 billing. HMS submits approximately 80 percent of claims through various electronic platforms, including

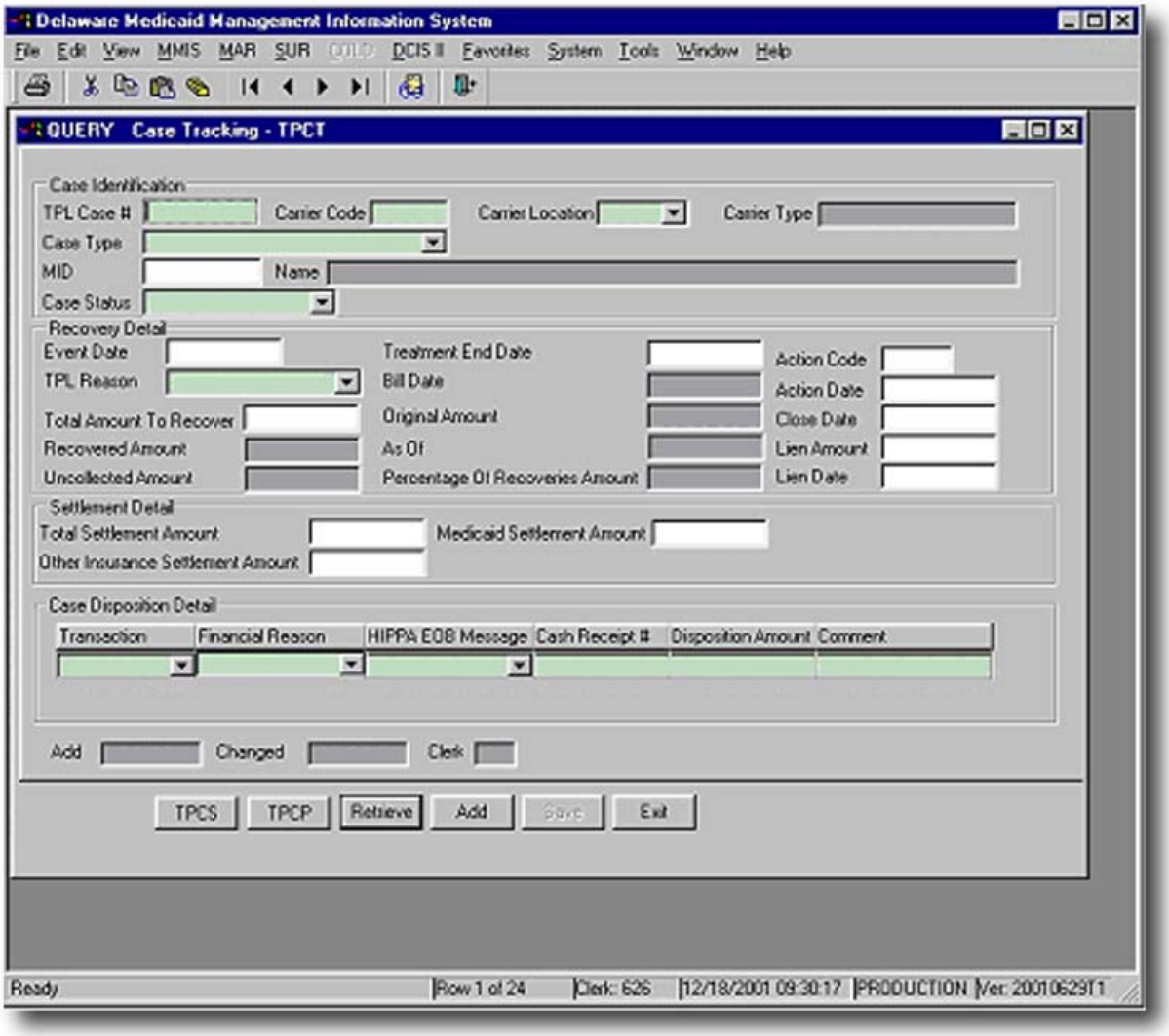
WebMD Transaction Services. WebMD Transaction Services transmits electronic claims to nearly 85 percent of group health reimbursement plans in the nation. Through WebMD Transaction Services, HMS receives faster turnaround on claims, automatic front-end pre-editing of claims, and a way to track claims in the adjudication process. Processing similar claim volumes on paper would take months and would generate increased rejections and lower recovery levels.

- **For non-WebMD Transaction Services carriers, HMS performs carrier-specific electronic billings**. This service is used primarily with BC/BS plans and TRICARE/CHAMPUS, 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, it maintains a staff of system and insurance specialists who continually work with insurers, PBMs, and other claims payors to develop and enhance electronic billing and remittance platforms.
- **Both Medicaid 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 manually enter into claims processing systems. This increased efficiency will mean earlier recoveries for Vermont Medicaid and lower cost and staff burden for insurers.
- **Each year, HMS bills millions of Part B claims directly to Medicare carriers as part of our Medicare third-party recovery service.** Wherever possible, HMS establishes CPU-to-CPU transmission of claims to speed adjudication. To reduce the burden on Medicaid, it offers the capability to receive electronic remittances from Medicare in ASC X12 835 Electronic RA format rather than paper remittances. HMS will establish the capability to submit Medicare Part B claims electronically to National Heritage Insurance Company (NHIC), Vermont's Part B carrier. HMS currently bills NHIC in electronic format on behalf of the Massachusetts and California Medicaid agencies.
- **HMS submits TPL claims within the timely filing limits established by the carrier.** In the past, HMS has successfully secured a waiver or extension to the timely filing limit from several carriers and pharmacy benefit managers.
- **HMS currently bills payors in HIPAA X12 837 format.** HMS also already receives and processes transactions that are ASC X12 835-compliant for some Medicare Part A intermediaries, Medicare B carriers, BC/BS plans, and for commercial insurers that are billed through WebMD. In addition, HMS is currently testing the NCPDP v.5.1 format with MedcoHealth and anticipates switching all pharmacy billings from NCPDP v3.2 to NCPDP v5.1 in the next few months.

p. Automate TPL Write-Offs, Including Ability to Perform Multiple Write-Offs

EDS will provide enhanced automation to process TPL write-offs, including the ability to perform multiple write-offs. Users can perform write-offs by accessing the Case Tracking window. To meet this requirement, we will leverage the case tracking solution already implemented for the Delaware Medicaid Program. Our proposed transfer and modify approach enables quicker implementation of this proven capability.

The following Case Tracking -TPCT window was developed for the Delaware MMIS and will be adapted for Vermont. This window supports the ability to write-off multiple accounts receivable at the TPL case level. In addition, users work with this window to set up, view, and disposition TPL cases.



Case Tracking - TPCT window from the Delaware MMIS

The TPCT window displays recovery detail and settlement detail information for each TPL case number. It also allows multiple case dispositions to account for money being received for a case at different times without closing the case. An example of this scenario would be money received from attorney fees and court costs. The Case Tracking window displays summary information for a case. For a TPL case, the window would include items such as the system-generated TPL case number, postpayment, and estate recoveries. Cases in the system are set up for a client, carrier, and case type.

q. Support Retroactive Insurance Recoveries

The current TPL system supports retroactive insurance recoveries, including data matches. In addition, we propose to team with HMS to provide the state with enhanced data matching that will increase TPL recoveries in Vermont. The next few pages present pertinent HMS accomplishments and qualifications to provide TPL-related services, such as data matching.

Data Match Sources

To identify the maximum possible instances of third-party coverage for Vermont Medicaid beneficiaries, a responsive vendor must perform comprehensive file matches with a wide range of health insurance carriers operating in Vermont and contiguous states. HMS performs these matches to identify other health insurance coverage, bill the liable carriers, return the recovered money to Vermont, and provide third-party coverage data that enable the Department of PATH to cost avoid claims.

HMS has assembled a comprehensive health insurance data exchange network for identifying other third-party coverage. The in-place carrier network and highly effective billing protocols far exceed the similar capabilities of any other vendor. Because of this network, HMS can ensure that Vermont Medicaid remains the payor of last resort and that the state continues to comply with federal requirements to cost-avoid claims when there is known third-party liability. Following are some key benefits of using HMS for data matching:

- **HMS currently has in-force data sharing agreements with 17 of the top 25 health insurers in Vermont.** Immediately upon contract award, HMS will pursue agreements with the carriers for whom it does not currently receive eligibility (Blue Cross Blue Shield of Vermont and MVP Health Plan, for example).
- **HMS uses this proprietary network to identify past and present third-party coverage eligibility periods that overlap with periods of Vermont Medicaid eligibility.** As new carriers are added to our match network, they receive written notice of our role and their responsibilities.
- **HMS pioneered the use of data matches with health insurers 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 health care organizations, including CMS' central office, the National Association of Insurance Commissioners (NAIC), the Health Insurance Association of America (HIAA), and the Blue Cross/Blue Shield Association.

Resources for Eligibility Data

Specific third-party resources from which HMS proposes to obtain eligibility data include the following:

- **Health Insurance Carriers, Self-Funded Plans, and TPAs—**HMS' health insurance data match project significantly increases revenue recoveries and augments cost avoidance from health insurance carriers. HMS has successfully billed more than 250 different health insurance carriers, including carriers that provide administrative services for self-funded plans. HMS uses sources such as health insurance industry reports from the NAIC, 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. HMS' specific insurer revenue recovery expertise has produced more than **$455 million** in recoveries for its state Medicaid agency clients.
- **Blue Cross/Blue Shield (BC/BS) Plans—**HMS has worked closely with the BC/BS Association to obtain BC/BS subscriber files for individual recipients. HMS currently has data match agreements with 25 BC/BS entities nationally. In addition, HMS has worked with the BC/BS Association to obtain subscriber files for individuals enrolled in the BC/BS Federal Employee Plan (FEP). It also is negotiating data matches with NASCO (National Account Service Company), whose national eligibility database includes eligibility from 1,200 national and regional accounts representing more than 5.8 million members. To date, HMS' BC/BS data match and billing efforts have resulted in more than **$220 million** in recoveries for its clients.
- **Medicare Supplemental (Medigap) Plans—**HMS has performed several identification and recovery projects using Medigap coverage information from commercial insurance carriers, BC/BS plans, and MCOs. It identifies payments for coinsurance and deductibles, pharmacy services, and other services where Medigap coverage was available. HMS regularly receives data from the large Medigap plans operating in the country.
- **TRICARE/CHAMPUS—**HMS has developed the most effective Defense Enrollment/Eligibility Reporting System (DEERS) matching and intermediary billing methodology for TRICARE/CHAMPUS identification and recovery. To perform the data match, HMS prepares a Medicaid eligibility input tape and sends it to DEERS for the scheduled annual match. If an Absent Parent File is available from Vermont, HMS also includes this information in the DEERS data match process, based on CMS regulations. Between annual data matches, HMS uses its direct access to the DEERS database to perform real-time, online eligibility verification lookups. This capability will enable HMS to perform coverage queries for newly eligible Vermont Medicaid beneficiaries without waiting for the next annual data match. In addition, HMS uses the online database to verify TRICARE/CHAMPUS leads received through nondata match sources. Using the DEERS match data, HMS has generated more than **$18 million** in TRICARE/CHAMPUS recoveries.

- **Medicare Part A and Part B (including CMS Enrollment Database Data Match)—** HMS has extensive expertise in performing data matches with Medicare eligibility files to identify Medicaid recipients with Medicare coverage. It also coordinates benefits between Medicaid, Medicare, and Medigap insurers and identifies Medicare enrollment/coverage that involves some unique challenges. Although numerous sources of Medicare data are available (specifically through CMS or the Social Security Administration), 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 can identify Medicare enrollment/coverage for Vermont Medicaid beneficiaries.

Through HMS' revenue recovery projects in 29 other states, it has determined that the following data sources offer the most comprehensive foundation of Medicare coverage data:

- Beneficiary data exchange (BENDEX) File
- Medicare Buy-In Files (Part A and B)
- Medicare Enrollment Database (EDB)
- Cost-of-Living Adjustment (COLA) File
- Medicare Adjudicated Claims File
- Medicaid Paid Claims File (where the presence of a crossover claim to Medicaid indicates Medicare coverage)

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

Upon contract award, HMS will work with the state to secure a Data Use Agreement with CMS to obtain EDB data. The EDB data, an extract from CMS' Health Insurance Master Record, include eligibility information for Medicare beneficiaries enrolled in both traditional Medicare and Medicare-contracted managed care organizations. HMS uses EDB data, once available, in all of its contracts where Medicare TPL is performed.

HMS will use the Medicare EDB data to identify dually eligible recipients for whom Medicaid has secondary payor liability. HMS integrates the data into its Medicare data match process to enhance its Medicare Part A disallowance identification and recovery project, Part B identification and billing project, and special recovery projects.

HMS brings Vermont a proven ability to consistently generate Medicare recoveries and cost avoidance. To date, HMS has generated more than **$534 million** in recoveries from Medicare on behalf of state agency clients.

Network of Third-Party Payors

HMS traditionally seeks to include the major carriers operating in a given state in its data match network. It also undertakes extensive and aggressive efforts to identify the maximum number of third-party resources and includes them in its network. HMS identifies these additional third-party coverage resources through the following means:

- Contacting the major municipalities, counties, and private self-insured employers and self-insurance pools in the state
- Working with the appropriate state department
- Conducting research using industry data sources (for example, the National Underwriters' ERISA Database, NAIC health insurer reports, the Judy Diamond Database, and managed care directories)
- Reviewing Medicaid's third-party resource 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 (for example, PBMs and behavioral health plans)

HMS will also research Vermont laws and regulations pertaining to Medicaid reclamation claims. It couples this knowledge with a team of health insurance-trained experts to develop the most comprehensive service available today.

Interstate Data Matches

HMS augments its intrastate health insurance data matches with interstate health insurance data matches, using insurance eligibility files from contiguous or nearby states. These files provide additional third-party coverage information for recipients who may have supplementary insurance coverage directly or through a responsible relative (for example, absent parents) outside of the state. These specialized data matches help HMS identify more third-party resources and recover more revenue for its clients.

Carrier Relations Team

HMS has an experienced, dedicated staff responsible for obtaining, reviewing, analyzing, and assuring the quality of carrier subscriber files for data matches. This Carrier Relations team creates channels of communication with carriers through routine contact and periodic site visits, during which team members obtain the carrier subscriber data and resolve claims adjudication issues.

Through the activities of this team, HMS accomplishes the following:

- Continually adds new carriers to its data exchange network. In the past year alone, HMS has added 23 new sources of eligibility (carriers, PBMs, and TPAs).
- Reengineers existing agreements with health plans to ensure that its billings and recoveries are accurate
- Coordinates with CMS and Medicaid to obtain Medicare eligibility data

Multi-Key Data Match Process

The key to HMS' highly successful revenue recovery projects is a complex series of electronic data matches. These matches will help HMS identify third-party coverage that has not yet been detected. HMS performs many different types of data matches and tailors each individual match to accommodate the characteristics of the source data it uses.

HMS data matches are on a level of technical sophistication that exceeds the capabilities of data match operations within state Medicaid agencies or competing vendors. HMS is able to identify many cases of new third-party coverage because it uses specialized software that produces the highest possible number of accurate "hits" (for example, identifications of eligibility for third-party coverage). Using multiple, successively applied match keys, HMS obtains eligibility information despite data discrepancies that may exist in records for the same beneficiary on various files.

Examples of HMS specialized match criteria include 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
- Other demographic variables of the beneficiary

Although technically complex, multiple match keys are effective tools that help identify the maximum number of third-party coverage, 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 noncustodial parent (NCP) files—a different first or last name, possibly no SSN, or an SSN with a one-digit difference.

HMS' approach overcomes these problems and generates accurate third-party coverage leads despite discrepancies in source data files. As a result, HMS can produce a significantly greater volume of eligibility match hits, resulting in increased TPL recoveries.

r. Create Tables to Edit for Timely Filing Limits

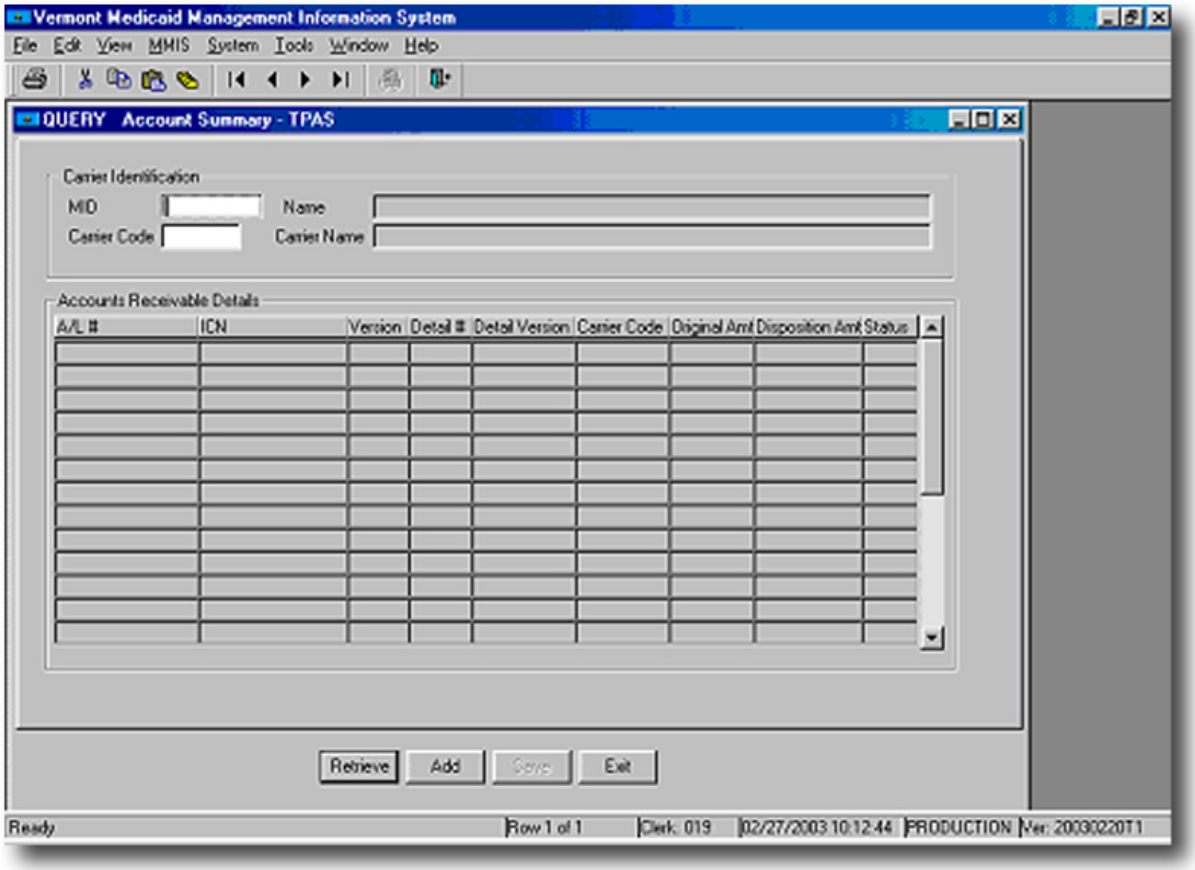
The proposed EDS solution will create a table to edit for timely filing limits by providing the user with access to the Carrier Information - TPIC) window shown previously in our response to "b. Maintain Third-Party Carrier Information on a TPL Carrier File" in this subsection. This

window allows authorized users to maintain information about carriers and other entities paid or billed by the MMIS. The TPIC window displays information about carriers, such as carrier name, carrier city, contact person, and billing media.

EDS will add a Claim Filing Limit field to the TPIC window to enable users to indicate the claim-filing limit for each carrier. The limit will be denoted in number of days. Indicating the claim-filing limit will also help in determining if a claim is too old to be retroactively billed. In addition, by knowing the claim-filing limit of the carrier, we can determine if it is within the carrier's timely filing limits.

s. Add Date of Service on Account Summary Window

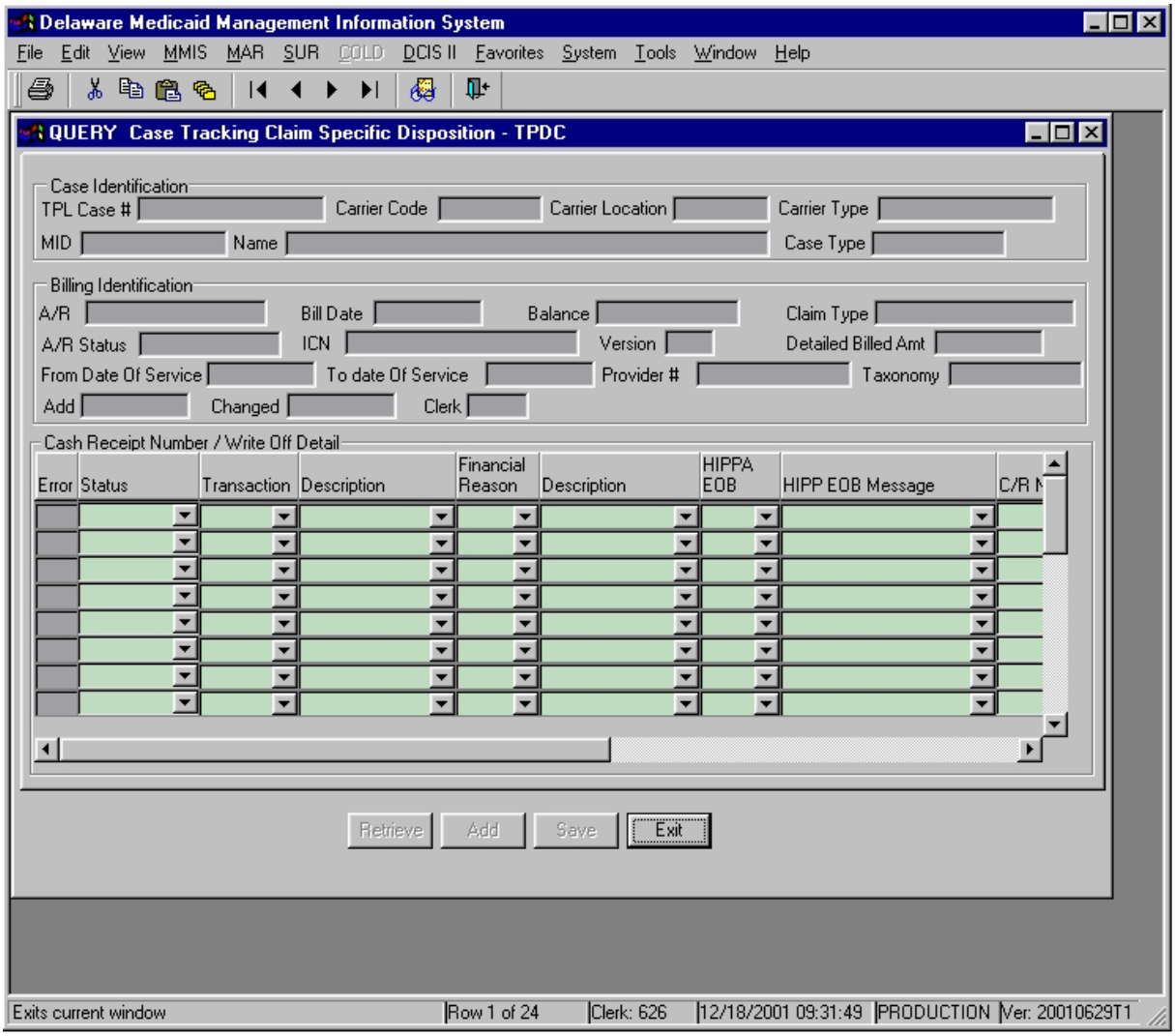
EDS will add the Date of Service field to the Accounts Receivable Detail portion of the Account Summary - TPAS window, shown below.



Account Summary - TPAS window

t. Reverse TPL Cash Disposition Made in Error

Our TPL solution will provide the capability to reverse a TPL cash disposition made in error by allowing users access to the following Case Tracking Claim Specific Disposition - TPDC window.



Case Tracking Claim Specific Disposition - TPDC window

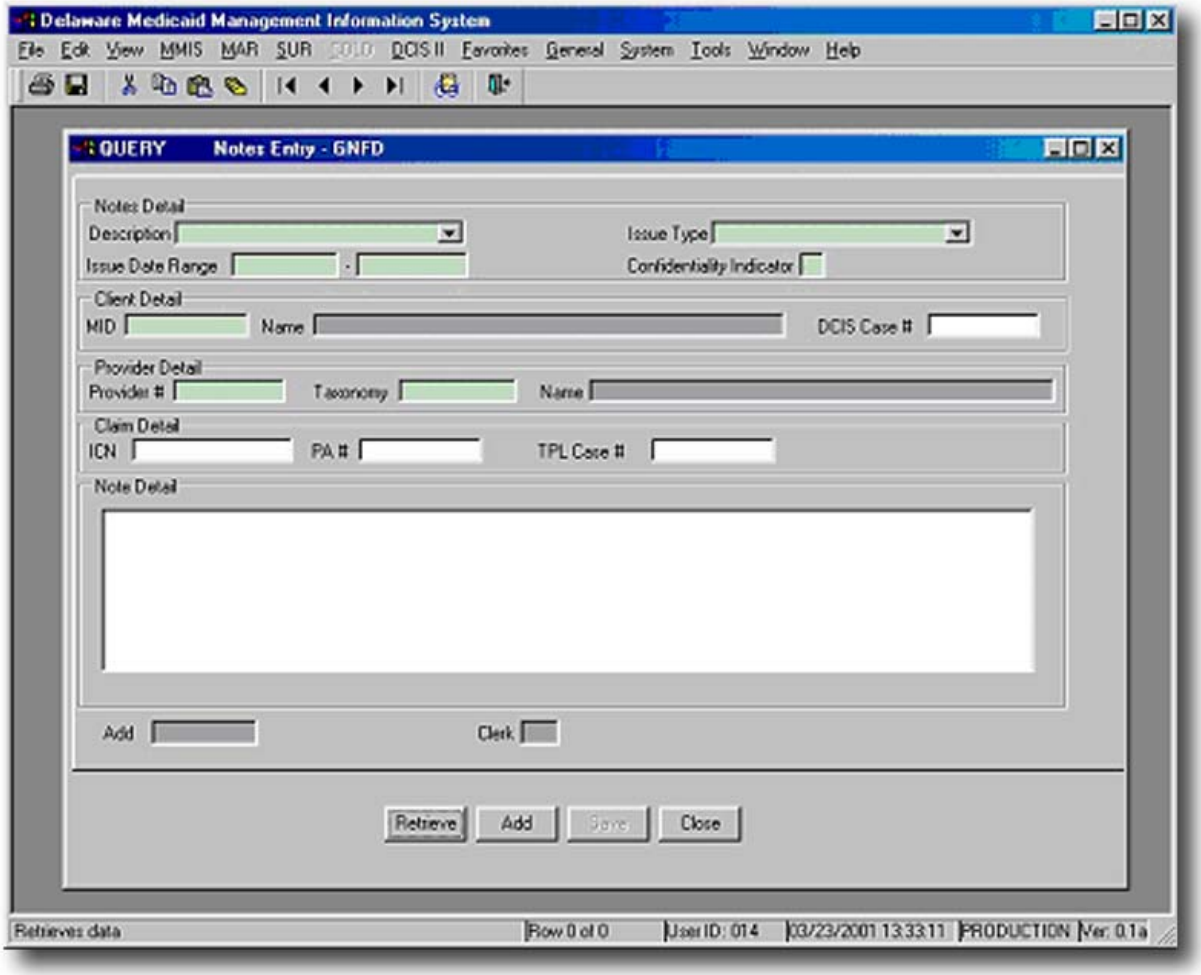
The TPDC window allows the user to delete transactions by updating the Status field. To delete a financial transaction, the user changes the status from ACTIVE to DELETE prior to the weekly financial cycle. Because the deletes are logical deletes, not physical deletes, the system keeps the transactions on the tables for audit trail purposes.

u. Perform Case Tracking Activities

To perform case tracking activities within the MMIS and eliminate the need for Vermont's current FoxPro system, we propose integrating elements currently used in the state of Delaware's TPL subsystem for case tracking. The Delaware solution is a close match to Vermont's requirement for tracking postpayment recoveries caused by health insurance, casualty, and estate claims.

The proposed case tracking system is designed to combine recovery information for a client and carrier combination into a single location for tracking. Windows for case tracking are set up to allow for adding claim and insurance premium recoveries to a case. Our approach to case tracking also provides windows to disposition money received to these recoveries. Upon case setup, the system automatically generates a unique case tracking number for identification.

Our proposed case tracking solution will also accept free-form user notes on the case tracking records by allowing users access to the following General Notes Entry - GNFD window.



Sample General Notes Entry - GNFD window from Delaware MMIS

Through the GNFD window, authorized users view and update notes associated with various functional areas of the MMIS, including client, managed care, and TPL.

By upgrading the Vermont TPL subsystem with the case tracking capability initially designed for Delaware, we will be able to relate members of a case. Once this happens, the user can enter policy information for all members with a single transaction, effectively tying the case tracking information with the current MMIS.

v. Provide Insurance Verification Mechanism and Online Inquiry to TPL Data Files

The proposed TPL solution allows for online inquiry to TPL data files through numerous windows in the TPL subsystem. We will work with HMS to provide an insurance verification mechanism that performs data matching with other government entities and programs, private insurance carriers, and workers' compensation. The insurance verification mechanism will provide prompt and accurate insurance information. HMS will perform the data match and then rely on the knowledgeable OVHA TPL staff to verify the coverage prior to recovery activity.

One of the pivotal elements that contributes to HMS' effective TPL identification is the extensive reach of HMS' insurance data match network. Our proposed solution contains the necessary functions to transmit information to and accept information from outside agencies, including governmental agencies, workers' compensation, and private insurers.

HMS' activity will be integrated fully into our proposed solution. EDS and HMS have collaborated previously to implement file transfers. Our approach to file transfers will allow HMS to use its existing process to become quickly productive, while ensuring that the transfer system is updated with the most current state-specific information.

Our complex match process grades and scores each match to provide for quality matches in the output, thereby eliminating the potential for mismatches. HMS' proven data matching approach will provide accurate and timely insurance information to the OVHA staff for verification.

Outputs

RFP Reference: 2.8.3.3.7, p. 2-176

EDS will meet or exceed the TPL output requirements specified in the RFP. We present our approach to meeting the output requirements in the following paragraphs.

a. Transmit Recipient TPL Resource Information to ACCESS Eligibility Files

The proposed TPL solution enables us to transmit beneficiary TPL resource information to the state's ACCESS eligibility files. We will initiate the transmission when we become aware of any beneficiary insurance coverage during the data match processing performed by HMS or through other TPL subsystem processing.

b. Reports

Our TPL solution will generate the reports specified in the RFP. We present our approach to providing these reports in the following paragraphs.

Audit Trail Report

We will provide audit trails of changes to TPL data through access to the Audit Trail - GNAT window previously shown in our response to “a. Maintain Third-Party Resources by Recipient on a TPL Resource File” of this subsection. This window was developed in PowerBuilder and contains easily accessible, built-in audit trail capability that tracks all modifications on the windows in real-time.

Integrated security protocols ensure that only authorized users can view the GNAT window. These protocols capture the identification number of the operator who modified the client data, the date and time when the change was made, and a snapshot of the before and after of the data field contents. The audit trail report enables state staff to track and monitor the manner in which the data is changed in support of Department of PATH policy.

Insurance Premium TXN Report

We will generate the Insurance Premium TXN Report, an example of which follows, to reflect premiums paid summary and detail. This report provides notification of all insurance premium transactions that generate a payment. The TPL subsystem uses the insurance policy and financial transaction information as input. These transactions are produced in the Generate Insurance Premium Payments transaction that is sent to carriers, clients, or payees. The Insurance Premium TXN Report displays the premium amount, policyholder SSN, and carrier name for the insurance premium payments.

TPLR021V MEDICAID MANAGEMENT INFORMATION SYSTEM PAGE 99,999
RUN DATE: MM/DD/CCYY HH:MM INSURANCE PREMIUM TXN REPORT PERIOD: MM/DD/CCYY THRU MM/DD/CCYY

POLICY HOLDER SSN	CARR CD	CARR LOC	CARR TYPE	COVG CD	CARRIER NAME	PREMIUM AMT
999-99-9999	XXXX	XXXX	XX	9999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	9,999,999.99

INSURANCE PREMIUM COUNT 999,999 TOTAL PREMIUM AMT 9,999,999.99

*** END OF REPORT ***

Insurance Premium TXN report

Insurance Premium Accounts Ledger

The state and EDS currently use the Insurance Premium Accounts Ledger, an example of which follows, to provide current weekly accounts receivable and accounts payable transaction information for each insurance premium carrier account. Payment information is included for payouts and refunds. The original amount of the account and the amount received also are included in the report.

```
FMDR51AB                                   MEDICAID MANAGEMENT INFORMATION SYSTEM                          PAGE  99,999
RUN DATE:  MM/DD/CCYY  HH:MM              INSURANCE PREMIUM ACCOUNTS LEDGER                 PERIOD: FOR MONTH OF  MM/CCYY
CARR  CARR                                                                                                          CARR
 CD   LOC   TYPE  A/L *          POLICY *   CLERK      TXN AMT    BALANCE        ORIG AMT
                  CON                                            CHECK NBR  REC DATE  CHECK DATE TXN    COMMENT

XXXXX XXXX XX 999999999999999 XXXXXXXXXXXXXXX XXX  $,999,999.99  $,999,999.99  $,999,999.99

              999999999999999                 XXX  $,999,999.99  XXXXXXXXX MM/DD/CCYY MM/DD/CCYY XXX XXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                      *** END OF REPORT ***
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Insurance Premium Accounts Ledger report

Federal, State, and Departmental TPL Reports

The proposed EDS TPL solution will meet all federal, state, and departmental reporting requirements by providing the following reports:

- TPL Recoveries Accounts Ledger
- TPL Benefit Recovery Summary
- TPL Cost Savings Report
- TPL Potential Cost Saving Summary Report
- Accounting Summary Report
- Case Tracking System Recoveries Report
- Case Tracking Recoveries by Month

Cost Avoidance Activity Reports

EDS will provide the state with the Accounting Summary Report that reflects cost-avoidance activity. This report will display the following information:

- Summary of the number of avoided Medicare claims and amount
- Avoided other insurance claims and amount
- Recovered claims and amount
- Total net claims and net benefit dollars saved for the state Medicaid program
- Figures for the current month and for the state fiscal year

Interfaces

RFP Reference: 2.8.3.3.8.a-g, p. 2-176

EDS' TPL solution provides for interfaces with each of the following RFP-specified entities:

- ACCESS Recipient Eligibility Files
- Recipient Subsystem
- PBM
- Global Clinical Record
- Government Entities
- Private Insurance Carriers
- Workers' Compensation

The current TPL subsystem provides an interface with ACCESS recipient eligibility files, the recipient subsystem, and the PBM. We understand the importance of ensuring an accurate interface to send and receive data with the various state agencies, in addition to third-party vendors. By having access to our comprehensive experience with the MMIS and the TPL subsystem, you will have an interface approach that is effective and minimizes risk to the state and other vendors.

We will modify the VermontAIM to provide an interface to the Global Clinical Record (GCR) system. We will make this modification before beginning other enhancements. This interface to National Systems & Research Company will include information from the core MMIS, including prior authorization, reference, provider, and claims processing areas. The planned implementation date for implementing this interface is August 2003.

The proposed TPL solution will also provide interfaces for insurance verification with government entities and private insurance carriers. HMS has cross-matching agreements with more than 85 percent of U.S. private insurers and most governmental health programs. We will use these existing agreements and HMS' technology to perform data matches with these private insurers and governmental agencies.

HMS integrates multiple third-party insurers' eligibility files into its TPL Identification and Recovery Program through the following steps:

- HMS creates a production controlled archive copy of the source file and appends a unique identifier suffix to each record. The suffix contains an account identifier, record source identifier, receipt date, and record number.
- The file is preprocessed into a common HMS standard format.

The updated multiple insurer eligibility files comprise HMS' TPL Data Exchange Network to be used in subsequent data matching processes to identify available third-party health insurance covering Medicaid-paid claims.

For the interface with the Unemployment Compensation Division within the Department of Employment and Training, EDS and HMS will work with the division to develop data matching requirements. Upon completion of the requirements definition, we will develop the interface to perform data matching with the Workers' Compensation Program.

To ensure a seemless transfer of the information gained through HMS' data matching activities, EDS and HMS will collaborate to implement file transfer capabilities. We will apply the knowledge and experience gained through implementing similar processes with HMS in other states to develop an efficient file transfer process.

Fiscal and Budget Application

RFP Reference: 2.8.3.4, Amendment 1-1

By implementing a new fiscal and budget application (FBA), the state will gain enhanced query, reporting, and analysis capabilities for financial data. To comply with the state's recommendation, EDS proposes to customize a commercially available product, Business Objects' Application Foundation software, to meet Vermont's specific needs.

Our proposed FBA solution will produce reports comparable to those detailed in Appendix S. Through our FBA solution, the state will benefit from more automated and streamlined reporting capabilities as well as advanced analytic functions. When implemented, the FBA will assist all program stakeholders in assessing the impact of new policies or reimbursement levels. In addition, the tool will enable them to create the necessary baseline of historical information to determine trend or potential program and financial impact of proposed legislation.

In the following subsections, we present our understanding of and approach to completing the FBA enhancement:

- Understanding of the Fiscal and Budget Application Enhancement/Modification
- Approach to Completing the Fiscal and Budget Application Enhancement/Modification

Understanding of the Fiscal and Budget Application Enhancement/Modification

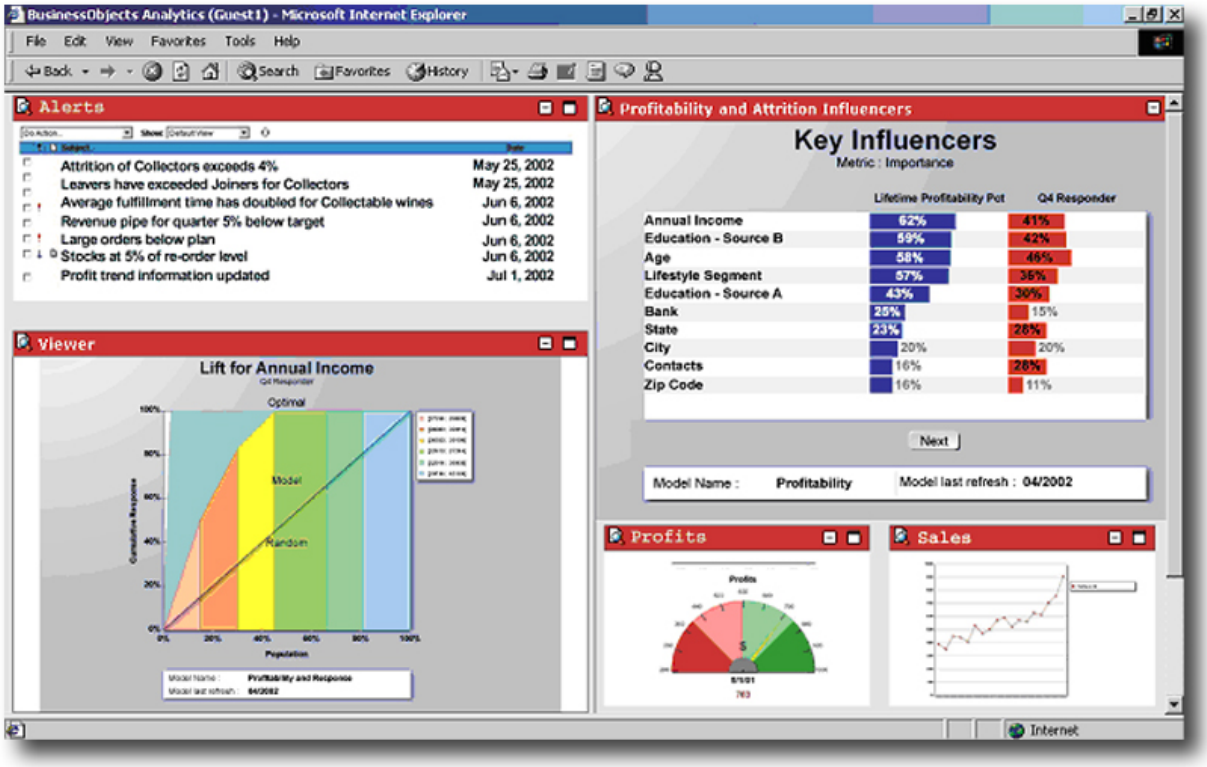
The Vermont-based EDS team, through day-to-day interaction with state staff, has become familiar with many of the state's reporting and analysis processes. We have worked with state staff in designing many of the reports to meet the budgetary and program financial reporting requirements. Now, through FBA, we can take the existing manual processes for developing and generating reports to the next level. We understand the criticality of consistent and accurate reporting, as well as the need for flexibility to meet the ever-evolving state and federal reporting requirements. Our FBA solution will replace many of the manual financial analysis and reporting processes while providing the state with increased analytical power to save time and money.

Through EDS' 21 years of supporting the state of Vermont, we have seen the need for the state to be able to accomplish the following through analysis and reporting processes:

- Ensuring that each program remains on target financially with what has been budgeted
- Monitoring changes in the beneficiary populations
- Analyzing eligibility criteria to assist in program service definitions
- Reporting dollars spent to optimize federal matching

Each of these capabilities will help the state maintain cost-effective state health care programs. The proposed FBA will enhance the ability of the state to efficiently analyze, monitor, and report fiscal information for the Vermont Medicaid Program.

Through the FBA, the state gains a more efficient method of generating the existing reports shown in RFP reference Appendix S. In addition, state users will be able to customize reports and analytic tools to meet the individual needs. FBA users will be able to perform trend analysis, budget estimations, and assessments of point-in-time dollars and how they relate to the budget. Each state-authorized user will have the ability to tailor the type of analysis, level of detail, areas to be analyzed, and the report structure to address individual needs and areas of interest. Application Foundation's robust analytic engine—combined with the MMIS' existing data sources and data extracts from external sources to be identified by the state—will allow users to specify an analytic and the method of output through reports, alerts, lists, or interactive charts and graphs. The following graphic is an example of the dashboard interface that we will customize to include information specific to Medicaid program analysis.



Sample of the Dashboard Interface to be Customized

We will customize the Application Foundation dashboard to provide information such as the following:

Function	Description
Alerter	Displayed when entire Medicaid program expenditures reach 80 percent of budget
Alerter	Exponential growth from one period to another for an individual funding source
Viewer	Graphic reporting weekly draw amounts based on funding source
Viewer	Graphic depicting the total program expenditures for each supervisory union
Influencer	Chart comparing category of service expenditures for current state fiscal year (SFY) to previous.
Influencer	Graphic based on current week expenditures in relation to year-to-date

We will apply our technical experience with BusinessObjects and our in-depth understanding of the Vermont Medicaid environment, the MMIS data, and the data analysis and reporting needs of the state. Together, the Department of PATH and EDS will refine the FBA framework to include appropriate administrative, interdepartmental, and projection financial data to allow for accurate and timely fiscal and budgetary analysis and reporting.

Approach to Completing the Fiscal and Budget Application Enhancement/Modification

We will work with the state to customize the Application Foundation software. By using Application Foundation, in conjunction with MMIS databases and data from other state systems, the state will have access to easy-to-use enterprise analytic applications. To gather data from systems outside the MMIS (such as the state's financial system VISION), we will accept interfaces from other systems and load that data into the FBA. In addition, the scalable architecture and user-friendly Web-based interface of Application Foundation will allow us to deliver enhanced analysis and reporting capabilities to a larger number of state-authorized users.

As with any new customized application, a significant effort is required to implement the proposed FBA solution. We estimate 35 staff months are required for the entire process, including design, development, testing, training, and implementation tasks. The estimated staff required for this project includes:

- Two BusinessObjects developers
- One programmer skilled specifically in Application Foundation
- One programmer skilled in coding batch extract and load programs
- Two post-implementation support staff to provide ongoing user training, system maintenance, and problem resolution

Enhancements/Modifications Manager Sean Daly will oversee the activities and progress of this team to be sure that the FBA solution is implemented on time and within budget. We also will provide pre-implementation user training for state staff so that they can quickly use the system and begin obtaining the benefits.

Our proposed FBA will meet the RFP-specified requirements as reflected in the following table. Immediately following the table, we briefly address each requirement.

Fiscal and Budget Application Requirements Checklist

RFP Requirement	Description	Meets or Exceeds
a	Encompass Medicaid Claims, financial, and eligibility data	✓
b	Contain data elements to produce financial analysis, reports and model expenditure trends by customized queries.	✓
c	Retain claims history by actual amounts paid within a given period	✓
d	Produce identical results regardless of the timing of the query	✓
e	Be updated to coincide with check runs	✓
f	Facilitate easy identification and tracking of claims adjustments	✓
g	Enable accurate and appropriate application of global claims adjustments	✓
h	Treat previously processed claims (e.g., adjustments) as separate transactions	✓
i	Allow users the option of running queries that account for any subsequent adjustments and one-time system payouts	✓
j	Facilitate the formulation of requisite, standard, and ad hoc reports	✓
k	Be accessible to multiple users with varying levels of access	✓
l	Include query capability to develop reports by time period; population; category of service; and so forth	✓
m	Automatically generate selected reports with a scheduling tool	✓

RFP Requirement	Description	Meets or Exceeds
n	Produce outputs in numerous formats, including, but not limited to: • Print • Text file (Options for Comma delimited as well as TAB delimited) • Excel file • HTML	✓
o	Be sufficiently flexible and robust to accommodate the data sets that comprise the reports listed in Appendix S and future fiscal requirements	✓
p	Accommodate a broad array of inputs and outputs	✓
q	Interface with other applications (e.g., MMIS, state's VISION financial system)	✓

Encompass Medicaid claims, financial, and eligibility data—Our solution will work with the existing Enhanced Vermont Ad Hoc (EVAH) database, giving authorized users complete access to data available within EVAH, including eligibility data with historical segments as well as claims and financial data. The claims data encompasses all claim types with both detailed and aggregate data. Financial data pertaining to the Medicaid and state health care programs, including TPL segments, also will be available through the FBA.

In addition to the MMIS and EVAH data currently available, we will work with the state to determine the external data sources that would be valuable. We will then request an extract from those external sources and develop an interface in the FBA to accept the extract.

Contain data elements to produce financial analysis, reports, and model expenditure trends by customized queries—Our solution will provide the state with the tools required to create custom trending reports to measure and track trends, as reflected in the reports listed in Appendix S of the RFP. In addition, the FBA will give users the ability to perform predictive analysis of state and MMIS data, using effective graphics to easily identify trends.

Retain claims history by actual amounts paid within a given period—This function is currently available in the existing Claims Analysis EVAH data model. We accomplish this function by loading one row per version of the claim. Once a claim is loaded into the tables, the row remains unaffected by subsequent adjustments to the claim. This method allows for reporting of point-in-time payment information. The Claims Analysis data model will be accessible to the FBA.

Produce identical results regardless of the timing of the query, such as identifying postpayment adjustments as separate transactions—Adjustments are identified using specific transaction codes. The FBA will have access to all versions of a claim, enabling the tracking of the adjustment process for individual or groups of claims. Further, the FBA will be able to produce identical results regardless of when a query is run, allowing "apples-to-apples" comparisons between figures although the reports may be run on different days.

Be updated to coincide with check runs—We will update the FBA on a weekly basis, in conjunction with the current EVAH cycle updates. This update is synchronized with the MMIS check runs.

Facilitate easy identification and tracking of claims adjustments—Adjustments will be easily identified using specific transaction codes.

Enable accurate and appropriate application of global claims adjustments—One of the helpful features that the FBA will bring is the ability to perform predictive analysis. Users can enter a situation and the system will predict the potential effects prior to implementing the change. For example, if a department is considering a mass adjustment of claims and wants to see either the financial or volume effects of the change, the FBA solution will allow the user to select the set of data and to execute the mass adjustment against the set. The system will perform the analysis and present the projected outcome of the mass adjustment.

Rate increases are another area where the predictive analysis is helpful. When legislative sessions are in the process of determining what type of rate increase or decrease to give certain provider populations, this tool will allow them to enter the different rate change scenarios to see the net effect before they decide to implement the change.

While the state is able to accomplish this analysis and reporting today through manual means, the FBA will speed the analysis process, significantly reducing the time and effort currently required to perform the analysis. We will work with the state to establish predefined groups that may commonly be targeted for this type of predictive analysis. By setting up the groups in advance, we can further expedite the state's analysis process. In addition to using the predefined groups for predictive analysis, users can execute ad hoc predictive analysis sessions.

Treat previously processed claims (adjustments) as separate transactions—The FBA will retain all versions of a claim, treating each version of the processed claim (adjustment) as a separate transaction.

Allow users the option of running queries that account for any subsequent adjustments and one-time system payouts—The FBA will allow users to run queries for subsequent adjustments and one-time system payouts.

Facilitate the formulation of requisite, standard, and ad hoc reports—Through requirements validation sessions, we will work with the state to determine the content and format of requisite and standard reports. On an ongoing basis, our reporting specialists, Ann Markle and Louise Brooks, will continue to be available to assist in the creation of reports for all users. FBA users will also have the capability to formulate ad hoc reports.

Be accessible to multiple users with varying levels of access—EDS will work with the state to determine who is authorized to access the various levels of data and analysis functions. The software's supervisor security feature will use individual user IDs and passwords to control access as specified by the state.

Include query capability to develop reports (report list) by time period (date paid or date of service); population (aid category, program, waiver/non-waiver); category of service (detailed, general, federal) and so forth—The state's users will be able to specify reporting parameters, including the following types of criteria:

- Time period
- Population type
- Category of service (COS) or program

Automatically generate selected reports with a scheduling tool—We will integrate our FBA solution with Broadcast Agent Scheduler (BCA), the existing scheduling tool. The BCA will refresh predefined reports on specified intervals. In addition, BCA can distribute the reports to designated users through either a repository or Web interface.

Produce outputs in numerous formats, including but not limited to print, text file, Excel file, HTML—FBA users will have the flexibility of specifying the output format desired. Export format options include print, text files, Excel files, and HTML.

Be sufficiently flexible and robust to accommodate the data sets that comprise the reports listed in Appendix S and future fiscal requirements—The proposed FBA solution is both flexible and robust. It will accommodate the data sets that comprise the reports listed in Appendix S of the RFP in addition to meeting future fiscal requirements. By building the FBA using industry standard tools, such as Application Foundations, we will be able to accommodate future enhancements. During the Enhancements/Modifications Phase, we anticipate delivering the reports listed in Appendix S in addition to the predictive and analytic functions we have described in this section. We expect that after the FBA enhancement is complete, the state may identify future requirements for the FBA. We look forward to working with the state to accommodate these new requirements through the customer service request (CSR) process.

Accommodate a broad array of inputs and outputs—Our FBA solution will accommodate a wide variety of inputs and outputs, including MMIS claims and financial data, in addition to various interface files provided to us from various state systems.

Interface with other applications (MMIS, state's VISION financial system)—We will work with the state to determine any other applications the FBA must interface. At a minimum, the FBA will interface with the VermontAIM and will accept interface files from the state's VISION financial system. We will build interfaces to accept export files from any additional applications identified by the state.

Contractor Responsibilities

RFP Reference: 2.8.3.4.1, Amendment 1-3

We will meet each of the RFP-specified contractor responsibilities. We will successfully accomplish the following:

- Implement, maintain, and update the FBA
- Provide support (for example, hardware, software, and resources) to refine standard reports and develop ad hoc reports, as requested
- Provide standard definitions for data input elements in concert with the state
- Develop system edits to ensure uniformity and standardization of all data elements
- Provide the capacity to support ongoing report activities

We address each of these contractor responsibilities through our proposed FBA solution described previously in this section.

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b. Acquisition and Utilization of Staff

RFP Reference: 3.2.2.10(b), p. 3-15

EDS is committed to the acquisition and utilization of qualified staff during the Enhancements/Modifications Phase. The work plan contained in the proposal outlines the tasks that EDS will perform and complete during this phase of the project. EDS staff from the local office on Hurricane Lane will be used, as well as experienced staff from the EDS' Technical Support Centre. The proposed staff is familiar with the VermontAIM, HIPAA compliance, redemption, and overall Medicaid operations.

c. Utilization of Staff Resources

RFP Reference: 3.2.2.10(c), p. 3-15

The use of staff resources during the Enhancement/Modifications Phase is represented in the work plan. Implementation of the proposed enhancements and modifications begins October 2003 and goes through March 2005. During the course of this project, EDS has estimated that a total of 543.6 person months will be dedicated to this phase of the project. Under the direction of Barbara Davis, Sean Daly will manage and monitor the performance of EDS staff during the Enhancements/Modifications Phase. Experienced staff dedicated to this phase of the project includes technical staff, managers, and operational staff. Staff will be involved in the following activities during the Enhancements/Modifications Phase:

- Training on project tools
- Developing and monitoring the project work plan
- Developing and maintaining resource, risk, and communications plans
- Writing the Requirements Specification Document (RSD)
- Establishing and maintaining the Project Workbook
- Developing the detailed system design (DSD) document
- Performing systems testing/user acceptance testing and implementing the proposed enhancements
- Developing detailed implementation plan (DIP)
- Writing manuals and procedures

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d. Approach to Infrastructure

RFP Reference: 3.2.2.10(d), p. 3-15
2.9, p. 2-179
2.10, p. 2-184
2.10, p. 2-184

Our Vermont-based team will continue to provide excellent support with no disruption to the state by using the existing hardware and software configuration as well as minimal additional hardware during the Enhancements/Modifications Phase. The infrastructure is a proven and reliable architecture that will ensure the stability of the enhanced system.

Required and Optional Enhancements

We will build on the existing architecture by converting the MMIS from the CA Ingres database to the leading-edge IBM DB2 Universal Database (DB2). By leveraging the experience we gained from our most recent implementation (completed in 2002) of the Delaware MMIS using DB2, we will successfully and efficiently perform this conversion. DB2 will provide the Department of PATH with a more robust and scalable platform for the future. Additionally, this approach will reduce costs by employing the same relational database management system (RDBMS) as is currently used by the Enhanced Vermont Ad Hoc (EVAH).

We will use the HOSTTEST server, with Sun Solaris 9 and DB2 v8.1 installed as a dedicated platform for enhancements and modifications development and testing. During the Enhancements/Modifications Phase, we will use separate hardware to perform required development and testing to support the existing MMIS. By using this approach, we can perform the enhancements with minimal disruption to the MMIS and the Department of PATH.

To accommodate the provider enrollment data integration enhancement, we will modify the MMIS to provide the capability to send mass e-mails to the state's provider community. This innovative technology will enable the state to reduce postage costs and reach providers more quickly than through traditional mailings.

Additional Infrastructure Enhancements

As part of our infrastructure upgrade, we will replace the existing microfilm equipment with the latest scanner technology. We will store and retrieve the scanned images using our current IBM OnDemand software and server. This capability will allow authorized users to view submitted paper claims through our Web interface. By replacing the current microfilm technology with a Kodak scanner, the state and EDS can retrieve claims information more efficiently by using an internal control number (ICN).

For example, when a provider tells a provider services representative that a submitted claim does not match the remittance advice, the representative will be able to immediately view an image of the submitted claim, thereby eliminating the typical research time required today to respond to the provider's inquiry. This will improve productivity in the provider services area, the claims area, and the TPL area, should a claim copy be needed by the state TPL staff. This approach also will allow multiple users to view the same claims information simultaneously.

The use of scanning technology also allows for the possible future use of optical character recognition (OCR) software for inputting paper claims into the MMIS. However, we believe that with the advent of the HIPAA electronic claim standards, we will likely see fewer paper claims in the next few years. As a result, an investment in OCR at this time may not be in the best interest of the state. We leave the door open to future enhancements that could bring OCR to the VermontAIM should we see more paper claims than we currently anticipate.

Required Enhancements and the Necessary Hardware and Software

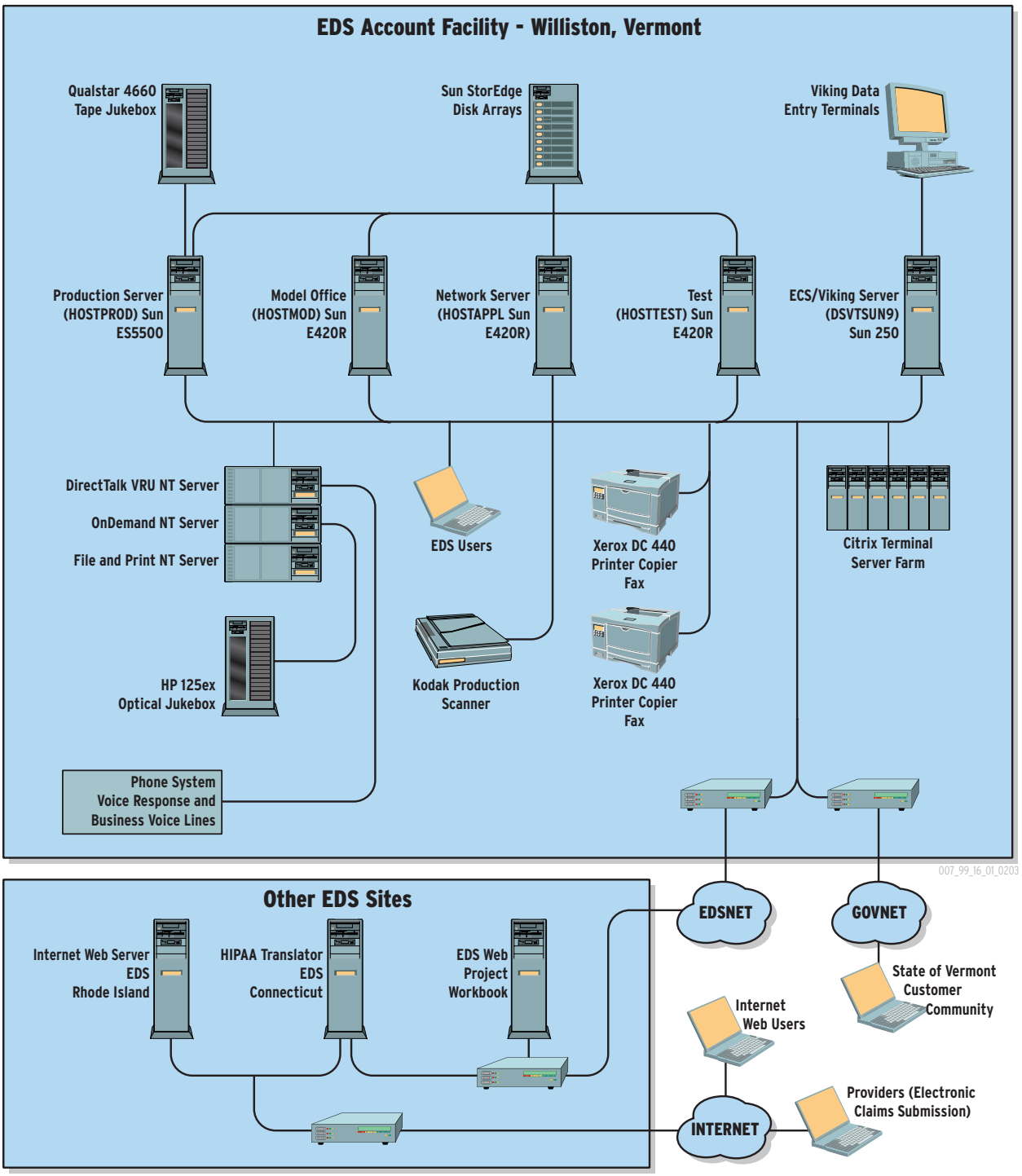
In the following table, we list each identified enhancement and the hardware and software required to implement each enhancement.

Enhancement	Required Hardware and Software
MMIS system modifications	No new hardware/software required
Implement IBM DB2 UDB	No new hardware required
ClaimCheck and ClaimReview software	No new hardware required
Provider enrollment data integration	No new hardware/software required
Internet	Implement on existing HIPAA Web server
Recipient Eligibility Verification System upgrade	No new hardware/software required
Third-party liability subsystem upgrade	No new hardware/software required
Scanner	Implement using new Kodak scanner with existing OnDemand software/server for storage and retrieval

Overall Architecture

The following diagram graphically depicts the future architecture. It builds on the existing and post-HIPAA architecture to include the hardware necessary for the required and optional enhancements.

An Enhanced Architecture Primed for the Future



This architecture will provide the state of Vermont with the technology needed to meet its future MMIS needs.

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e. Approach to Facilities and Infrastructure Acquisition and Installation

RFP Reference: 3.2.2.10(e), p. 3-16

By maintaining operations at our existing site in Williston, Vermont, we can eliminate potential disruptions caused by moving account operations or the hardware infrastructure. By retaining EDS as your fiscal agent, you will avoid the risk and time required to test, validate, and approve the hundreds of build-out tasks required of another contractor.

We also have procured additional space within the existing facility, which is separate from the current account space. We can use this area during implementation of enhancements and modifications to further eliminate any interference with existing operations. If facility upgrades are required, the EDS real estate department will assist in the procurement of additional space or the reconfiguration of existing space. Additionally, we will continue to use the current infrastructure as described in the "Approach to Infrastructure" subsection of the "Work Plan and Schedule (Takeover)" section to provide ongoing operational support for the MMIS.

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f. Approach to System Security, Backup, and Disaster Preparedness

RFP Reference: 3.2.2.10(f), p. 3-16

EDS uses a methodical, consistent approach for our customers, regardless of the phase of the project on which we are working. As such, we will apply the same effective security, backup, and disaster recovery procedures to the Enhancements/Modifications Phase as to the Operations Phase. In this subsection, we present an overview to EDS' approach to security and contingency planning to demonstrate our commitment to meeting Vermont's data access and recovery needs.

We demonstrated our disaster recovery capability by restoring the MMIS at our recovery site and performing critical functions in the first quarter of 2002. The disaster recovery exercise was extremely successful. We are confident in our ability to restore the Vermont MMIS in the event of a disaster.

Security Administration

We recognize your need to monitor our security administration activities to determine whether features built into the system are effectively used. We fully support your intent to conduct periodic reviews of our processing sites and monitor the required periodic password changes. Upon obtaining state approval of our security plan, we will continue to maintain the plan throughout the life of the contract, ensuring continuous effectiveness to protect the MMIS.

System Access Controls

Data access is controlled through software called NIS by Sun and Computer Associates' Autosys product. This sophisticated security software controls access to data, logs any attempted violations, and provides the ability to terminate requests that would breach security. Additionally, the software allows users to access and share authorized data. Only the technical manager or designated personnel may approve access to data.

The following table presents the information security features that protect Vermont's MMIS data.

Information Security Features

NIS Security Databases with CA-Unicenter support	
Logon ID database	Contains an entry for each user. The logon ID identifies the user and status, whether the user is an OVHA, vendor, or EDS employee. Validates all user information upon entry to the system. Allows common user identification for all application environments using the logon ID. Matches the logon ID with appropriate logon ID record and password. Uses passwords controlled by authorized network personnel.

User Access

Our network security management team issues user IDs to all OVHA and EDS staff needing access to the EDS network and to the VermontAIM applications. The EDS security administrator processes all state authorization user ID requests. The IDs restrict access to the network itself, to individual VermontAIM environments, and to the specific applications within each environment that the user has authorization to access.

The IDs have associated passwords, which users will be required to change every 30 days. Should the need arise to change a password unexpectedly, the user can request a new password from the network security help desk, or a member of the EDS or OVHA leadership can authorize the issuance of a new password to the user. In the event that the user should no longer have access, an EDS or OVHA leader can immediately request that the user ID be deleted.

Users' access to data is controlled by their access to specific applications. If the user is not a member of the systems teams who are supporting the MMIS, the user's access is restricted to production applications only. Most users have read-only access to the applications for which they have authorization. The Department of PATH and EDS will designate the staff members who can access operational readiness testing functions.

System Support Access

Systems teams that are supporting the VermontAIM have broader access to the files and software libraries needed to fulfill their responsibilities. These team members include both the on-site and off-site programmers who are part of the project staff and the technical teams who support operations in Vermont.

Only the team members who actually support the VermontAIM can access those files and programs. In addition, those team members are restricted to the functions and files for which they have authorization from the systems manager.

Online access is also restricted to read-only access for systems support team members to view file and library contents, but not to modify them. EDS grants separate access to selected individuals for actual modifications of volumes and libraries solely for data management functions. These functions consist of such tasks as creating backup volumes on a routine basis, restoring them as requested by the EDS project leadership team, and moving files to different volumes as needed to gain additional space. We also grant access to selected individuals for production code promotion. All production program libraries are protected, and documented promotion procedures are in place to ensure that only approved changes are made.

EDS continually researches and reviews innovations in security tools and features. We work with security development companies to perform analyses and beta testing at our data security lab in Plano, Texas. EDS corporate recommendations influence industry products and allow us to have ready access to the most recently developed and best security tools that protect your critical business data.

Integrity and Confidentiality

Our underlying philosophy in the area of program integrity is to focus on your requirements for business operations. For the Department of PATH, our employees will abide by state and federal rules and policies related to confidentiality and program integrity through strict adherence to security and audit trail processes and procedures. Moreover, they sign agreements to that effect. No one on our staff releases information without authorized consent. This compliance ensures that all data is adequately protected. For more information on the confidentiality of the MMIS and related data, please refer to our response to RFP requirement 2.6.10 in the “Privacy, Security, and Confidentiality” subsection of the “Work Plan and Schedule (Operations)” section.

Backup and Recovery

Protecting Vermont information is a fundamental goal for both the state and EDS. Avoiding potential disasters while building data processing reliability begins with comprehensive planning. The resulting configuration for on-site processing, off-site processing, and backup facilities emphasizes advanced communications linkages; data centers; and reliable, alternative processing contingencies.

We recognize the significance of effective backup and recovery procedures to quickly restart operations and reconstruct the system and affected data in the event of an unexpected interruption in the delivery of MMIS services. EDS has a disaster recovery plan that incorporates procedures to follow for backup and recovery situations, including the following examples:

- A major disaster in which the central computer installation and resident software are destroyed or damaged
- A problem that is system or application dependent, resulting from network failure, software error, or operational errors in which one or several days' processing is invalid, making data on the master tables also invalid
- System downtime caused by the failure of one or more components of the MMIS application software

Our procedures maximize system availability for MMIS users. EDS distinguishes unplanned system downtime for failure and error recovery from scheduled downtime for maintenance. Our approach to maximizing system availability includes the following features:

- Scheduling routine preventive maintenance activities to occur during nonworking hours
- Maintaining access to corporate resources for replacement servers, monitors, terminals, and controllers should the equipment fail
- Maintaining service agreements with our major vendors, such as Sun, which enables us to receive rapid on-site service should one of our pieces of equipment fail
- Rerouting network communications as needed to bypass component failures

Localized, preventive activities allow us to avoid most potential disasters and establish up-front corrective action plans to minimize or correct problems before operational capacity is lost.

EDS meets the RFP requirements for backup and recovery by following stringent disaster prevention practices, and developing and strictly adhering to the proven disaster recovery plan. EDS establishes disaster prevention procedures for on-site processing, such as complete daily backups of server data. Standard backup procedures require keeping copies of software with the backup files at a secure off-site disaster recovery location.

The primary off-site location selected to process MMIS data in a disaster situation is at EDS corporate headquarters in Plano, Texas. EDS maintains all of the necessary hardware, software, and network infrastructure to restore operations of the Vermont MMIS as quickly as possible in the event of disaster. EDS periodically performs recovery testing and full recovery. Furthermore, the EDS disaster recovery data center is equipped with uninterruptible power supply systems, which allow operations staff to perform controlled shutdowns of equipment.

In the event of a software failure, our computer operators can restore libraries within hours. The operators restore and verify the integrity of each file and database before allowing user inquiry and update.

EDS' unique position in the marketplace enables us to provide superior backup and recovery solutions. We have the computing resources and available personnel to respond quickly. We develop custom contingency plans for each component of the MMIS with the approval and guidelines of the OVHA. EDS has a reputation for responding to customer needs in unusual circumstances and an outstanding record of providing uninterrupted service in the MMIS market.

Our approach includes appropriate disaster prevention recovery plans, corresponding actions, assigned responsibilities, and comprehensive support resources. These full disaster prevention and recovery plans include procedures for EDS on-site and off-site processing locations and the EDS backup processing site. Our disaster recovery activities, discussed later in this section, facilitate the fastest possible recovery from unavoidable disasters. We provide you with the right resources and apply the necessary procedures to correct the problem and meet contractual performance requirements.

Disaster Preparedness

As described in our response to RFP requirement 2.6.15 in the "System Reliability" subsection of the "Work Plan and Schedule (Operations)" section, we have developed a Business Continuity and Disaster Recovery Plan that will quickly restart operations and reconstruct the system and affected data in the event of an unexpected interruption in the delivery of MMIS services. We have established the system security portions of a Security Plan and a Contingency Plan to instruct the Department of PATH in responding to a system emergency or the unavailability of the system. Our work plan contains details about our proven and thorough business continuity planning process and how it applies for you.

EDS will continue to provide the high standards of security, backups, and disaster preparedness that we provide you with today. As part of this preparedness, we commit to performing the following:

- We will maintain the exceptional level of privacy, security, and confidentiality required by federal and state regulations, which we perform today. As new regulations arise, we will implement them in a fashion similar to the recently completed HIPAA activities.

- Physical site and data security, which safeguards the operation and integrity of the MMIS, will continue to be as integral a part of our solution as it is today. We already use swipe card readers on all entrance doors and keypad electronic locks on the server room doors. We will continue to use motion detectors that cover key areas and access points. In addition, we will continue to use temperature and humidity alarms in the server room and use the services of a security company to monitor the alarm system.

- The MMIS audits all online and batch update transactions, either through database audit processes or batch reporting processes.

- The MMIS includes appropriate checkpoint/restart capability and other features to ensure reliability and recovery.

- We will take complete daily and weekly backups that are housed off-site for all software and operating programs, data, files, and the database. Restoration of lost data currently takes at most two days (much less depending on the size and complexity of what needs to be recovered) for data that must be recovered from off-site backups.

- The EDS Vermont team maintains a Business Continuity and Disaster Recovery Plan to facilitate restoring normal operations of the MMIS in the event of a catastrophic or other serious disaster event. EDS maintains a recovery site with adequate infrastructure to restore critical operations such as claims processing and paying providers.

- We currently perform disaster recovery drills twice per year. We last demonstrated our disaster recovery capability by restoring the MMIS at our recovery site and performing critical functions in the first quarter of 2002. The disaster recovery exercise was extremely successful. We are confident in our ability to restore the Vermont MMIS and perform critical processes within two days of a declared disaster.

On-Site Processing

Our extensive backup capabilities for MMIS files, programs, and system software prevent your sensitive data from being lost in case of a disaster. EDS provides data backups that are consistent with the OVHA's business requirements. We will perform complete daily and weekly backups of each server. Standard backup procedures require keeping copies of software with the backup files at an off-site disaster recovery location. This precaution provides access to data if the corruption of a file dictates the need for its restoration or if an on-site disaster occurs.

Backup Facilities

EDS has assigned a secure disaster recovery area (DRA) for all VermontAIM backup files, programs, system software, and documentation in case of loss of primary data through an unforeseen disaster. The primary off-site location selected to process MMIS data in a disaster is in Plano, Texas. EDS maintains all necessary hardware, software, and network infrastructure to restore operations of the Vermont MMIS as quickly as possible in the event of disaster. EDS periodically performs recovery testing and full recovery. The EDS disaster recovery data center is equipped with uninterruptible power supply systems, which allow operations staff to perform controlled shutdowns of equipment.

We maintain current copies of files through the use of daily backups of MMIS databases and files, ensuring that the DRA contains the most current copies of MMIS databases, files, and code. Our system administrators back up MMIS programs and system software daily and weekly. We store these backups in the off-site DRA. The environment in the recovery area is climate controlled to protect the integrity of the data, and all media are periodically checked for readability.

Periodically, we review the existing procedures for MMIS operations backup and recovery, verify their completeness and accuracy, and add new procedures to complement the data center and LAN components that the procedures should include. Should discrepancies appear in the procedures for the existing MMIS, we work with you to define requirements for modifications to the procedures and to establish priorities for the completion of these modifications.

Service Interruption Recovery Plan

If disaster strikes, we are ready. Our business recovery procedures provide guidelines for restoring service at any site that supports the VermontAIM. EDS' recovery procedures prepare our personnel to replace sites, equipment, networks, and documentation as rapidly as possible. The EDS leadership team verifies that the plan meets requirements for federal certification, EDS' corporate standards, and your requirements for routine error recovery and disaster recovery procedures and plans.

We provide you with a detailed service interruption recovery plan that identifies all databases, files, data sets, scripts, and prerequisites. Our plan includes all elements necessary to conduct business after a worst case scenario that results from operator error, system failure, or a disastrous event at our data center or at the Vermont fiscal agent facility. The plan includes the following elements for all sites where we conduct MMIS operations, store data, or both:

- Checkpoint and restart capabilities
- Retention and storage of backup files and software
- Backup hardware for the servers, LAN, and data-entry equipment
- Network backup for telecommunications
- Specific steps to continue operations in the event of a component failure at potential failure points with corresponding backup operating procedures
- Detailed file backup plan and procedures with the following components:
  - Off-site storage of crucial transaction and master tables
  - Detailed schedule for backing up critical files and rotating them to off-site storage
  - Maintenance of current system documentation and source program libraries at an off-site location

Upon receipt of your approval of the plan, we will maintain the plan in the then-current form throughout the term of the contract. In the following subsections, we describe our approach to assessing levels of disaster and administering the plan.

Disaster Recovery

The service interruption recovery plan identifies all individuals and their responsibilities in terms of specific recovery actions. These individuals identify files, libraries, system software, and critical data sets. They also establish a schedule for duplication to restore VermontAIM data up to the date of physical loss at the data center or at EDS' Vermont fiscal agent facility. The service interruption recovery plan also includes names of individuals responsible for executing the recovery and formatted instructions for recovery procedures.

The plan also considers the data center resources necessary to recover data and continue processing. Such resources include server sizing, total tapes, total disk space, and total execution time necessary to recover data and process Medicaid claims. This consideration enables our data center staff to accurately assess the VermontAIM resource requirements in the event of a disaster and to arrange for recovery and continued processing at the backup data center.

Disaster Assessment

Prompt and accurate damage assessment is essential to a complete recovery in the event of a disaster. EDS defines three levels of disasters.

Three Levels of Disasters

Level One Disaster

Disrupts processing for less than 24 hours. Prompt assessment by experienced technical staff establishes the tasks necessary to return to normal operations, ensuring service can be restored within 24 hours.

Level Two Disaster

Disrupts processing for 24 to 72 hours. Again, proper assessment is critical and allows management to allocate the necessary resources to restore normal operations.

Level Three Disaster

Disrupts processing for more than 72 hours. A level three disaster is the result of a catastrophic event and causes all processing activities to be relocated through the use of backup facilities. Once the disaster has been assessed as Level Three, key personnel identify the materials needed to recover from the disaster, place an order to have them retrieved from off-site storage, and ship the data to the backup facility where restoration can begin.

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The state benefits from planning for a complete and timely recovery for all three levels of disasters.

As a result, in the event of a disaster, all databases and activity files necessary for restoring service are identified. We also establish a duplication schedule with the DRA.

On-Site Disaster Recovery Procedures

In the event of a disaster at EDS' Vermont fiscal agent site, we can resume the image and entry function by transferring it to another site. Vermont-specific image and entry functions are maintained on disk and can be quickly shipped to another EDS Medicaid project site. Normal production rates are maintained with overtime and additional shifts at these alternate sites.

We further promote a timely return to accurate processing by temporarily transferring necessary data entry personnel to an alternate site. Claims adjudication and other manual functions will be performed at the temporary processing site in Pennsylvania or may be performed at another EDS facility in the region, such as New Hampshire.

In the event of a telecommunications failure, data entry equipment features allow data to be stored on disk until service can be restored. Server backup processes are used to back up data. These backup files are created daily and weekly, allowing files to be restored to their most current version in the event of processing difficulties. This ability to restore files on a daily basis reduces the chance that data will require re-entry.

The following table presents an overview for the plan we will follow in the event of a disaster at the EDS Vermont fiscal agent site. The plan is designed to recover full operational capability for the VermontAIM.

Key Elements of Project-Site Service Interruption Recovery Plan

Task	Description
Provide Disaster Recovery Management	EDS provides management and controls the disaster recovery process at the local facility and processing center. The management team monitors the disaster recovery process to completely and accurately recover data files according to the specified time frames.
Notify Disaster Recovery Team	The EDS management team notifies appropriate managers, programmers, and disaster recovery specialists that a disaster has occurred. Disaster recovery specialists address recovery for facilities, communications, and telecommunications.
Notify the Department of PATH of Disaster	EDS' management team notifies the Department of PATH that a disaster has occurred and continues to keep the Department of PATH informed throughout the recovery process. The management team describes the disaster, the steps being taken to resume operations, and the impact on the provider community.
Assess Scope of Disaster	Our managers and programmers carefully evaluate the extent of the disaster and begin planning for recovery of operations. We assess the scope of the disaster, rating it as a Level One, Level Two, or Level Three disaster.
Service Interruption Recovery Plan	Our managers and programmers review the service interruption recovery plan and use it to guide the recovery process. Managers assign specific personnel to the tasks detailed in the service interruption recovery plan to provide for the complete and accurate recovery of VermontAIM operations.
Estimate Recovery Time	Our managers estimate the time required to recover VermontAIM operations. This estimate depends on the scope of the disaster and the tasks required for recovery. We inform the Department of PATH of the scope of the disaster and the time required for recovery.
Provide Temporary Image and Entry	We provide temporary processing, as well as entry of claims and file update transactions, at our assigned backup facility. This temporary arrangement allows EDS to continue the imaging and entry of claims while recovering the local facility.

Task	Description
Locate Alternate Facility	The management team identifies and secures a temporary backup facility. We maintain project management at this temporary facility until the existing facility can be repaired.
Obtain Equipment	The EDS management team obtains the necessary equipment from our hardware planning group or local vendors to resume operations at the temporary facility. In an emergency situation, EDS can obtain equipment in short periods of time, as our contracts with equipment suppliers include provisions for disaster-level reaction.
Establish WATS and Local Lines	EDS contacts the telephone company to install wide-area telephone service (WATS) lines and local telephone lines at the temporary facility. These lines allow the continuance of provider relation services and telecommunications at the temporary facility.
Relocate and Install Equipment	Our hardware planning group receives and installs equipment at the temporary facility. Equipment from office furniture to computer processing equipment is installed to make the temporary facility totally operable. We relocate our various groups to the temporary facility.
Mail Room	We install mail room equipment and organize the mail room in preparation for claims receipts. Once the mail room is set up, we can process all mail and claim receipts at the temporary facility.
Operations	We install all data processing equipment necessary for operations at the temporary facility. Data processing equipment includes printers, a minicomputer, disk packs, tape drives, and terminals for data entry and online access.
Systems	We relocate all systems personnel to the temporary facility. The systems personnel can then maintain MMIS operations from the temporary facility.
Claims Processing	We relocate all claims processing personnel to the temporary facility. Claims processing personnel include all data entry, mail room, and adjudication personnel. The relocation of these personnel allows claims entry and processing to be performed at the temporary facility.
Provider Relations	We relocate all provider relations personnel to the temporary facility. Provider relations personnel resume services to Vermont provider inquiries.
Begin Operations	The disaster recovery process is complete at this point; EDS performs all VermontAIM functions at the temporary facility.

Our comprehensive disaster prevention and recovery approach assures you that all reasonable measures will be taken to continue VermontAIM processing in the event of a disaster at the local processing center. Within 48 hours of a disaster, our goal is to have processing restored in a backup data center.

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g. Design and Development Approach

RFP Reference: 3.2.2.10(g), p. 3-16

Our approach to the design and development of the Enhancements/Modifications Phase will be based on the project management tools that have already proven to be successful in the large-scale implementations we have conducted for you and numerous other EDS customers. To ensure the reliable, on-time implementation of enhancements and modifications to Vermont's MMIS, our team will complement the approach you already know today with the latest generation of tools and methodologies. In addition, to support the design and development of all enhancements and modifications, we bring a team with the experience, processes, and capabilities to ensure your success in achieving Vermont's goals and objectives for this phase of the project.

Supporting the best practices for project management and control established by the Vermont team is EDS' deep corporate commitment to maintaining and continually improving a methodology architecture that supports all EDS projects, including all design and development projects. Many of the templates, tools, and practices adopted as best practices for Vermont were selected from the larger body of EDS' project management and system development methodology architecture, which is incorporated in EDS' Global Solutions Management System (GSMS). Our team will enhance the practices you know today by adopting additional GSMS best practices to be applied to the Enhancements/Modifications Phase.

GSMS takes the best of EDS' corporate methodologies and combines them into a single proven, documented, and repeatable project management approach. GSMS is a common global solution process set for application/information engineering and operations work. GSMS is a system of global processes, based on existing corporate methods and tools and incorporating the best practices EDS uses around the world. The scope of GSMS is operational and comprises software application development, implementation, and support. GSMS comprises multiple corporate methods that are integrated into one process set:

- Project Management Version 2.3 (PM 2)
- Systems Life Cycle Version 3 (SLC 3)
- Production Support Method
- Enterprise Testing Method
- Requirements Determination Process (RDP)
- Estimating

We will use the flexible GSMS approach to globally and consistently increase our process and organizational maturity to ensure that we continue to sustain superior execution in our delivery to you. We look forward to applying the best of project management and control methodologies to support the reliable, timely operations that meet the state's expectations. For more information on these methodologies, please refer to our discussion of GSMS in the "Project Management and Control (Enhancements/Modifications)" subsection of section "J. Enhancements/Modifications Narrative."

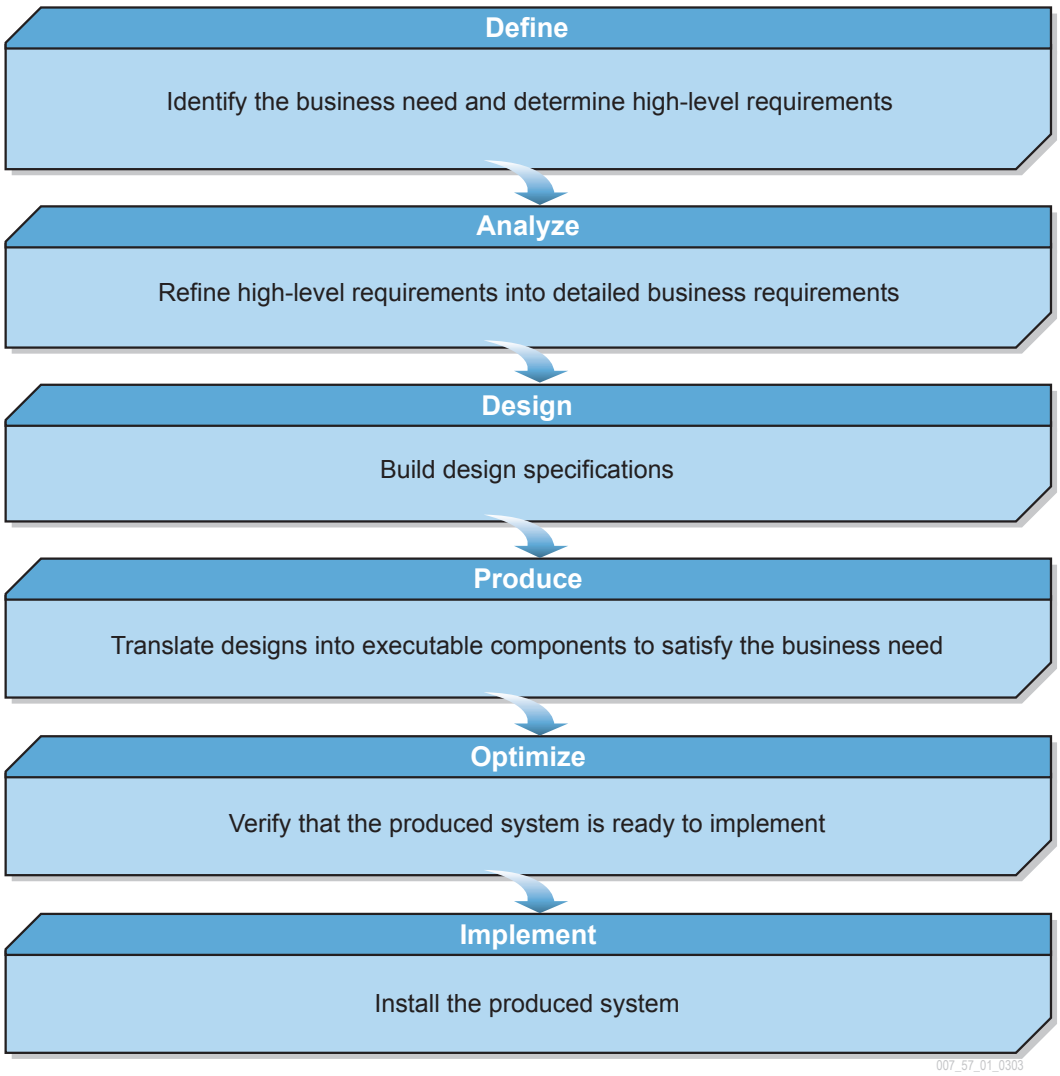
System design and development involves two components: managing and communicating the status, issues, and changes impacting the Vermont MMIS; and the actual system development methodology used to deploy and change components of the VermontAIM to specifically address your needs. We will follow our proven, regular communications plan and channels to ensure prompt, effective communication between you and the Vermont-based team. For most of our design and development projects, the key component of the GSMS methodology that we will apply is SLC 3.

SLC 3 is a highly comprehensive tool set that systematically addresses every step needed for successful systems development and deployment. The methodology offers information regarding major work to be done, work products to be produced, and participants involved in a programming engagement. The methodology does not replace the experience or skills of a programming team, but it serves as a stimulus for decision-making inherent to programming. Our approaches to design and development that you are accustomed to today are based on the SLC 3 methodology. However, we have adapted each process to meet your specific needs.

SLC 3 presents a complete and integrated approach to supporting the Vermont MMIS design and development tasks. Because our systems engineers and leadership team are trained and experienced in the use of this methodology, you can continue to expect on-time, accurate implementation of system change requests and system enhancements.

The SLC 3 methodology emphasizes your involvement throughout the process and supports iterative development, client/server computing, and advanced human-computer interface design. It also offers practical guidelines and procedures, proven techniques, and suggested templates and examples to help the programming team successfully complete MMIS design or development projects. Each system change involves completion of the following activities within each of the six SLC 3 tasks depicted in the following graphic.

SLC 3 Tasks



SLC 3 establishes standards and control methods that provide our technical staff with guidelines for designing, developing, testing, implementing, and maintaining system changes.

The first four phases will be repeated as a group to produce intermediate results for your verification, approval, and validation. This phased repetition, or iteration, helps focus on different areas and requirement levels as the system evolves. The last two phases are performed when the iterative portion is complete. Each phase includes individual plan and test components. Additionally, all phases have an underlying component, called manage, which enables continuous monitoring and control of process resources and results.

Benefits

SLC 3 offers many benefits that help EDS provide superior products and services to you:

- Aligns information technology with your business requirements
- Strengthens communication with you
- Delivers all EDS best practices
- Reduces risk by applying iteration to verify and validate intermediate results
- Facilitates process customization to meet your unique needs
- Reinforces consistent, repeatable processes and therefore allows continual improvement
- Facilitates continual improvement as EDS develops, field tests, and deploys new practices and technologies throughout the company
- Establishes a common basis for communication with you and throughout EDS
- Assists the project team in blending its requirements with engineering discipline and proven best practices from across EDS
- Provides a foundation for increasing systems engineering process maturity
- Reduces time and effort expended on retraining personnel about processes when the personnel transfer from one team to another

Our SLC 3 methodology will provide you with a formally documented, top-down, structured, repeatable, and measurable approach to managing and controlling system maintenance and modification activities. SLC 3 is a proven methodology that offers low risk to the state. In addition, SLC 3 documents EDS' collective experience of the best ways to conduct specific phases of system design and development projects.

While the SLC 3 methodology provides an overall approach to the design and development function, the actual day-to-day approach for design and development in the Enhancements/Modifications Phase will consist of specific steps, which we detail under the following headings:

- Develop Requirements Specification Document
- Develop Detailed System Design
- Perform System Development/Testing

These steps will ensure careful planning and implementation of changes to the MMIS. Each step will be successfully executed with the team approach you are accustomed to today. During the last 21 years, we have successfully worked together on many projects of all sizes. As we embark on the enhancement portion of this project, we will continue to provide you with our committed, experienced staff that you have come to know over the years. In addition, we will leverage the many talents of other EDS team players to ensure the success of every enhancement you select. These enhancements will continue to bring your MMIS into the forefront of advances in the health care industry.

Develop Requirements Specification Document

The key purpose for developing the Requirements Specification Document (RSD) is to use it in discussing our understanding of the project requirements in requirements validation sessions. This communication is critical to assure that the enhancements and modifications meet with your satisfaction. We will develop an RSD for each enhancement project.

This step requires our teams to work together to ensure that each party understands the approach and requirements for each enhancement. Our experience with you will be an asset in this process since it enables us to better understand your direction and preferences. As we review the RSD with you, it is our intent to manage the scope of each enhancement to provide the most comprehensive solution that maximizes the dollars you have allocated. After we have met to review the RSD, we will submit a final version of the document to you for final approval.

Develop Detailed System Design

After the requirements validation sessions, we use state input to develop the Detailed System Design (DSD) document. The DSD is a comprehensive, detailed requirements document that incorporates state input from the requirements validation sessions.

Some of the information provided in a DSD includes:

- Requirement overviews
- Definition of inputs and outputs
- Layout definition and detail
- Listing of interfaces with other areas of the MMIS
- Specific features
- Documentation of processes
- Process flows

Sign-off on the DSD indicates that the state and EDS have full understanding of the requirements of the change and assures that the enhancement satisfies your expectations.

Perform System Development/Testing

With all this planning and state approval behind us, the systems engineers are ready to begin the development work. This effort begins with establishing test and production environments and developing test plans in standard formats. We then submit the outline and sample contents for state review and approval and then follow up with the System Test Plan itself. Once the System Test Plan is approved, we begin construction.

During construction, we install, modify, and enhance system components. We perform system tests and document test results. The state then has the opportunity to review and approve test results.

The final effort in this step is creating or updating documentation. We do not consider the change complete until associated documentation reflects the changes. We will submit updated documentation to you for review and approval.

Perform System Conversion

If a conversion is required, such as the recent EVAH conversions, we will construct the required conversion programs, unit test the conversion process, and perform a preliminary conversion. The results of this preliminary conversion are submitted to the state for review and approval.

Prepare and Conduct User Acceptance Testing

User acceptance testing and operational readiness testing processes verify that the enhancements as installed for Vermont are ready for production processing. The state will work with EDS to perform tests that demonstrate that the enhanced MMIS is ready to process all inputs, price claim records correctly, meet reporting requirements, use a properly functioning data communications network, and back up files properly.

Operational readiness testing includes a volume test with several days' worth of production capacity claim records volumes to demonstrate that the MMIS and our fiscal agent staff are prepared for full production. In addition, our operational readiness testing will include a pilot test of actual claims processing in a full operational environment through the check request process. We will also demonstrate and verify physical plant security, data security, and fire/disaster prevention and recovery procedures.

Following the testing, we will submit an Operational Readiness report to the state for review and approval. We then prepare an Acceptance Test Resolutions document and submit user acceptance test results to the state for review and approval. Your acceptance of these results indicates that the implementation effort can begin.

Walkthroughs and Joint Reviews of Deliverables

Walkthroughs and joint reviews with designated and authorized state staff of deliverables and test results are an integral part of our quality approach during the Enhancements/Modifications Phase. Walkthroughs of test results serve the state by:

- Providing an opportunity for the state to gain insight as to how our testing will verify operational readiness for implementation
- Facilitating understanding, answering questions, and expediting the deliverable approval process
- Determining your satisfaction and approval or concern with the output

Our work plan details our approach to providing walkthroughs of the deliverables, as well as test data and systems to be tested. The work plan also details our communication with you for the review of contract deliverables and for the review of operational readiness (demonstration) test results. Deliverable and test result walkthroughs occur in addition to the regularly scheduled status meetings with the state.

These comprehensive steps, in conjunction with our SLC 3 methodology, provide an effective process for all design and development to occur in the Enhancements/Modifications Phase of the contract.

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h. Implementation Approach

RFP Reference: 3.2.2.10, p. 3-16

A key component of a successful implementation and project operation is maintaining control over the scope of work to be performed under the contract. Based on the RFP, our proposal, and the specifications in the Detailed System Design, we will have a mutually agreed-upon scope of work, including processing capability, performance, and required beneficiary and provider interaction and communication. However, we fully anticipate that there will be system and processing changes dictated by you, state legislation, or CMS.

Since these changes may occur during the Enhancements/Modifications Phase and subsequent to final approval of the DSD as well as throughout the contract, we propose the use of our proven change management/change control process to manage the implementation of these requests without adversely influencing the ongoing operation of the MMIS.

As described in the response to bullet (a): "Project Management and Control Methodology" in Section J: "Enhancements/Modifications Narrative," the joint Change Control Board will oversee the implementation of all change control requests by approving, modifying, or rejecting requests and then prioritizing each request. The Board will consist of key members from both your organization and ours with the authority to make change request decisions. The Board will also oversee our approach to implementation of all design and development changes.

The Board monitors project progress and resolves implementation issues at an operational level. The Change Control Board uses status reports to determine whether a requested change is within scope of the RFP, proposal, and contract. The status reports also provide information to determine the need for changes, the program risks associated with implementing or not implementing a change, and the priorities for changes. The Board approves changes occurring outside of the agreed-upon scope of work or requests additional research before making a decision on a requested change. Minutes to the Change Control Board meetings are published to the Project Workbook.

As the Enhancements/Modifications Phase progresses, the Change Control Board will serve as a clearinghouse for recommended and required changes to the MMIS. The Board will review proposed changes against the RFP, proposal, and the RSD and weigh change criticality against the risk of implementing a change in the base system. The Board can take any of several steps:

- Deny the change based on lack of need, high risk, out-of-scope request, or cost to implement.
- Approve the change as within the scope, to be implemented as part of the base enhancements and modifications, and to be operational on the operations start date. The Board will prioritize, schedule change implementation, and assign resources to accomplish this change in the required time frame.

- Approve the change as outside of the project scope, to be implemented as part of the base enhancements and modifications, and to be operational on the operations start date. The Board will mutually agree on the cost to state for the change, prioritize, schedule change implementation, and assign resources to accomplish this change in the required time frame.
- Approve the change as within the project scope, but to be implemented as part of ongoing systems operations after the operations start date. The Board will prioritize, schedule change implementation, and assign resources to accomplish the change by the scheduled release date.
- Approve the change as outside of the project scope, but to be implemented as part of the ongoing systems operations after the operations start date. The Board will mutually agree on the cost to the state to change, prioritize, schedule change implementation, and assign resources to accomplish this change in the required time frame.
- Request additional information upon which to make an informed decision. The additional information may include number of beneficiaries affected, number of claims affected, number of providers affected, additional description of the change or the process, or the cost to make the change. The Board may set a date for the information to be furnished.
- Reprioritize a change request based on other change requests. Just like you, we have a finite amount of resources assigned to the MMIS project. Situations may occur where more change requests than resources (either us to implement or you to test and approve) are available to implement the changes. In these cases, the Board will be responsible for reprioritizing a change in relation to other changes that may have higher or lower importance, risk, cost, or resource requirements.

The Change Control Board will meet according to a mutually agreed-upon schedule. We propose that the Board initially meet every two weeks. After the implementation, we propose that this schedule change to once per month.

i. Testing Approach

RFP Reference: 3.2.2.10(i), p. 3-16

We have many years of Vermont-specific experience developing test work plans and schedules to ensure the quality and accuracy of all requests for enhancements and modifications. Continuing your relationship with us offers the added benefit of focusing on enhancements and modifications rather than acclimating to a new vendor. Our proven approach to testing involves thorough unit and system testing in our model office environment for all modifications to the MMIS software or files prior to promoting the changes to the production environment. This model office environment runs on a separate platform from the production environment, allowing us to evaluate the impact of any changes without actually affecting any existing processes or programs. Our staff of experienced systems engineers and business analysts adheres to a testing approach that meets your high quality standards.

We have an established work plan for the scheduling and implementation of all enhancement or modification requests. Our team follows the same steps, regardless of whether the request is for an enhancement or a modification to an existing function. However, the type of request influences the complexity of the testing required. For example, our test plan for a change request to modify an edit would not be as involved as the test plan for creating a new financial report.

We have handled a variety of requests and have the resources and experience to handle the wide-ranging variety of requests from the Department of PATH. For example, we have received and met the Department of Dental Health's change request to modify an existing edit to limit extractions of an erupted tooth or exposed root to tooth numbers 1 through 33. In this case, our test plan for the dental edit only involved entering claims using the procedure code for extractions for a tooth in both categories and reviewing the results.

We can also accommodate more involved requests, such as an enhancement request for a new financial report, as in the case of the Financial Summary – General Assistance Program report. This report lists expenditures of services paid under funding source C for beneficiaries considered dual eligibles where general assistance vouchers for emergency services were used.

Implementing a new financial report involves creating a report, entering claims where General Assistance (GA) vouchers are applicable, setting up recipient and reference files for GA voucher payments, running a weekly financial cycle, and verifying both the claim data and the report data. In all cases, EDS' understanding of the current system and processes allows us to provide a more thorough testing approach and better identify how changes to one area can affect another area.

We recently established an in-house work group that meets every Wednesday at 9 a.m. to review all Plogs and CSRs to ensure the requests are supported with clear documentation of the change to be performed, an effective date if applicable, and the impact the change will have on the customer or provider community. In addition to reviewing the validity of the request, this team decides what provider notification, if any, is required.

This team consists of a business analyst (BA), the systems engineer responsible for backup duties for the week, a member of the claims team, a member of the provider services unit, and the systems manager. By including all of these areas, we carefully consider all relevant issues that could affect processing integrity. Should any questions arise during these reviews, our policy is to contact the appropriate state personnel for verification of state policy or clarification of your request.

The following is a description of the life cycle of a CSR/Plog.

CSR/Plog Life Cycle

Step	Description
1	A request is generated. The request can originate from a variety of sources, either internal or external.
2	A written request on a CSR/Plog request form is presented to the Wednesday work group for review of requirements and identification of issues for resolution. To determine if a CSR or Plog should be created, the work group asks if the work to be performed involves a new process, window, or report or if it involves a modification to existing code. This group reviews all the documentation and discusses what needs to occur to meet the request. Some of the concerns that are considered include the amount of time needed, verifying that all current documentation is in order, ascertaining if the policy is clear, and determining if there is an effective date associated with the request work before a schedule and estimate can be given. The system manager approves the change and determines who will be assigned the task.
3	Once a decision has been made that all the documentation is in order and approval has been obtained, Cherie Bergeron, the systems manager, signs the request. A BA then enters the new request into the tracking system under the appropriate subsystem, where a tracking number is assigned to the request. The request is then sent to a systems engineer for an estimate of time to complete the request. If it the request is a Plog, Cherie will assign the request to a systems engineer and determine the priority.
4	If the request is a CSR, the BA enters the estimated time, changes the status to HOLDA, and gives the systems manager a copy of the CSR along with an approval cover letter to be presented to the customer at the weekly fiscal agent meeting for discussion, signature, and determination of priority.

Step	Description
5	Once approval is received, the assigned SE commences work on the request. When the coding has been completed and unit tested, the status is changed to TEST status and is deemed ready for the BA to set up a test plan along with test cases that will be processed through the model office and reviewed for accuracy. Test results may be shared with subject-matter experts (SMEs) for verification of accuracy when appropriate.
6	When test results are positive, we schedule a walkthrough between two systems engineers and the tester to verify that the change was implemented as requested and that testing scenarios were appropriate and sufficiently extensive. This walkthrough also allows for discussion of reference file changes, documentation updates, and provider notification to be issued as the changes are promoted to production. Once the status of the CSR/Plog has been changed to production status, the BA sends out an e-mail with a Microsoft Excel spreadsheet detailing the CSRs/Plogs promoted to production for that week.
7	We store the CSR/Plog requests along with the test plan and results for future reference.

The Vermont-based team will agree on all test cases that validate system functionality, including reports and software. Testers will evaluate and document the actual results for each test case, and this information will be reviewed by the state. The Department of PATH staff can address any questions or concerns to the appropriate tester involved.

We evaluate test results by providing the test cases, test description, and expected and actual results for each agreed-upon test plan for all subsystems. Information available to the state for review at any time includes displays of computations, special reports, input data, expected output/outcome, and actual output or outcome. If any discrepancies are identified, we will discuss them with you and make the necessary corrections.

We will also document test case results. If system modification is needed, developers will take the necessary steps to make appropriate corrections. We will communicate all system modifications with you and deliver a modification testing work plan. Our team will perform thorough testing, including unit, subsystem, and system integration tests to ensure that the VermontAIM properly performs these functions:

- Interfaces with all other systems
- Processes and pays claims appropriately
- Performs all types of system updates
- Produces all types of reports and other outputs

We emphasize the importance of communication throughout the testing process. As such, we will conduct weekly test meetings to keep you informed of current testing activities. Additionally, we will provide detailed documentation, such as test case scenarios, expected test results, and test schedules. We commit to working closely with you to identify any additional documentation that may be required.

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j. Operations Approach

RFP Reference: 3.2.2.10(j), p.3-16

Our approach to operations during the Enhancements/Modifications Phase is to have two experienced teams—one devoted to operations and one to enhancements and modifications—who will work side-by-side during 2004, when both operations and enhancements and modifications projects will be in progress. In 2004, these teams will coordinate their efforts to meet two key objectives:

- Uninterrupted service excellence to the state, providers, and recipients in ongoing fiscal agent operations
- The on-time implementation of enhancements and modifications that further improve service to Vermont Medicaid stakeholders

Both of these teams bring extensive Vermont Medicaid experience. These team members have supported Vermont in operating the VermontAIM for the past 10 years, transitioning to managed care (including the development of the PC*Plus* managed care network), and operating the successful Enhanced Vermont Ad Hoc system. In addition, these team members have developed and supported the Quality Improvement Process (QIP) that has successfully implemented nearly 50 projects to improve service excellence for Vermont.

Separating Leadership Responsibilities

The Operations and Enhancements/Modifications teams will have separate key leaders who will focus on the separate tasks. Client Delivery Executive Barbara Davis and her team of key managers will continue running operations. Enhancements/Modifications Manager Sean Daly will be responsible for the daily operations of the enhancements and modifications team. Sean has seven years of experience with Vermont MMIS-based systems and has supported the tristate HIPAA project. Sean will be 100 percent dedicated to the enhancements and modifications project with a separate team reporting to him. This allows Barbara to focus on the many and varied demands of everyday operations.

Coordinating Team Efforts

Although responsibilities will be clearly delineated, **both teams will work with the understanding of their common objectives and interdependence.** Representatives from both teams will participate as appropriate in requirements validation sessions. They will work closely together throughout this part of the project, attending common status meetings and communicating regularly to ensure their efforts are properly coordinated. Barbara will play a key liaison role between the two teams, providing her input and insight to Sean as he starts the project and assigns subject-matter experts (SMEs).

Protecting the Integrity of Operations

Coordination between projects will be especially critical as the teams determine how to share valuable SMEs. **We will carefully protect the integrity of ongoing account operations in assigning SMEs from the operational team to support enhancements and modifications**. We will backfill any operational SME positions required to support the Enhancements/Modifications Phase with experienced personnel from EDS' U.S. Government Leveraged Information Services organization. This approach has proven successful for Vermont in the current Health Insurance Portability and Accountability Act (HIPAA) remediation project. Personnel in our Leveraged Information Services centres know Medicaid and can step in to fulfill responsibilities for ongoing operations as required.

Minimizing Operational Change

Additionally, **we will minimize change during 2004 when these phases overlap by continuing our operations efforts as they are today—using established processes and experienced personnel.** This approach minimizes change, allowing the team to focus its extra energy on coordinating efforts for the enhancements and modifications. We will ensure that key processes, such as change control, are performed using consistent methodology so state personnel supporting both operations and enhancements and modifications will do so in the same manner.

This approach to coordinating efforts between the operations and enhancements and modifications teams in 2004 will lead to smooth operations and the successful implementation of enhancements and modifications. For more specific details on operations, see section "I: Operations Narrative."

k. Approach to Relations With State Personnel, Providers, and Other Stakeholders

RFP Reference: 3.2.2.10(k), p. 3-16

As we work with the state to implement the mandatory and optional enhancements and modifications described in RFP section 2.8, frequent, open communication with the Medicaid program's providers and other stakeholders is absolutely essential. Many of the enhancements and modifications will affect state business processes as well as provider and other stakeholder relations with the program. EDS understands the impacts better than any other potential vendor due to our detailed knowledge of both the Vermont Medicaid Program and the state's processes.

A practice of open and regular interaction with state personnel, providers, and other stakeholders is a key ingredient to maintaining the solid foundation on which the MMIS operates and can continue to grow to meet the business needs of the state. The members of the EDS team consider themselves part of your team and are committed to maintaining both structured and informal interactions with the Department of PATH, providers, and other stakeholders to ensure the smooth implementation of enhancements and modifications to support the evolution of the Vermont Medicaid Program.

Open Communication and State Approval of Enhancements

As we evaluate the scope of work for all enhancements and modifications, the full involvement of the Department of PATH will be necessary to move toward a new MMIS model that supports Vermont's business needs. We will seek and gain the approval of the Department of PATH as we begin to work on the enhancements and modifications. By defining points of input and specifying contacts during this process, we will continue the open communication we currently have with the state through e-mail and phone calls (voice mail).

We will also continue to use the S-Log system. This system was developed in 1993 by the Vermont-based team as a tracking mechanism for nonelectronic, written correspondence received from the state that requires our action. When such correspondence is received, it is entered into the S-Log system and assigned a sequential number by our administrative staff. The document is photocopied and the original filed with the S-Log documentation. The S-log sign-in sheet lists the recipient of the document, the date it was received at our facility in Williston, the date on the document itself, the name of the individual sender, a brief description of the documents (for example, rate changes and procedure code additions/deletions), and a section to enter a response date if required. Copies of the document are then distributed to the appropriate manager or team member to respond to the request.

Each week during our regularly scheduled fiscal agent meeting, we inform the state of our progress, any testing that has occurred, and the results of this testing as the enhancements are implemented.

Provider Focus Groups

As we move into the training and testing phase of the enhancements and modifications, the provider community will play an important role. As the mandatory enhancement of ClaimCheck and ClaimReview is implemented, the potential exists for providers to experience denial of claims or decreases in reimbursement for services that are currently paid. We have had great success in the past in using provider focus groups for testing new functionality and enhancements. We expect that provider focus groups will continue to supply candid, useful feedback regarding the effect of the change. Any feedback we receive will be communicated to the state during the weekly fiscal agent meeting.

An example of our successful use of provider focus groups occurred during the implementation of the Provider Electronic Solutions software. Providers representing each individual billing claim form were contacted to submit test claims. This allowed the providers a complete walkthrough of the new software prior to its release and helped us test each phase of the electronic claim submission process. We will continue to communicate information to providers through the *Advisory* newsletter, remittance advice banner pages, e-mail, and special mailings when necessary. As the Web enhancement progresses, providers will be able to view progress and additional information online.

Provider Association Meetings

Our provider representatives are actively involved with several provider associations throughout the state, including Vermont Patient Accounts Managers (VPAM), the Healthcare Finance Managers Association (HFMA), and Bi-State Primary Care Health Partners. Our provider representatives attend scheduled provider association meetings to assist with billing concerns or explain upcoming changes and modifications. These meetings are the ideal place for presentations regarding upcoming changes. Our provider representatives will use these forums to inform providers about enhancements and modifications as they move toward completion.

Consistent Points of Contact for Other Stakeholders

We have a full understanding of the relationships required between EDS and other vendors supporting the many Medicaid programs. To ensure that no disruption of service occurs, we have established several points of contact with whom other stakeholders can communicate. These individuals have become subject-matter experts to these stakeholders. Solid relationships between stakeholders and points of contact have evolved based on the commitment, trust, and efficiency demonstrated by our team members in addressing stakeholder concerns.

EDS Points of Contact

Area Description	Point of Contact
Contract compliance—overall	Barbara Davis
HIPAA compliance—overall	Chrissie Racicot
Pharmacy benefits manager contractor	Cindy Littlefield
Recipient benefit counselor	Chris Haskins
Global clinical record contractor, technical	Bob Randall
CMS	Louise Brooks
BusinessObjects support for the Office of Vermont Health Access (OVHA) and the Department of Developmental and Mental Health Services (DDMHS)	Louise Brooks
BusinessObjects support for other state entities and the EDS staff	Ann Markle
Drug manufacturers	Chris Dapkiewicz
Banks	Cherie Benoit
Office of Investigations, Office of Inspector General	Cherie Bergeron
Medicaid Fraud Unit	Judy Isham
Vermont Program for Quality in Health Care	Cindy Littlefield
Anthem Health Care (state audit reports)	Ann Markle
Legislature regarding changes and impacts upon MMIS	Cherie Bergeron
Ombudsman's office	Niki Holton
Vermont Patient Accounts Managers	Barbara Jackson
Healthcare Finance Managers Association	Chris Haskins
Bi-State Primary Care Health Partners	Valerie Lewis
Community Mental Health Centers	Chris Haskins
New Hampshire/Vermont Strategic HIPAA Implementation Plan (NHVSHIP)	Sarah Johnson
New England Medical Equipment Dealers (NEMED)	Chris Haskins

Through the years, the Vermont-based team has established many solid relationships with other stakeholders by recognizing the importance of consistent communication with our point of contact employees. These continued relationships will ensure uninterrupted service for all programs.

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I. Use of Subcontractors

RFP Reference: 3.2.2.10(l), p. 3-16

We are excited to be the prime contractor for the Department of PATH's MMIS Core Claims Processing Takeover. We have served as prime contractor on many large-scale, multiple-subcontractor Medicaid projects, and we have the local experience necessary to manage subcontractors. If we implement our proposed optional enhancements for the third-party liability (TPL) subsystem, we will use one subcontractor, Health Management Systems (HMS), to provide ongoing TPL data matching services. This best value solution will continue building on our firm foundation in Vermont, using results-oriented teaming partners who bring world-class employees and solutions to benefit the state and Vermont residents.

HMS is a pioneer in applying information management techniques to enhance client recoveries and reduce program costs with recoveries of more than $1.2 billion in Medicaid funds. HMS, a Medicaid TPL service contractor since 1985, has served as a TPL contractor for health and social service agencies in 28 states and the Centers for Medicare and Medicaid Services.

Client Delivery Executive Barbara Davis will serve as focal point for all work performed by subcontractors. **We accept full responsibility for subcontractor activities and will be the state's single point of contact.** We will measure quality and reimburse subcontractors only upon satisfactory delivery of a product. Quality is measured by producing timely deliverables, exceeding expectations, and satisfying the state with the work we perform. In addition, we will ensure that any subcontractors with access to data will adhere to the privacy standards established by HIPAA for the performance of business associates. Barbara will meet with the state to share status on subcontractor work as needed and will meet regularly with each subcontractor partner to discuss tasks, performance, and any issues the state or EDS identifies.

We include a statement in all subcontracts stating that we will monitor the subcontractor's performance on a regular basis and terminate the contract if they do not meet deliverable requirements or do not deliver quality products and services. For example, we currently have in place a process whereby Barbara and the leadership team review the weekly and monthly TPL data matching reports for accuracy and completeness. During a monthly status call with the subcontractor, we review the results and discuss any open issues or concerns. We also use the meeting as an opportunity to advise the TPL subcontractor about any state or legislative changes that may affect the TPL data matching process. We give a 30-day termination notice to noncompliant subcontractors that are unable to correct deficiencies. We ensure that the vacancy will not affect the state and the provider and client communities by carefully managing the selection of a new subcontractor and the transition period.

A subcontractor may not terminate or change its relationship with us without prior approval as specified in the contract. To avoid unnecessary project interruption, we will work with the state's legal and contracting staff to obtain all necessary approvals before replacing the subcontractor.

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m. Cost Containment Mechanisms

RFP Reference: 3.2.2.10(M), p. 3-16

Cost containment mechanisms save dollars that are critical to the Department of PATH in fulfilling its mission. As economic challenges and budget pressures increase, cost containment mechanisms become ever more critical in helping the state serve its needy population. As a result, we take seriously our commitment to identifying opportunities to contain costs.

EDS has an established history of supporting the state in identifying cost containment mechanisms. For example, **we recently implemented J-codes as a measure that will save the state $350,000 every year.** We celebrate with you that this savings can be channeled back into the program to help make up for budget shortfalls.

In this section, we propose cost containment mechanisms that feature the specialized skills of subcontractors who bring unique expertise in pharmacy benefits management and disease management. These subcontractors are:

- **Heritage Information Systems (Heritage)**, a pharmacy benefits management company that performs clinical management and pharmacy auditing services for some of the largest payors in the country, including 13 Medicaid states
- **TrestleTree,** a privately owned company developed to provide a fresh approach to disease management that reduces costs of care by identifying target populations with laser accuracy, investing the time of health professionals, documenting the individual life/health story of each person identified with the disease-state, and providing focused intervention to influence the pharmaceutical choices made by the patient

Both of these subcontractors have established records in achieving quantifiable cost savings for their clients. For example, Heritage's service offerings have offered the following savings opportunities:

- Return on investment for retail pharmacy audits of more than six to one
- Recovery of seven to eight percent of all home infusion therapy/durable medical equipment (HIT/DME) dollars spent by the Plan

Within one year of receiving TrestleTree's disease management services, the company's first client reduced its medical claims cost for participants by 42 percent—a first-year return on investment (ROI) of 2 to 1.

We provide further information about potential cost containment mechanisms and the subcontractors that we propose to work with in providing these offerings in the following sections:

- Heritage Pharmacy Benefits Management
  - Retail Pharmacy Audits (Heritage)
  - HIT/DME Audits (Heritage)
  - Implementation Plan for Heritage Services
  - Heritage Organizational Overview
- TrestleTree Disease Management
  - Overview of Pilot Evaluation Project (PEP)
  - Implementation Plan for TrestleTree Services
  - TrestleTree Organizational Overview

Heritage Pharmacy Benefits Management

As the Department of PATH works to increase the state's control over fiscal agent and program expenditures, addressing rising prescription drug costs will be key. A pharmacy benefits manager with a proven record in Medicaid can offer significant support in developing cost savings mechanisms.

EDS selected Heritage because of its proven record of cost containment in the pharmacy benefits arena. Additionally, Heritage brings experience in serving Medicaid populations in 13 states.

Heritage services can provide the following benefits:

- Identify fraud, abuse, and waste in the drug program
- Support the recovery of fraudulent payments
- Reduce or eliminate future fraud, abuse, and waste by the sentinel effect of pharmacy audits
- Identify overpayments relating to infused and injectible medications, services billed in association with the administration of HIT, and DME items
- Improve provider education through immediate feedback on the specific criteria, claim, and clinical issues that result in a recommendation for approval or denial of a drug claim
- Reduce administrative costs in the PA area by quick response and reduced need for manual support
- Place more drug classes on prior authorization and screen for more clinical issues while handling only denials at the state/fiscal agent help desk

We provide further detail about the Heritage offerings for cost containment in the following sections:

- Retail Pharmacy Audits
- Home Infusion Therapy/Durable Medical Equipment Audits
- Heritage Organizational Background

Retail Pharmacy Audits

Fraud and abuse have been prevalent in the third-party pharmacy benefit system since its inception. As the industry and its payment mechanisms evolve, so do the methods of fraud and abuse. **Today, a fraudulent claim can be generated, submitted, and approved for payment in a matter of 15 seconds.** With virtually 100 percent of prescription claims being processed online, most human intervention has been removed from the adjudication process, and the pharmacy benefit is largely unmonitored. Combined with most plans' decisions to forgo explanation of benefits (EOB) forms for pharmacy benefits, the pharmacy payment system is more prone to undiscovered abuse than other types of health care fraud. As a result, pharmacy programs must audit if they wish to manage pharmacy benefits.

Some payors are interested in realizing immediate returns on their audit investment while others are more interested in the long-term benefits of an established sentinel effect in their network. This sentinel effect is achieved when providers realize that they put themselves at risk by defrauding a particular payor and either stop committing fraud or focus their fraudulent activities on other payors who are not actively auditing. Pharmacists are more likely to engage in fraudulent or abusive billing systems when there is no audit program in place.

> *According to statements taken by Heritage auditors in a particular fraud case in Ohio, the president of a small pharmacy chain was quoted as telling his staff to "stop submitting bogus claims to a third-party agency for which Heritage had started auditing and to start defrauding another organization which had no audit program in place."*

Heritage's program meets both these short-term and long-term objectives. Our direct-mail audit program identifies potentially fraudulent pharmacies and begins to establish a sentinel effect. On-site audits bring immediate returns in the form of fraud and abuse recoveries or recoveries for compliance violations. Compliance violations usually take the form of inadequate records, documentation shortfalls, or subtle manipulation/gaming of the system. While compliance violations may not always constitute fraud, they represent loss to the payor and are recoverable.

Heritage is prepared to be as aggressive as the state desires in identifying both noncompliance and fraud. Your financial returns will be directly related to how aggressive you want to be in addressing identified discrepancies. The combination of Heritage's pharmacy auditing technology, proven audit methodologies, and on-site audit experience will maximize the return on the state's audit investment.

Phase 1: Set-up

Heritage's ranking program profiles each pharmacy in the network, calculating an array of statistics, standard deviations, and other markers for each pharmacy. The program then electronically compares profiles to those of known fraudulent providers. This approach allows Heritage to target the providers more likely to have engaged in fraud or abuse and minimizes the audits of pharmacies where there is likely to be no fraud. The ranking process allows Heritage to spend its client's audit dollars wisely, that is, on providers from whom recovery is more likely.

The following graphic illustrates a typical ranking. The stores are listed by total risk index and each marker is color coded for the individual provider based on the number of standard deviations from the network mean.

Typical Ranking of Fraudulent Providers

Each network pharmacy is profiled using numerous quantitative "program-metrics" that are calculated at the store and network levels.

Number of Standard Deviations from Mean:	Color:
More than 3	
More than 2, less than 3	
More than 1, less than 2	
More than the Mean, less than 1	

	A	B	C	D	E	F	G
	150000	1000	2.2	77.2	671.22	27.5	2
	7000	85.99	51.6	73.2	888.58	30.1	1.
	29000	85.9	73.2	66.3	594.29	41.3	1.
	5000	127.17	55.6	85.1	1430.66	44.4	1.
	4000	131.58	24.3	127.4	608.57	45.9	2
	89000	100.59	61.5	64.2	1625.98	31.8	1.
	13000	74	57.4	68.1	463.73	30.9	1.
	245000	52.9	48.2	65.3	851.74	20.5	
2889672MI	199000	63.12	57.5	48	985.08	24.4	1.
2502020MI	143000	55.93	51.7	58.4	747.73	23.1	1.
3029138MI	87000	62.75	56.9	59.1	542.26	24.1	1.
3349010MI	74000	57.96	53.5	67.1	767.82	25.1	1.
1774295MI	47000	52.48	62.3	64.6	483.96	20.3	2
2570941MI	44000	93.07	21.9	73.6	900.29	23.2	
2859109MI	26000	67.36	56.7	68.7	532.11	24.6	1.
3513082MI	6000	75.93	70.2	52.7	398.65	32.1	1.
3513940MI	370000	51.73	52.4	58.9	685.26	20.7	1.

Using quantitative program metrics, the system profiles each network pharmacy and helps auditors focus their efforts on pharmacies with a greater likelihood of fraud.

The top-ranked pharmacies are tentatively selected for audit and a list of pharmacies is forwarded to the state for approval. This set-up phase generally takes about 30 days from the time that Heritage receives viable data.

Phase 2: Direct Mail Audits

To maximize audit exposure, Heritage implements a direct-mail audit program that involves an EOB-type mailing to members. Much like the pharmacy-ranking program, the direct-mail system selects members whose profiles are consistent with those used as unwitting vehicles for pharmacy fraud. Approximately 50 such beneficiaries per pharmacy are selected to receive audit letters.

Heritage's professional mailing explains to the beneficiary that an audit is in progress and asks the beneficiary to review and verify a list of selected prescription claims that were billed on his or her behalf. The letter includes full-color images of most prescription drugs billed, so patients can confirm that the drug they received looks like the drug pictured. This capability allows Heritage to identify product-substitution schemes, brand/generic-switching, and phantom billings.

Audit Response Form

"Any" Insurance Company
Audit Response Form

Pharmacy: **ABC Pharmacy**
123 Main Street, Anytown, USA

Patient Name: **James Blank**
Card Holder's Name: James Blank ID#: 012345678

Drug: **CLARITIN-D TAB CR**

Date	Rx#	QTY	CoPay	Plan Payment	Correct	Not Correct
2/14/97	0624740	90	12.00	77.80	✓	_____
5/25/97	0624740	90	12.00	77.80	✓	_____

Drug: **ORUVAIL CAP 200MG ER**

Date	Rx#	QTY	CoPay	Plan Payment	Correct	Not Correct
3/27/97	6016534	240	12.00	246.50	_____	✓
6/11/97	6016534	240	12.00	246.50	_____	✓
7/17/97	6016534	240	12.00	246.50	_____	✓

Patient Total: $30.00 $510.36

If any of the pictures above do not look like the drugs you received from ABC Pharmacy, please describe the drug you received in the box below.

Drug Name	Color (red, blue, etc.)	Shape (round, etc.)	Form tablet, cap, etc.)	Words/#s (markings)

"I have reviewed the listed claims, and my responses are accurate to the best of my knowledge."

Signature: James Blank Telephone:_____ Date:_____

Comments: PLEASE FOLLOW UP ON THIS!

By reviewing forms with pictures and descriptions of the drugs, beneficiaries can easily help identify product-substitution schemes, brand/generic-switching, and phantom billings.

The patient checks off which prescriptions and refills he or she received and returns the form in a prepaid return mail envelope. Heritage's average response rate for such mailings is higher than 72 percent. Some members will not respond, and some will respond immediately. Other members will bring the form to their pharmacist—a desirable outcome in that it generates an awareness of the audit and fosters a sentinel effect. The results of notifying the pharmacy are several:

- Honest pharmacists are validated and will appreciate the effort.
- Pharmacists who contemplate cheating will likely reconsider.
- Fraudulent pharmacists realize that they are likely to be caught and may stop, though it is usually too late to escape detection.

Letter responses are logged at Heritage, and any negative or questionable responses are flagged for review by pharmacist auditors. These negative responses are one of the factors that identify specific pharmacies for on-site audits. Since all responses are logged in on a claim-by-claim basis, Heritage generates very detailed pharmacy-specific final reports for the plan. The direct-mail phase can be in place within 60 days of receipt of data, and it generally takes six to eight weeks to attain the 70 percent response rate.

Phase 3: On-Site Audits

On-site audits are the next step in the audit process. Providers are selected for on-site audits based on one or more of the following:

- Evidence of potential wrongdoing (per responses in direct-mail audit)
- Client request for on-site visit
- Complaints or tips
- Qualitative or quantitative outliers (high position in the ranking)

Pharmacies selected for on-site audits are generally notified of the upcoming audit in writing two weeks prior to the audit. One week before the audit, a Heritage representative telephones the pharmacy to:

- Ensure the pharmacy received and read its audit notification
- Answer any questions the pharmacist may have about Heritage and the audit
- Put the pharmacist at ease with regard to the audit
- Obtain directions, store hours, and other relevant information

Heritage draws a sample of paid claims for review by auditors in each audit. Depending on the state's preference, Heritage may draw either a targeted claim sample or a statistically representative sample that allows for an extrapolation of overcharges. The extrapolation formulae are based on proven statistical models and yield a reliable estimate of overcharges for each pharmacy.

While on site, the sample claims are compared to on-site records that may include:

- Hard-copy prescription files
- Computer files and records
- Third-party signature logs
- Refill authorization logs
- Computer printed daily transaction logs
- Purchase invoices
- Other relevant information

Auditors review each claim to assess compliance with the applicable rules, regulations, and guidelines set forth by the state and federal governments and the plan. Where claims violate these guidelines, discrepancies are documented, applicable pharmacy records and documents are electronically scanned into laptop computers, and a list of discrepancies is compiled.

At the end of the audit, the auditor prints the list of discrepancies and reviews it with the pharmacist in charge. At this time, the pharmacist is given the opportunity to produce any additional documentation that may mitigate the discrepancies. Any additional documentation is considered, and a new discrepancy list is produced before the auditor leaves the pharmacy. The pharmacist signs the report to indicate that he or she has had every opportunity to produce documentation.

This process minimizes the need to administer a postaudit appeals process. In Heritage's experience, much of the documentation received after an audit is unreliable since it often cannot be established whether the documentation existed at the time of the audit or was manufactured postaudit.

Generally, the on-site visits are completed in a half-day, and final reports are delivered to the state within three weeks of the completion of each audit. At that point, the state may request repayment from the pharmacy, withhold payment from the pharmacy, or further a case against the pharmacy.

Phase 4: In-Depth Audits

Occasionally, fraud is suspected or discovered during the on-site audit. The investigation and quantification of fraudulent dollars require a more involved on-site audit that can vary from one day to a week or more, depending on the scope and type of fraud, and the level of cooperation received from the pharmacist.

In this phase, auditors develop the fraud case against the pharmacy by collecting evidence from pharmacy documents and from interviews with pharmacy staff, members, and physicians. Heritage's investigators are expert in conducting professional, efficient investigations.

Where warranted and with the client's authorization, Heritage acts as an advocate in presenting audit results and evidence to law enforcement or judicial authorities. Heritage offers the following services:

- Prepare the case for the prosecution
- Organize the evidence
- Determine the best strategy for prosecution whether at federal, state, or local level
- Establish contacts for the client
- Serve as intermediary between judicial authorities and client

The prosecution of fraud is the most effective tool in establishing a sentinel effect. All in-depth time and material expenses are subject to the state's prior approval. Before conducting the in-depth audit, Heritage will meet with the client to establish the scope of the specific investigation and the desired outcome.

Retail Pharmacy Audit Potential

Heritage has been conducting retail pharmacy audits for more than 20 years for a variety of payors—including Florida Medicaid, Michigan Medicaid, and Hawaii Medicaid—with great success. **Heritage has realized significant savings for its clients with ROI of more than six to one.** The long-term savings associated with the sentinel effect exponentially increase the overall savings associated with Heritage's auditing services.

Home Infusion Therapy/Durable Medical Equipment Audits

The purpose of a HIT/DME audit is to identify overpayments relating to infused and injectible medications, services billed in association with the administration of HIT, and DME items. Because a single provider will sometimes provide both HIT and DME services, records relating to these services may be found in the same chart. Since DME often supports HIT care, the audit generally includes both HIT and DME categories. However, should the state prefer to focus on one of the two areas, the audit can be limited to either HIT or DME.

Heritage auditors will conduct selective site visits to assess the appropriateness of claims. Auditors travel to the provider site and review patient charts to identify potential overpayments. The site visit begins with an entrance interview, during which the lead auditor discusses protocols and procedures with the provider, establishes appropriate contacts, and asks a variety of questions about pharmacy practices. The lead auditor will also answer any questions posed by the provider at this time.

The chart review involves the review of both financial and clinical charts. Auditors fully document discrepancies and inappropriate billings. To maintain a permanent record and appropriately document findings, auditors will digitally scan any records relating to apparent discrepancies or overpayments. Chart reviews generally include an auditor's review of the following items:

- Prescriptions/physician's orders/certificates of medical necessity (CMN)
- Delivery records
- Nursing notes/home visit documentation
- Prescription compounding records
- Medical progress notes
- Billing records (usually HCFA-1500 forms)

Therapy is examined longitudinally to target any breaks, discontinuations, changes, or other modifications that could affect billing. Through review of the paid claim data and via an on-site chart and compounding-record review, Heritage generally identifies a variety of issues and overpayments falling into categories including the following:

- Payments for prescription drugs or items in excess of the contracted price, per diem, or reimbursement rate
- Claims submitted after termination of coverage or after patient is deceased
- Rental payments that exceed the purchase price of DME-related equipment
- Mismatch of therapy and equipment (for example, an enteral pump billed during parenteral therapy)
- Solutions used for compounding multiple patients billed as single-unit solutions (for example, double-billing for individual vials)
- Provider billed for the wrong drug
- Home health services billed during admissions or inpatient stays
- Provider billed a larger quantity than ordered by the physician
- Provider billed inappropriate per-diem or supply charges (may include unbundling)
- Items not ordered by the physician, or orders not documented in the patient chart
- Billing for items that are not covered and should not be reimbursed
- Billings do not match the quantity a provider purchased in that time period
- Duration of therapy exceeds that ordered by the physician
- Inappropriate dosage of medication (taking into account the weight of patient as available and appropriate)

Where possible, Heritage's audits are provider-friendly and seek to keep the provider involved in the process. For instance, entrance and exit interviews are conducted in each audit, giving the provider an opportunity to ask questions and obtain a comfort level with Heritage's processes.

The exit interview generally involves the review of a printed list of discrepancies. Auditors generate such a list onsite, using a portable laser printer. This list is reviewed with the pharmacy staff to determine if any additional mitigating documentation can be provided. If not, the provider is asked to sign the document, affirming that he or she is unable to provide any additional documentation. This process eliminates any surprises to the provider and facilitates the recovery process.

HIT/DME Audit Reporting

Heritage will submit a final report to the state, documenting the audit methodology and its findings. The final report will include an executive summary that provides vital statistics relating to the audit, such as location and duration, auditor and provider contacts, and types of findings.

The report will also include a claim-level reporting of all documented overcharges. This report will include the claim number, date, patient ID, drug/procedure code, discrepancy, payment information, and a calculated overcharge amount. The claim-level report is comprehensive and also includes a comment field for the auditor to further describe the problem or issue relating to the claim. In this way, the report includes enough specificity and detail to be a stand-alone implement for the recovery of overcharges.

HIT/DME Audit Potential

Heritage has audited numerous home infusion providers for numerous payors across the country. In Heritage's experience in these audits, the recoverable issues are often driven by the same underlying factors:

- Centralized billing offices
- Complex billing requirements (for example, compounding, nursing services, and DME)
- Ambiguous HCFA-1500 forms

These audit drivers have consistently produced recoveries that amount to 7 to 8 percent of all HIT/DME dollars spent by the state. For a typical client, that figure translates to approximately $1.80 per covered life in the first year of audit.

Implementation Plan for Heritage Services

The following three-page chart is a summary-level plan for implementing Heritage services.

ID	Task Name	Duration	Start Date	Finish Date	Prede-cessors	Resource Names
1	**Administration**	**22 days**	**4/1/2003 8:00**	**4/30/2003 17:00**		
2	Contract awarded	1 day	4/1/2003 8:00	4/1/2003 17:00		state
3	Contract and confidentiality agreement negotiated	20 days	4/2/2003 8:00	4/29/2003 17:00	2	Heritage Information Services (HIS), EDS, state
4	Contract and confidentiality agreement signed	1 day	4/30/2003 8:00	4/30/2003 17:00	3	HIS, EDS, state
5	**System Implementation**	**54 days**	**5/1/2003 8:00**	**7/15/2003 17:00**	**4**	
6	Review data requirements and associated issues with the state	5 days	5/1/2003 8:00	5/7/2003 17:00		HIS systems engineer (SE)
7	Test data	5 days	5/1/2003 8:00	5/7/2003 17:00		
8	Production data	5 days	5/1/2003 8:00	5/7/2003 17:00		
9	Pharmacy/medical claims	5 days	5/1/2003 8:00	5/7/2003 17:00		
10	Provider files	5 days	5/1/2003 8:00	5/7/2003 17:00		
11	Eligibility files	5 days	5/1/2003 8:00	5/7/2003 17:00		
12	Request test data, production data, provider reference files, record layout	1 day	5/1/2003 8:00	5/1/2003 17:00	4	HIS SE
13	Forward test data, provider reference files and record layout	14 days	5/2/2003 8:00	5/21/2003 17:00	12	EDS
14	Become familiar with state's program and policies	21 days	5/22/2003 8:00	6/19/2003 17:00	13	
15	Create tape layout	6 days	5/22/2003 8:00	5/29/2003 17:00	13	HIS SE
16	Load test claim data	3 days	5/30/2003 8:00	6/3/2003 17:00	15	HIS SE

ID	Task Name	Duration	Start Date	Finish Date	Prede-cessors	Resource Names
17	Perform standard data validation and create crosswalk	4 days	6/4/2003 8:00	6/9/2003 17:00	16	HIS SE
18	Provide State with analysis of test data	1 day	6/10/2003 8:00	6/10/2003 17:00	17	HIS SE
19	Validate data	5 days	6/11/2003 8:00	6/17/2003 17:00	18	EDS/state
20	Request additional test data if needed	1 day	6/18/2003 8:00	6/18/2003 17:00	19	HIS SE
21	Provide additional test data if needed	10 days	6/19/2003 8:00	7/2/2003 17:00	20	HIS SE
22	Modify tape layouts if required	2 days	7/3/2003 8:00	7/4/2003 17:00	21	HIS SE
23	Receive production data (pharmacy and medical claims - 24 months)	0 days	7/4/2003 17:00	7/4/2003 17:00	22	HIS SE
24	Load production data	5 days	7/7/2003 8:00	7/11/2003 17:00	23	HIS SE
25	Complete test run on state data in HERCULES	2 days	7/14/2003 8:00	7/15/2003 17:00	24	HIS SE
26	**Initial Deliverables**	**133 days**	**5/1/2003 8:00**	**11/3/2003 17:00**		
27	**Program Assessment**	**10 days**	**7/16/2003 8:00**	**7/29/2003 17:00**	**25**	
28	Complete initial Business and Clinical PlanFormance	5 days	7/16/2003 8:00	7/22/2003 17:00		HIS SE
29	Publish clinical and business reports on CyberFORMANCE	1 day	7/23/2003 8:00	7/23/2003 17:00	28	HIS SE
30	Complete initial program assessment	5 days	7/23/2003 8:00	7/29/2003 17:00	28	HIS clinical manager
31	Review assessment and recommendations for interventions with state [as scheduled]	0 days	7/29/2003 17:00	7/29/2003 17:00	30	HIS account manager
32	**Auditing**	**127 days**	**5/1/2003 8:00**	**10/24/2003 17:00**		

ID	Task Name	Duration	Start Date	Finish Date	Prede-cessors	Resource Names
33	Review audit process with state	5 days	5/1/2003 8:00	5/7/2003 17:00	4	HIS account manager
34	Receive approval from state	5 days	5/8/2003 8:00	5/14/2003 17:00	41	
35	Prepare pharmacy ranking report	5 days	7/16/2003 8:00	7/22/2003 17:00	25,42	HIS SE
36	Review ranking report with state and agree on audit strategy	3 days	7/23/2003 8:00	7/25/2003 17:00	43	HIS account manager
37	Send first set direct mail letters	5 days	7/28/2003 8:00	8/1/2003 17:00	44	
38	Review DM audit letter responses	50 days	8/4/2003 8:00	10/10/2003 17:00	45	
39	Perform first set of desk audits	20 days	7/28/2003 8:00	8/22/2003 17:00	44	
40	Perform first set of on-sites	10 days	10/13/2003 8:00	10/24/2003 17:00	44,46,47	

Heritage Organizational Overview

Founded in 1980 as an auditing and consulting company focused on prescription drug plans, Heritage employs a staff of 74 full-time personnel and 15 consultants that include registered pharmacist auditors, clinical pharmacists, health care information analysts, pharmacist researchers, biostatisticians, systems analysts, programmers, and health care consultants. Delivering pharmacy benefit management solutions is the exclusive mission of Heritage. As such, 100 percent of Heritage's efforts are devoted to developing and deploying its suite of advanced cost containment and quality improvement services.

Those include:

- Clinical Management Services
  - Population-based disease management programs
  - Retrospective drug utilization review (retroDUR)
  - Prior authorization programs
  - Case management applications
  - Prospective drug utilization review (proDUR) consulting services and systems
  - Expert, Web-enabled drug program management information systems
  - Counter-detailing and provider education tools
- Pharmacy Auditing Services
  - Retail pharmacy audits
  - Claims processor/fiscal agent audits
  - Mail service pharmacy audits
  - Home infusion therapy/durable medical equipment audits
  - Other pharmacy-related health care audits

Heritage provides its services to some of the largest payors of prescription drug benefits in the country, including 13 Medicaid states:

- Texas
- Florida
- Missouri
- Idaho
- Kansas
- Minnesota
- Michigan
- Delaware
- Rhode Island
- West Virginia
- Hawaii
- Washington, D.C.
- Wyoming

Heritage's main office is in Richmond, Virginia, with satellite locations in Miami, Florida; Philadelphia, Pennsylvania; Jefferson City, Missouri; and Hawaii.

Heritage Auditing Services

The audit team is led by a vice president of auditing services with more than 10 years of pharmacy-related audit experience, and a CPA audit manager with experience as a senior manager in a large accounting firm. Additionally, the CEO, senior vice president, vice president of clinical services, and vice president of account management all support and provide leadership for the audit function.

Currently, Heritage employs a staff of more than 30 full-time employees in the auditing department, including 12 full-time auditors, all of whom are registered pharmacists or Pharm.Ds. Their real life experience in the pharmacy industry makes them ideal auditors who are more apt to identify discrepancies resulting from fraud, abuse, or noncompliance with the state's policy. Furthermore, licensed pharmacist-auditors are highly credible with the pharmacists being audited.

Rounding out the audit staff are experienced pharmacy technicians and audit analysts who assist the pharmacist-auditors with reporting and analyzing the findings. Heritage also employs two investigators with extensive law enforcement experience and health plan fraud unit experience that investigate beneficiaries suspected of "doctor shopping" and assist in performing in-depth audits.

TrestleTree Disease Management

The mission statement created by the Department of PATH outlines its ultimate goal to assist Vermonters in finding "a path to a better life." The agency expounds upon this mission statement with a vision statement that supports the premise that "Good health supports happiness and success." These values underscore the need for Vermonters to be treated as individuals able to grow and change. The statement further pledges to "help people discover their strengths and realize their full potential." As your current fiscal agent, EDS continues to support these values and presents a potential alliance partner whose commitment to "reduce health care costs by investing in the growth potential of people" aligns perfectly with the visionary plans set forth for Vermont.

Initially, EDS considered TrestleTree as an alternative solution to meet the state's objectives outlined in section 1.1.2 for bidders to "propose cost containment ideas for increasing the state's control over fiscal agent and program expenditures." After reviewing TrestleTree's offering and exploring its organizational mission, we were excited about the opportunity to present a new partner that will proactively promote your vision for the citizens of Vermont.

TrestleTree offers Vermont a unique approach to disease management (DM) services. TrestleTree's approach is a unique blend of tools, specialized training, and expertise. This blended approach creates a path that allows Vermont to combine the vision for good health with the cost containment objectives. Unlike other DM service offerings, TrestleTree's approach encompasses patient-focused interventions designed to modify health behaviors, improve health care outcomes, and offer quantifiable reductions in medical and pharmaceutical expenses.

This optional enhancement recommends a pilot program. This approach allows the state to fully analyze the benefits associated with the TrestleTree offering.

- Intervention alternatives that result in the improved health of Vermont beneficiaries
- Clinical monitoring, program trending, and financial analysis
- Reduced benefit expenditures for pilot participants

The following section documents some of the clinical improvements achieved for a client receiving TrestleTree services.

- A 300 percent reduction in illness-related work absenteeism (as compared to pre-TrestleTree work year)
- Sustained, regular monitoring of illness consistent with disease-specific best practice protocol, according to the reports of 90 percent of participants

Ultimately, the benefits associated with the contingency payment schedule and the reduction in benefit expenditures are compounded when you realize your vision of improved health outcomes for the citizens of Vermont. We summarize our approach for Vermont in the following sections:

- Overview of Pilot Evaluation Project (PEP)
  - Personalized Health Management
  - Coaching Techniques for Better Health Management
  - Savings Analysis
  - Monitoring and Reporting Capabilities
- Implementation Plan for Trestle Tree Services
- TrestleTree Organizational Overview

This document will explain how TrestleTree's staff invests their time and effort to meet both the unique health challenges and great potential for health success of each participant.

Overview of Pilot Evaluation Project (PEP)

To demonstrate the viability and benefits of TrestleTree's offering, we recommend a Pilot Evaluation Project (PEP). Initially, we voluntarily enroll 300 to 500 Medicaid beneficiaries to participate in this evaluation project. The pool of available participants would be developed after an analysis of Vermont's medical and pharmaceutical claims data.

This data offers the best opportunity to identify potential participants who have claim records indicating one of the following disease states.

- Diabetes
- Asthma
- Coronary artery disease (CAD)
- Chronic obstructive pulmonary disease (COPD)
- Hypertension
- Dyslipidemia

With a partner to guide them toward a path of healthier living, individuals laboring with chronic illnesses can improve their health outcomes and spend less on medical care. Once this pool of potential participants is identified, TrestleTree will proactively target these beneficiaries to encourage voluntary participation in the PEP. Pilot sites to conduct these outreach activities are typically identified during the analysis phase. We will target our outreach activities at the treatment centers that specialize in treating the targeted disease categories.

We recommend a 12-month PEP with interim evaluations at six- and twelve-month intervals. Neither the state of Vermont nor Vermonters participating in the program will incur costs associated with the services provided by TrestleTree. Instead, we propose a quarterly evaluation of medical and pharmacy claims data to document the financial impact and the actual benefit savings that will determine TrestleTree's contingency payment amount.

Personalized Health Management

Intensive time with a skilled, trusted health care professional ranks as key and essential to interrupting a negative, costly course of illness for people struggling with diabetes, asthma, CAD, or COPD. TrestleTree uses pharmacists as health coaches to offer beneficiaries.

- Personalized care to those who need it most
- Ongoing connections that lead to a new path of health behaviors

Instead of relying on a nurse call center approach or educational pamphlets to elicit healthier behaviors, TrestleTree's staff of pharmacist health coaches proactively develops dialogue through ongoing monthly contacts with assigned patients. TrestleTree's pharmacist coaches provide strategies for health success and evaluate a beneficiary's medications for safety and savings.

Key ingredients for success—Interaction with the coaching staff creates a focused level of intensity to improve the participant's health care regimen and creates an unprecedented level of trust with each program participant. The coach's interactive involvement is key to TresteTree's success. Its coaching techniques have proven essential in achieving benefit savings for our clients.

- **Disease-State Knowledge—**Each TrestleTree pharmacist health coach possesses cutting-edge information about medication safety, disease-specific best practice protocols, and evidence-based medicine guidelines. The participants receive the best information available about medication safety issues, disease-specific guidelines for adherence to a treatment protocol, and empowering information about health behaviors that can lead to a healthier lifestyle.
- **Clinical Health Coaching—**TrestleTree supplements the pharmacists' clinical knowledge with the specific coaching techniques necessary to drive health behavior changes. While most health care professionals are limited to directing or telling a patient what he/she must do, TrestleTree's pharmacists receive specialized training to *influence* a participant's behavior patterns. To *influence* is to understand the context of the person, to spend adequate time to create goal-setting and accountability, and to listen as well as tell. These health coaches employ a unique strategy that changes the dynamics associated with the participant's health care behavior and, ultimately, achieves significantly better health care outcomes.
- **Diverse Demographics and Domain Expertise—**Diversity is a leading contributor to the factors that distinguish the TrestleTree team of pharmacist health coaches. While the coaching staff maintains a high level of professionalism and the highest levels of pharmaceutical training, their diverse cultural backgrounds allow them to understand a beneficiary's circumstances. The coaching staff speaks multiple languages and brings knowledge of disease-states specifically related to age, gender, culture, or job-specific issues. TrestleTree leverages this diversity to improve the health outcomes across Vermont's entire disease population.

Coaching Techniques for Better Health Management

Each health coach is guided by several proven strategies designed to help participants lead healthier lives.

- **Establish a Potent Working Relationship—**Initially, each TrestleTree participant spends one hour with his or her pharmacist health coach. The coach listens, assesses, and builds a one-on-one health care connection. Arrangements are made to connect participants with their health coach on a regularly scheduled basis. All communication occurs through teleconferencing.

- **Work Multi-Behaviorally on Disease State—**Recent health behavior research suggests that simultaneously addressing three health behaviors (for example, weight loss, exercise, smoking reduction) generates change. In other words, simultaneously working to change several health behaviors of the participant lets the participant see results within each behavior category. Consequently, each TrestleTree participant will work with the coaching staff to develop a Life Map. This map identifies numerous, diverse health behavior goals to promote quick movement toward behavioral outcomes.
- **Work Within a Stages-of-Change Framework—**Behavior changes that apply to medication adherence, disease monitoring, weight loss, exercise, stress management, smoking reduction, and food choice restructuring are only achieved when an individual adequately prepares for the ardent work necessary to achieve the benefits associated with the change. Spontaneous action seldom results in lasting change. TrestleTree's health coaches are rigorously prepared to understand and implement a stage-of-change assessment across each clinical behavior for each participant. This assessment supports the appropriate formation of goals for each stage to achieve maximum results.
- **Establish Accountability for Each Participant—**After the participant's or family member's 60-minute initial intervention appointment, monthly next steps interventions will be scheduled in 30-minute increments. This approach creates a formidable health care relationship designed to assist each participant in moving toward the action and maintenance stages for each critical health behavior. When high positive clinical outcomes are achieved, there is a direct correlation between the participant's high-touch accountability and the guidance received from a health coach partner.
- **Rigorously Assess Clinical Outcomes—**TrestleTree's coaching staff conducts a monthly audit of clinical health behaviors outcomes. While it is clear that participants change over time, the coaching staff's focus remains health behavior change for each participant. Monthly outcome audits are a vital tool to assess the quality and effectiveness of TrestleTree's program.

Pharmacist health coaches receive intensive training in creating health change-focused relationships with their patients. They develop individualized plans for modifying health behaviors that are linked to successfully avoiding costly catastrophic health events and provide follow through in patient participation. Coaches use T-Rx, a proprietary software tool designed to address both safety and savings in the patient's pharmaceutical utilization. T-Rx allows the pharmacist coach to observe in real-time the patient's medication regimens and potential drug interactions between all types of medications: prescription, over-the-counter, and herbal. T-Rx also monitors the overlap of every beneficiary's prescription drugs to the state's formulary. Coaches can examine formulary issues, including generic utilization, formulary brand utilization, and therapeutic equivalent information, for potential state and patient savings while patients also receive safety recommendations for each prescription.

Savings Analysis

TrestleTree seeks to employ an absolute savings strategy to examine claims savings or document a client's ROI. We deploy this strategy by using an observational time series design: the change in outcomes (medical claims) is computed from a modeled baseline to the same program period for the same cohort of participants. This approach provides the most direct assessment of TrestleTree's impact on medical services. TrestleTree's impact on pharmacy claims can be easily derived from an analysis of the patient's pharmacy-spend data subsequent to the intervention of the pharmacy coach using the T-Rx on safety and savings. Increased compliance to approved formularies by the participants translates to a decrease in pharmacy expenditures for participants enrolled in the TrestleTree program. We capture and track this data using pharmacy claims data.

Monitoring and Reporting Capabilities

TrestleTree is committed to regular, ongoing quality assessments of its interventions and the impact of coaching on clinical outcomes. Pharmacist health coaches conduct monthly audits of each participant's progress on the following clinical health outcomes: disease-state monitoring, medication adherence, food choice changes/adherence to treatment plan, weight loss, smoking reduction, and exercise adherence.

Each participant creates a multidimensional objectives plan at the beginning of the coaching relationship and updates this plan continually through their monthly interventions with the coach. TrestleTree provides quarterly reports to each client about the clinical health behavior achievements of the participants and conducts an annual analysis of savings in medical/pharmacy claims through the methodology described above.

Outcomes Examples—Results of the most recent clinical outcomes audit for TrestleTree's participants reveal the following clinical achievements.

- Eighty percent of participants are engaged in regular, ongoing, weekly exercise.
- Eleven-pound average weight loss for all participants—This figure represents a range of zero to 80 pounds and includes asthma participants for whom weight loss was not a behavioral goal.
- Eighty percent of participants have initiated and maintained disease-appropriate alteration in food choices, such as the reduction of sodium or fat.
- Participants report a 300 percent reduction in illness-related work absenteeism (as compared to pre-TrestleTree work year).
- Ninety percent of participants report sustained, regular monitoring of illness consistent with disease-specific best practice protocol.

A recent assessment of TrestleTree's disease management program for a corporate client was conducted by Watson Wyatt, the international benefit consultant. Using an observational times series design, Watson Wyatt assessed medical claims savings by computing outcome from baseline to the program period for the same cohort of participants (a classic before-to-after program design). Results of this study produced several data points that were particularly pleasing to TrestleTree's client. Most notable were the following:

- TrestleTree's program resulted in a 45 percent reduction in the participants' medical claims during their participation in the program.
- The client realized a 1.5-to-1 ROI for the first year of participation in the program. This ROI increased to a 2-to-1 return during the last two quarters of the program year. Watson Wyatt's trend analysis indicated that these savings or the client's ROI would continue to increase throughout the year and suggested continued upward movement for the second year.

Implementation Plan for TrestleTree Services

In this section, we present a high-level implementation plan for implementing TrestleTree services.

Vermont Pilot Plan of Action

Week	TrestleTree Responsibilities	Vermont Responsibilities	EDS Responsibilities
1	• Pilot contract is executed. • Pharmacist health coaches (PHC) are assigned to Vermont. • Electronic file of eligible employees is requested.	Vermont and TrestleTree representatives meet to gain approval of enrollment process, timetable, and printing proofs.	EDS provides medical claims and pharmacy claims data feed of eligible beneficiaries for the pilot program to TrestleTree.
2	Four-part mailing series is sent to printers.	Vermont and TrestleTree representatives meet with strategic site for planning session of enrollment event, such as a teaching hospital.	
3	• Eligible beneficiaries database is loaded into TrestleTree Enrollee Management System (EMS). • Four-part mailing series is sent to mail service center.		
4	Piece one of four-part mailing series is sent to beneficiaries' homes inviting them to call a toll-free telephone number to enroll.		
5	• Piece two of four-part mailing series is sent to beneficiaries' homes inviting them to call a toll-free telephone number to enroll. • Eligible beneficiaries are enrolled; terms and conditions and privacy policy distributed and signed; and first steps interview is scheduled, and appointment card is distributed. • TrestleTree sends an electronic list of enrolled participants to state.		

Week	TrestleTree Responsibilities	Vermont Responsibilities	EDS Responsibilities
6	• Piece three of four-part mailing series is sent to beneficiaries' homes inviting them to call a toll-free telephone number to enroll. • TrestleTree team holds on-site enrollment fair at strategic site.		
7	Piece four of four-part mailing series is sent to beneficiaries' homes inviting them to call a toll-free telephone number to enroll.		
8	• Client participants are sent welcome packets with brochures and notes from TrestleTree confirming first appointment. • First steps interventions begin with beneficiaries.		

TrestleTree Organizational Overview

This overview validates TrestleTree's record of success and articulates the value its services can provide to the citizens of Vermont.

TrestleTree is a privately owned company that evolved in response to three ominous vectors converging in the health care sector.

- Soaring volume of medical claims with 70 percent of health care dollars being spent on 20 percent of the population
- Reduced availability for health care professionals to interact with their patients
- Exploding pharmacy spending enhanced by the industry's direct-to-consumer marketing strategies

The intersection of these ominous trends demanded a fresh approach to disease management—an approach built on the following fundamentals:

- Laser accurate identification of target populations
- Critical investment of time by highly trained health professionals
- Documented records to capture the individual life/health story of each person identified with the disease state
- Focused intervention to influence the pharmaceutical choices made by a patient and reduce the use of higher-priced drugs when safe, lower-priced formulary brand alternatives or generic equivalents were available

Consequently, TrestleTree has stepped into the eye of this health care storm and made an immediate impact with its revised approach to disease management. TrestleTree's unique approach has produced results that align with Vermont's vision: providing a path to better health for all Vermonters.

TrestleTree's first client is a leader in the trucking industry—J.B. Hunt Transportation. Like Vermont, TrestleTree proposed a pilot program for this organization. **Within one year of receiving TrestleTree's disease management services, this client reduced its medical claims cost for participants by 42 percent—a first-year ROI of 2 to 1.**

Participants reported an average weight loss of more than 11 pounds. More than 80 percent of the participants adhered to a weekly exercise program. This exceeds the national average by nearly 65 percent. Participants also made significant food choice changes, and the coaching staff continually monitored their disease markers.

These results prompted J.B. Hunt to expand TrestleTree services across its entire trucking organization. This decision has created significant savings for the company's bottom line but has also created a staff of health-conscious employees.

Containing Vermont Medicaid Costs

By selecting these proposals, the Department of PATH has the exciting opportunity to take advantage of the cost containment mechanisms proposed by EDS to protect future Medicaid program costs. The results for the state will be:

- Reduced pharmaceutical expenditures
- Improved compliance with drug formularies
- Decrease in fraud, abuse, and waste
- More efficient, less costly, and improve prior authorization processes for drugs
- Highly individualized disease management for targeted populations with chronic diseases
- Reduced claims payments for patients with the most significant health care costs
- Healthier patients with chronic illnesses

EDS looks forward to the opportunity to partner with the Department of PATH and implement these cost savings innovations.

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n. Assumptions or Constraints in Developing and Completing the Work Plan and Schedule

RFP Reference: 3.2.2.10(n), p. 3-16

We conducted an in-depth review and analysis to develop our work plan for Vermont. Our approach took into account the many facets of project management including time, resource allocation, and available project management tools. The following elements were included in our assumption when developing our proposed work plan and schedule:

- Project management tools including the Project Workbook and systems life cycle
- Issue identification, tracking, and reporting procedures
- Change control and configuration management procedures
- Timely submission/review of all deliverables by EDS and the state
- Established communication protocols
  - Status meetings
  - Status reports
  - Updated work plan documents
  - Continual and frequent interaction between all players
- Management of subcontractors
- Leveraging existing space, facility, and operational staff
- Continuation of current staff

Some constraints that might impact the completion of the work plan and schedule include:

- Timeliness of contract signing
- Major changes identified to the scope of the enhancements at the time of the requirements validation meetings
- Unexpected delay in equipment delivery and setup
- Unanticipated loss of essential staff at either EDS or the state
- Any unforeseen natural disaster

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o. Critical Path Diagram

RFP Reference: 3.2.2.10(o), p. 3-16

On the following pages, we present critical path diagrams for project start-up and for each of the mandatory and optional enhancements and modifications. We selected this approach for the following reasons:

- Only the initial set-up tasks (shown in the Enhancement Environment critical path diagram) applied to all work performed in this phase.
- Each of the mandatory and optional enhancements and modifications is a stand-alone task and can be accomplished without reference to the other enhancements and modifications.

With this understanding, we thought you would find that the individual critical path diagrams offer the best value in terms of understanding the interrelationships of the tasks needed to complete each of the mandatory and optional enhancements.

The following individual critical path diagrams start on the following page:

- Enhancement Environment
- MMIS System Modifications
- Platform Conversion
- ClaimCheck and ClaimReview
- Provider Enrollment Data Integration
- Internet
- Recipient Eligibility Verification System Upgrade
- Third-Party Liability Subsystem Upgrade
- Fiscal and Budget Application

We have included these individual critical path diagrams on the CD-ROM version of this proposal.

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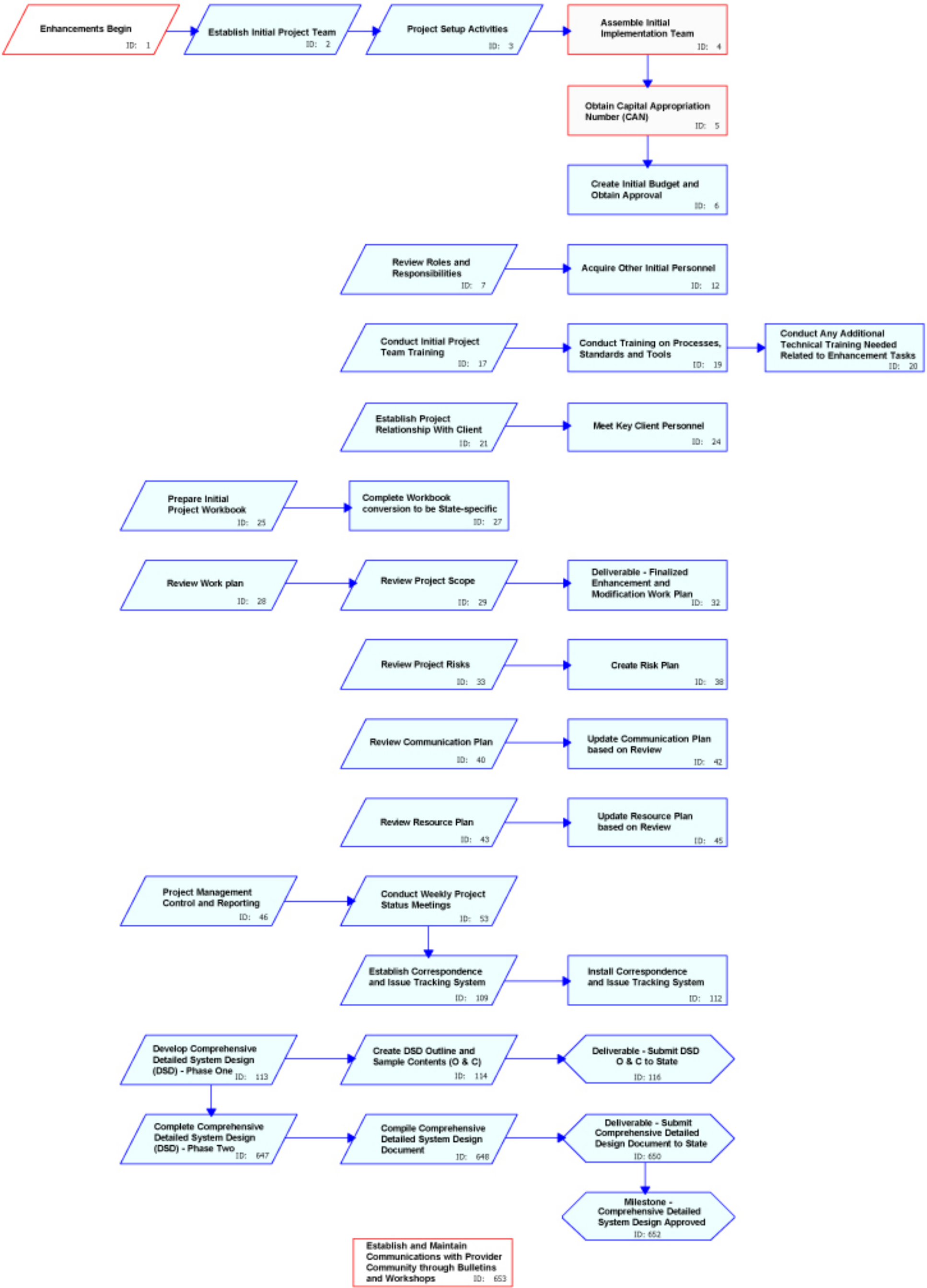
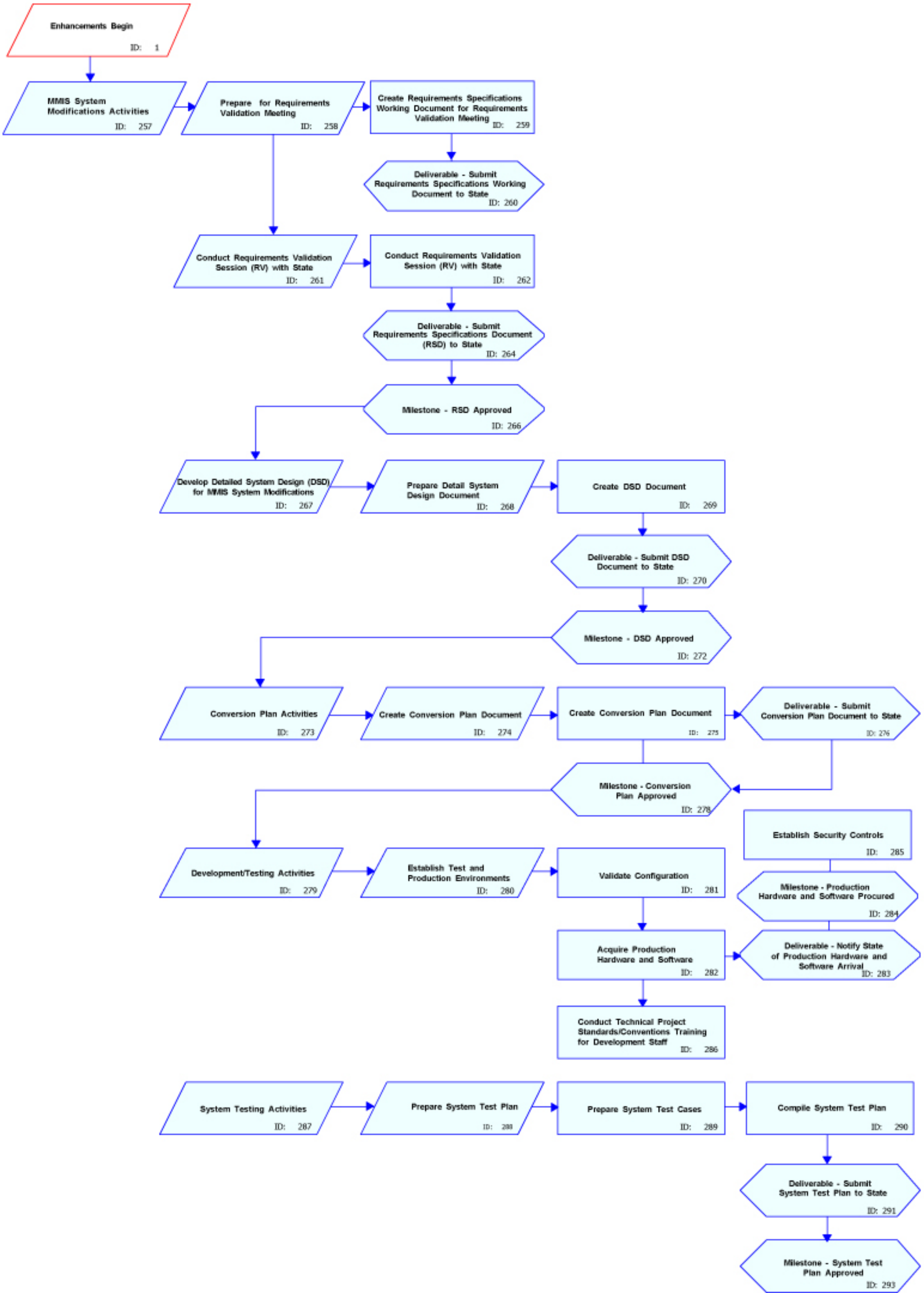
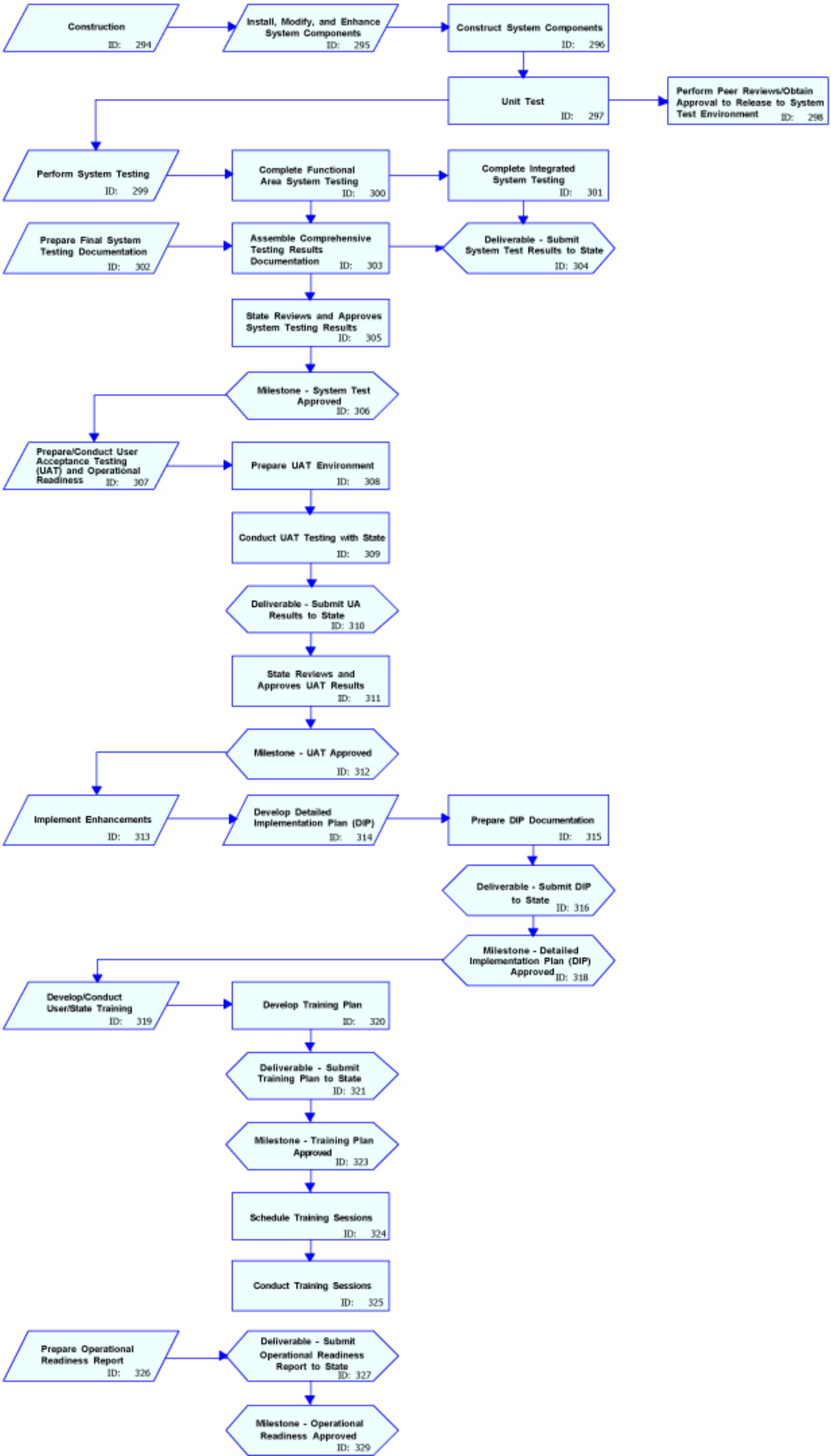
Critical Path Enhancement Environment



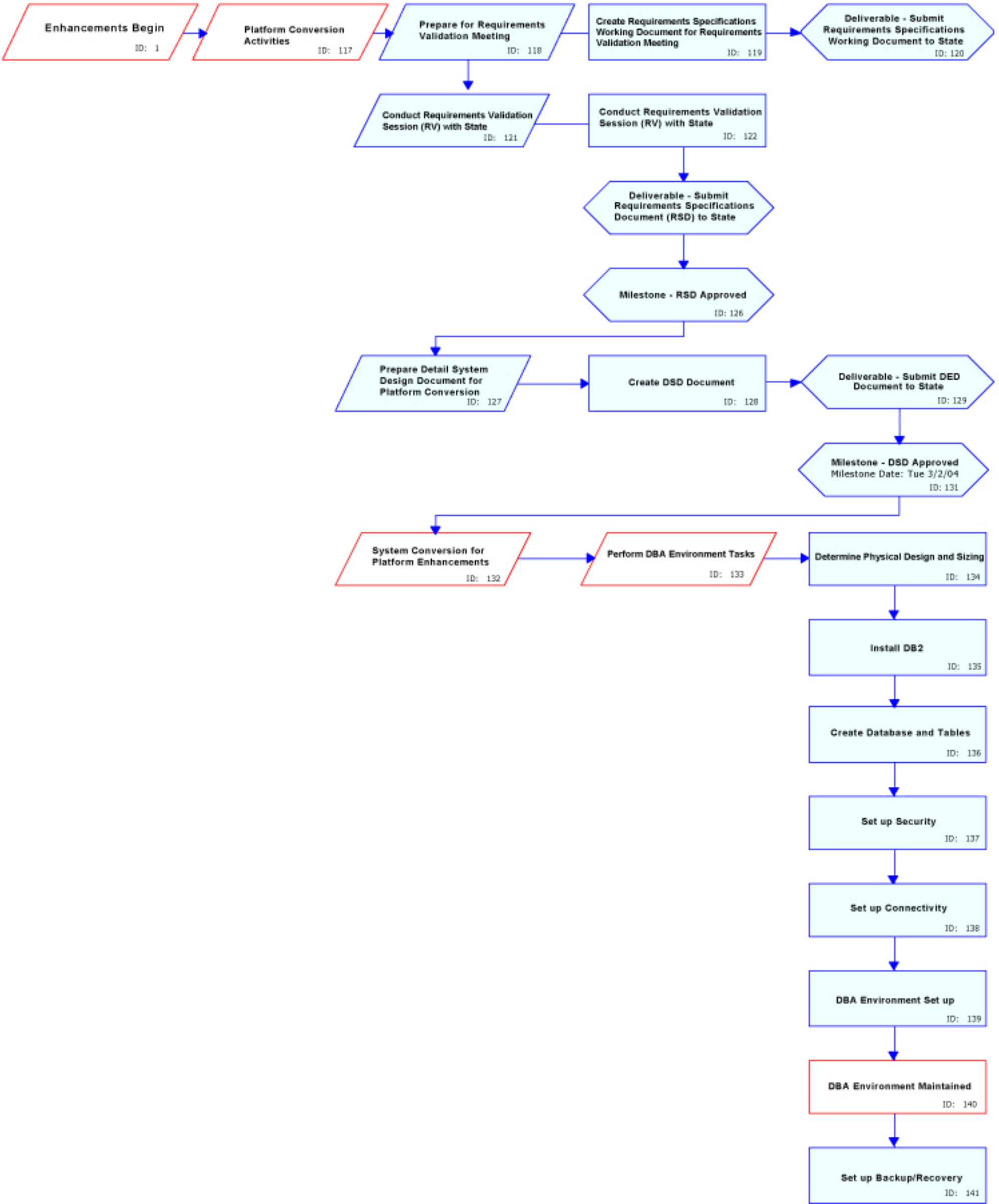
Critical Path MMIS System Modifications



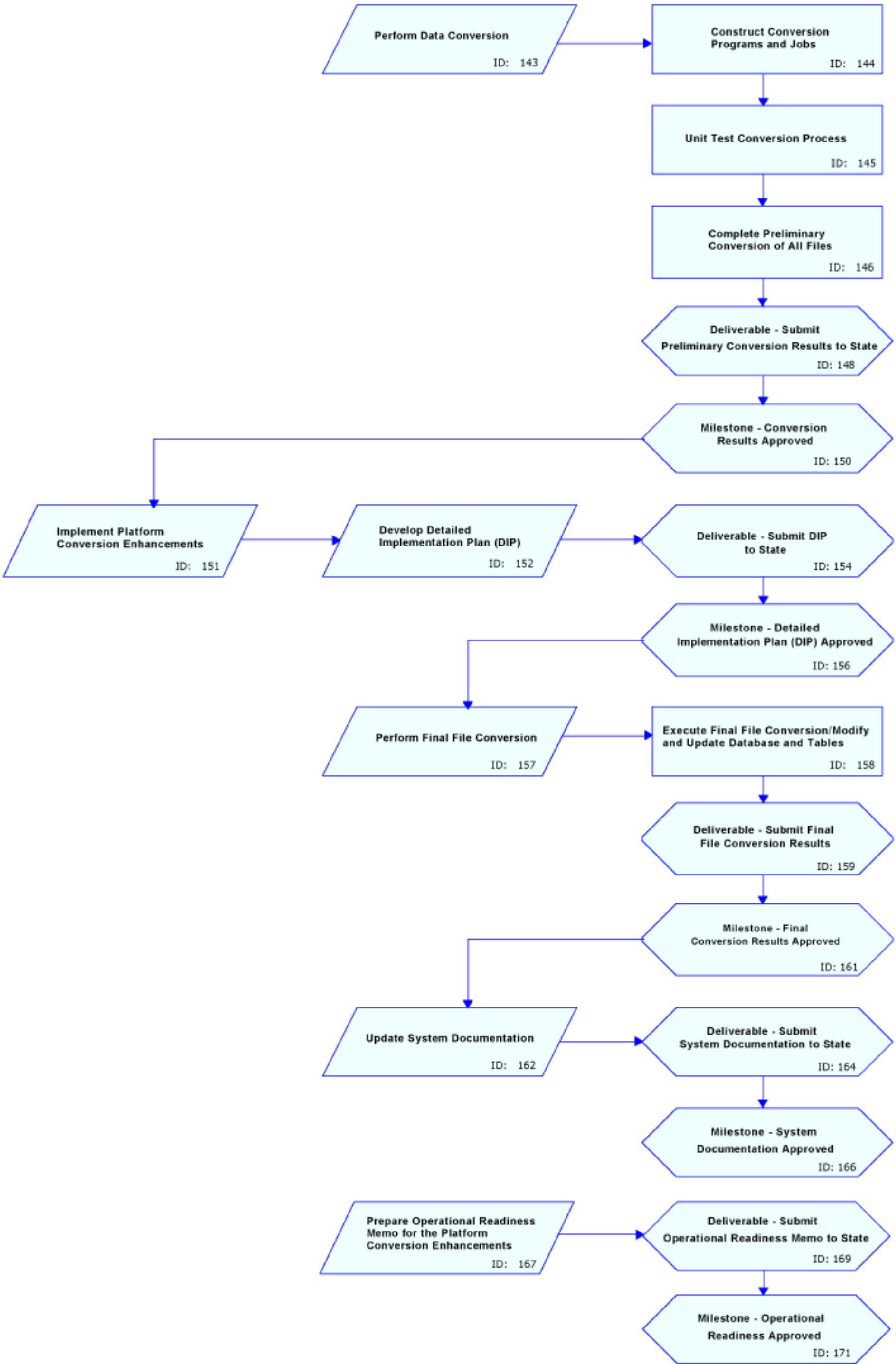
Critical Path MMIS System Modifications (continued)



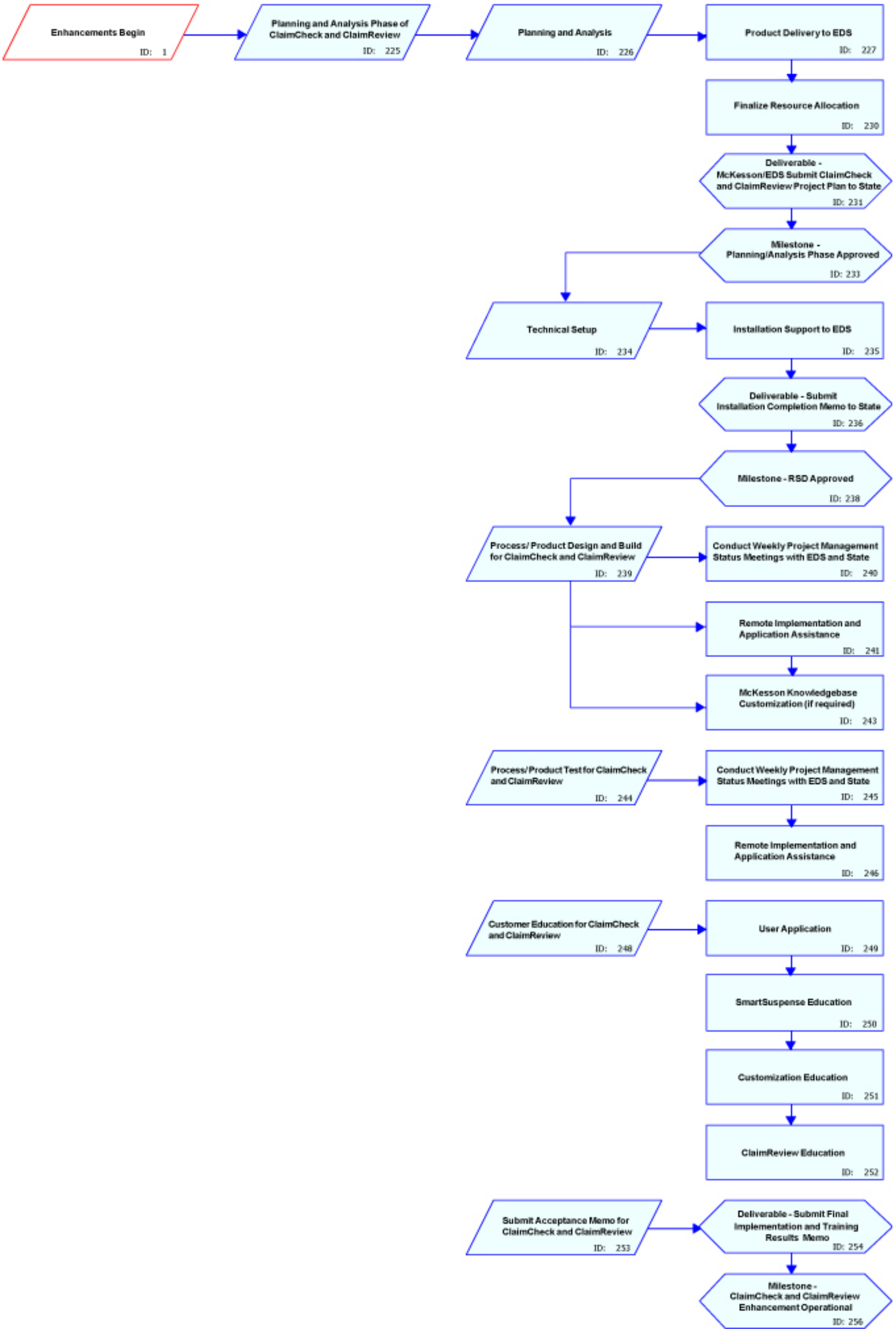
Critical Path Platform Conversion



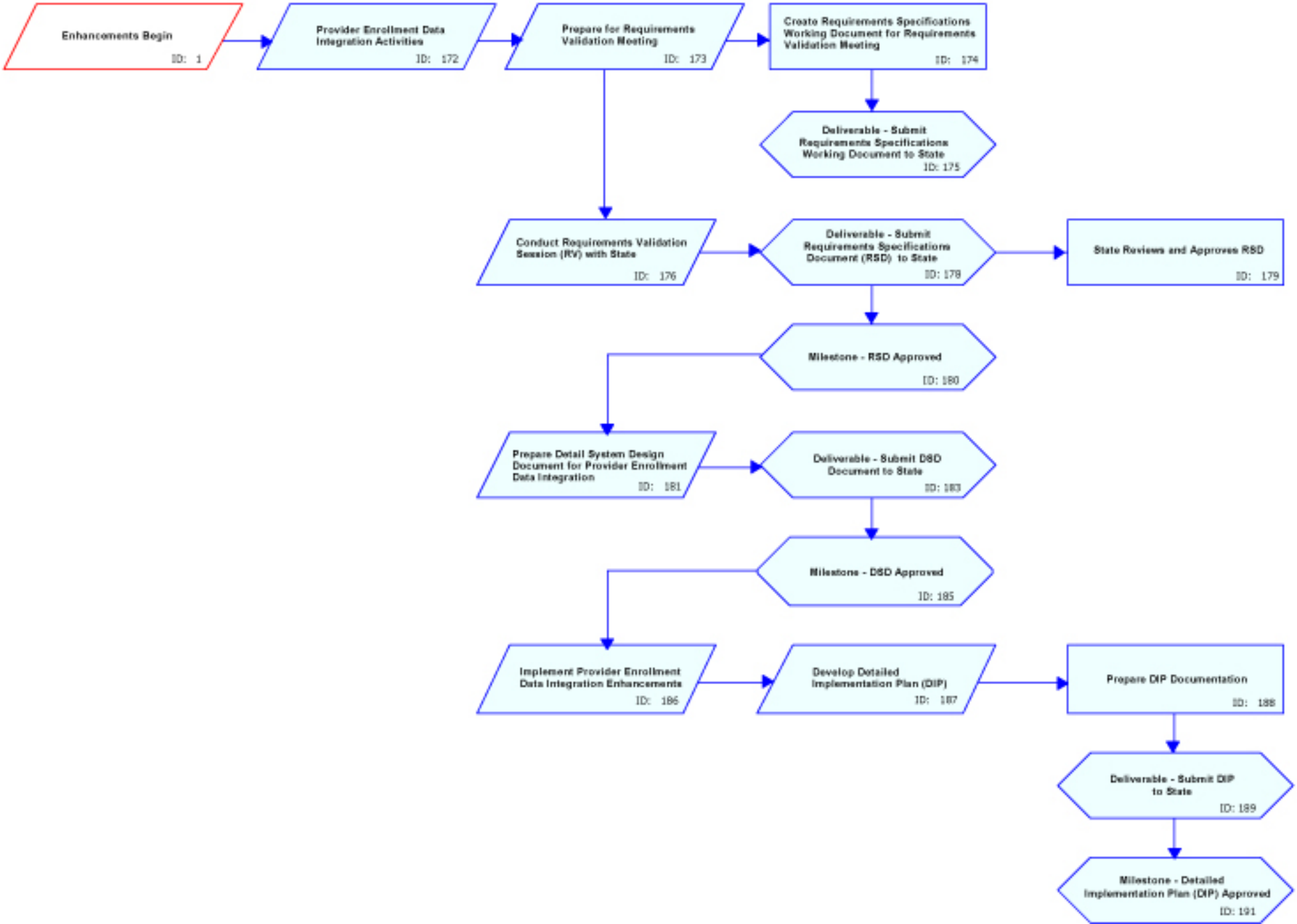
Critical Path Platform Conversion (continued)



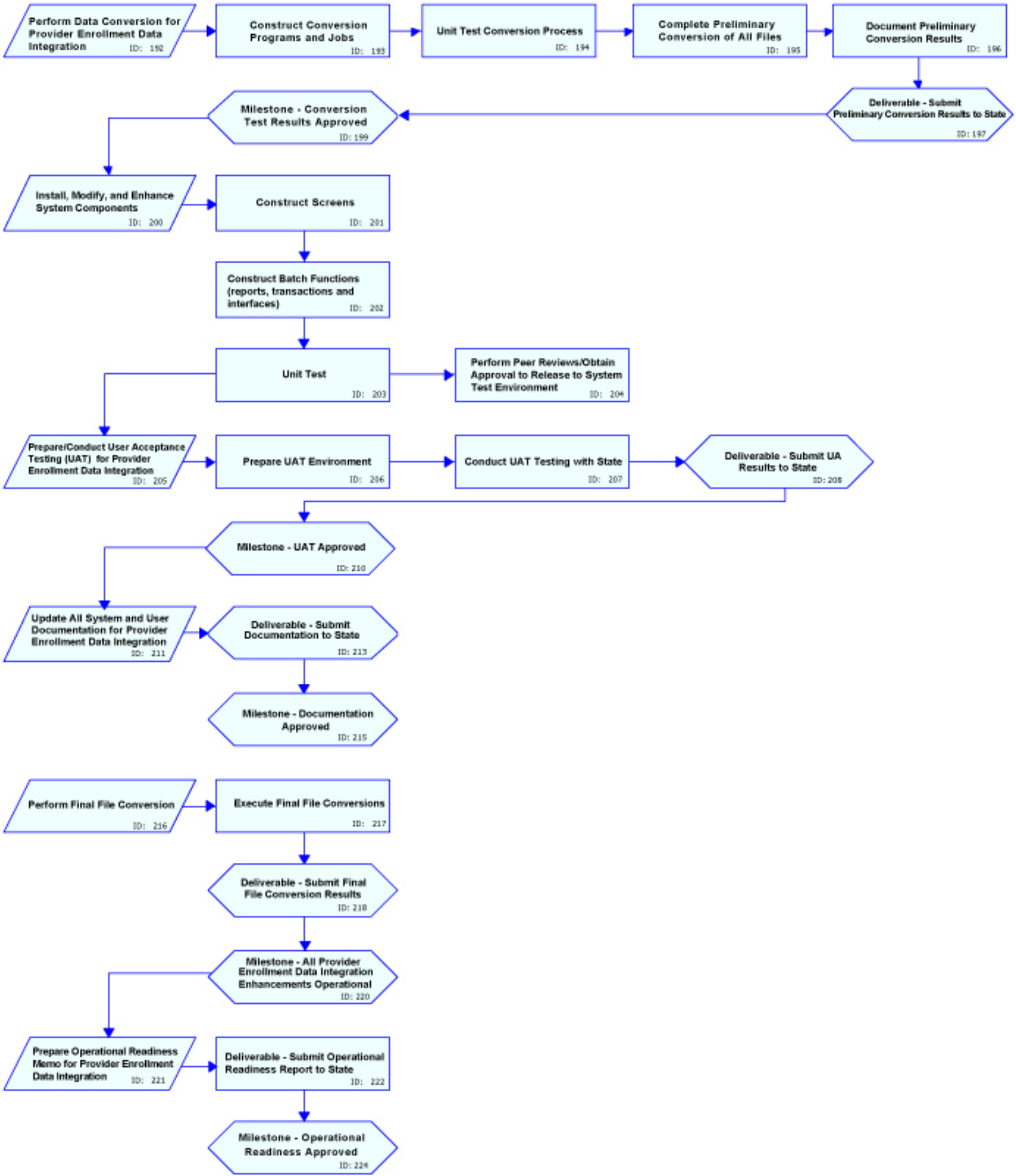
Critical Path ClaimCheck ClaimReview



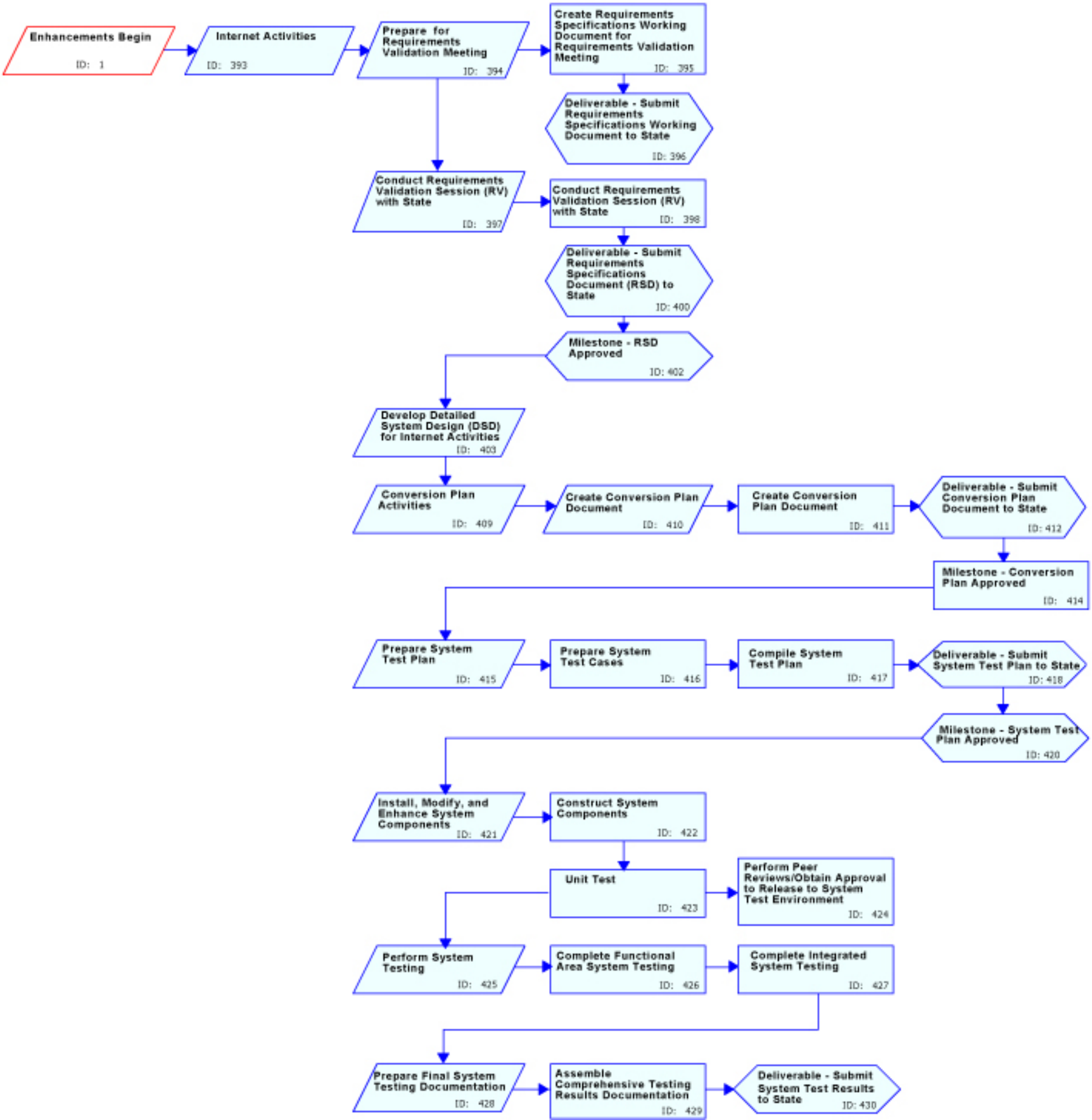
Critical Path Provider Enrollment Data Integration



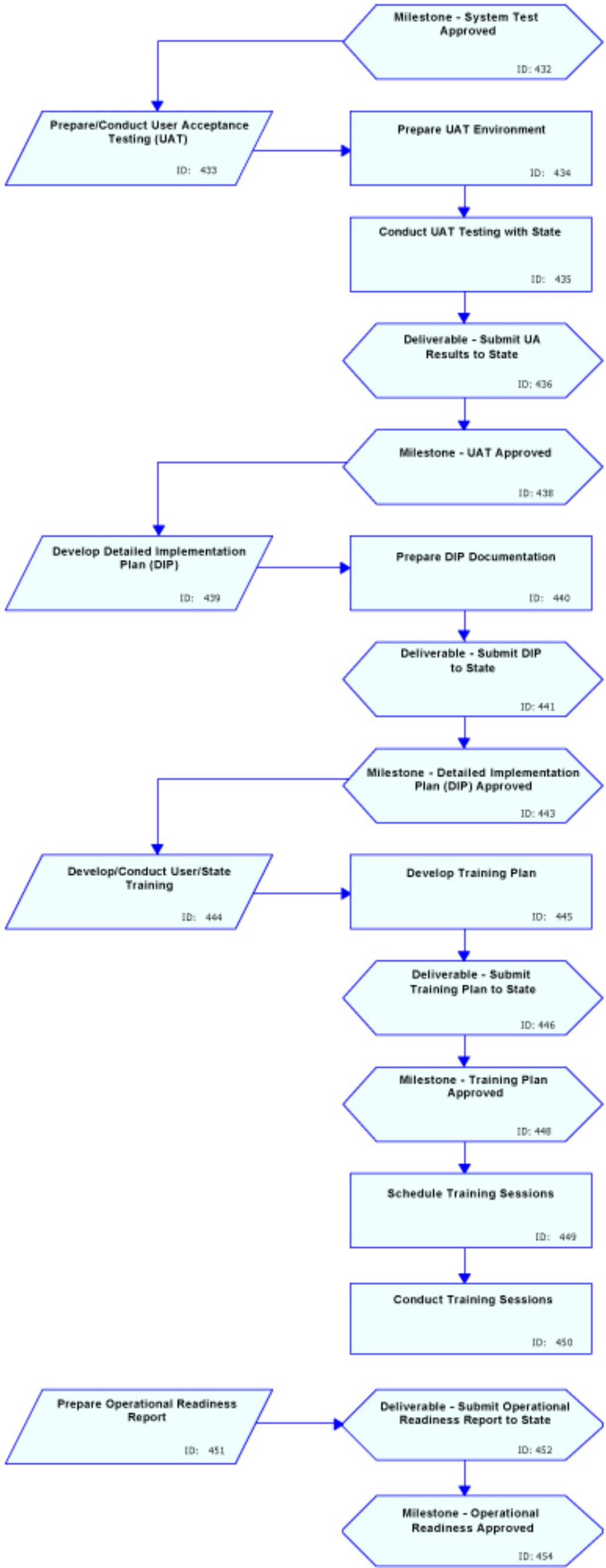
Critical Path Provider Enrollment Data Integration (continued)



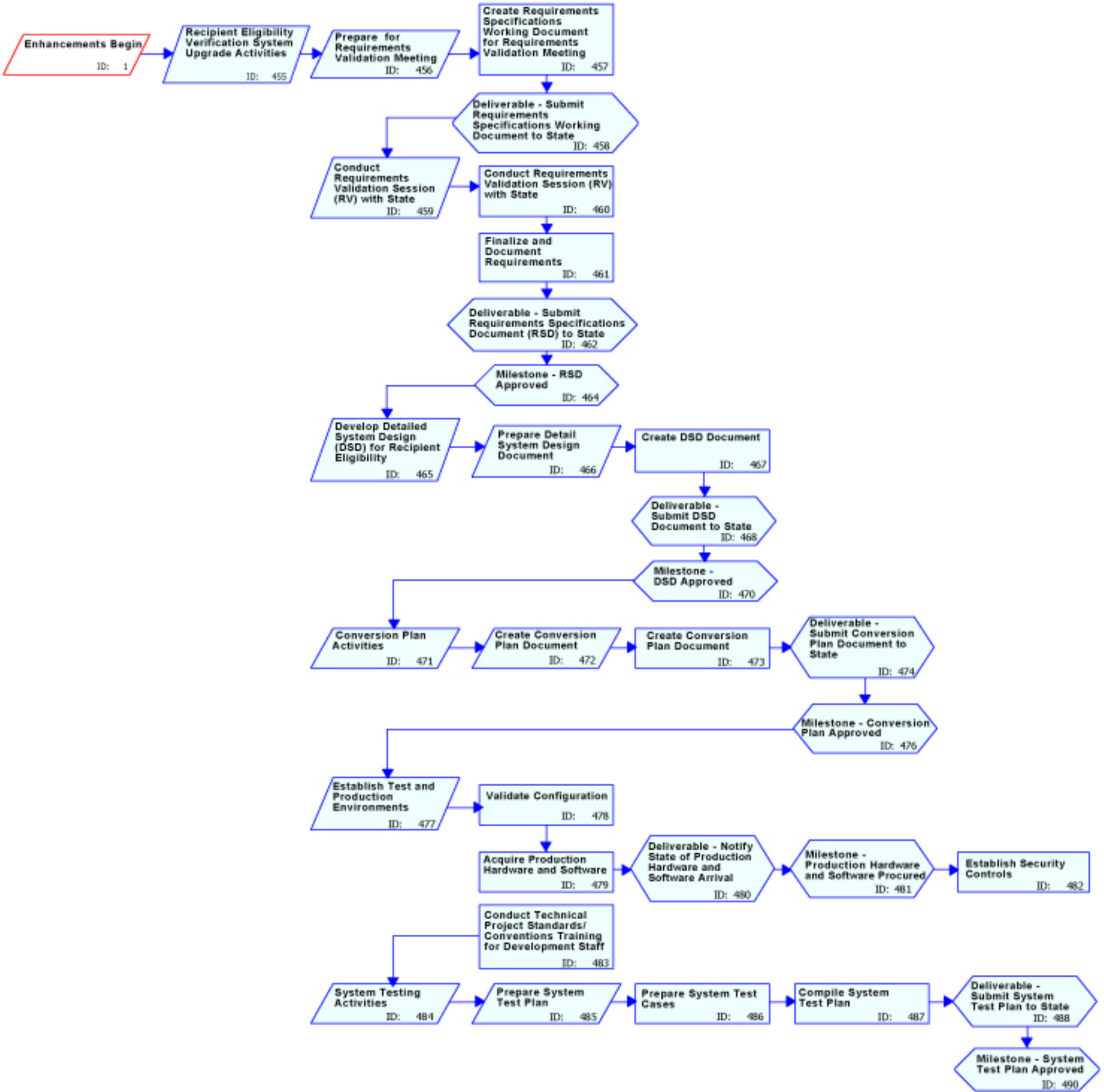
Critical Path Internet



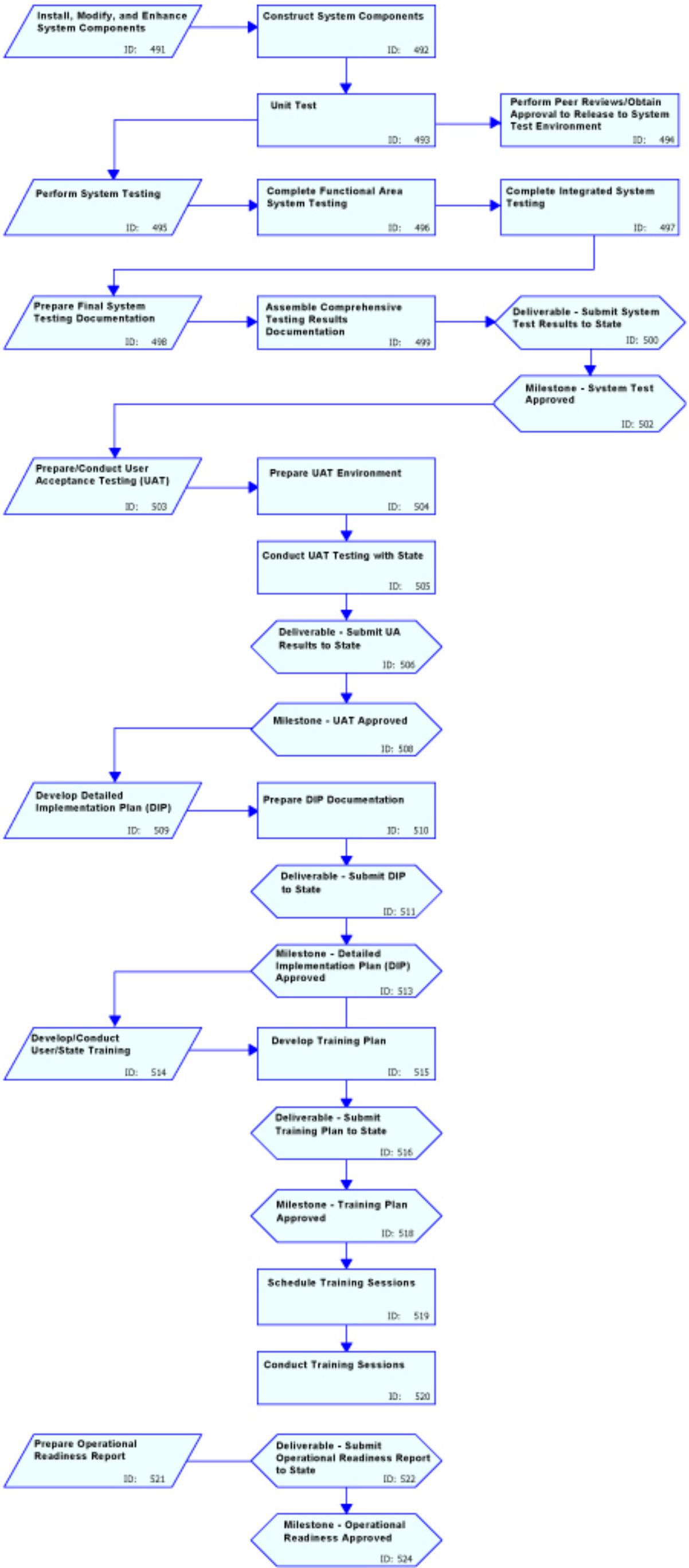
Critical Path Internet (continued)



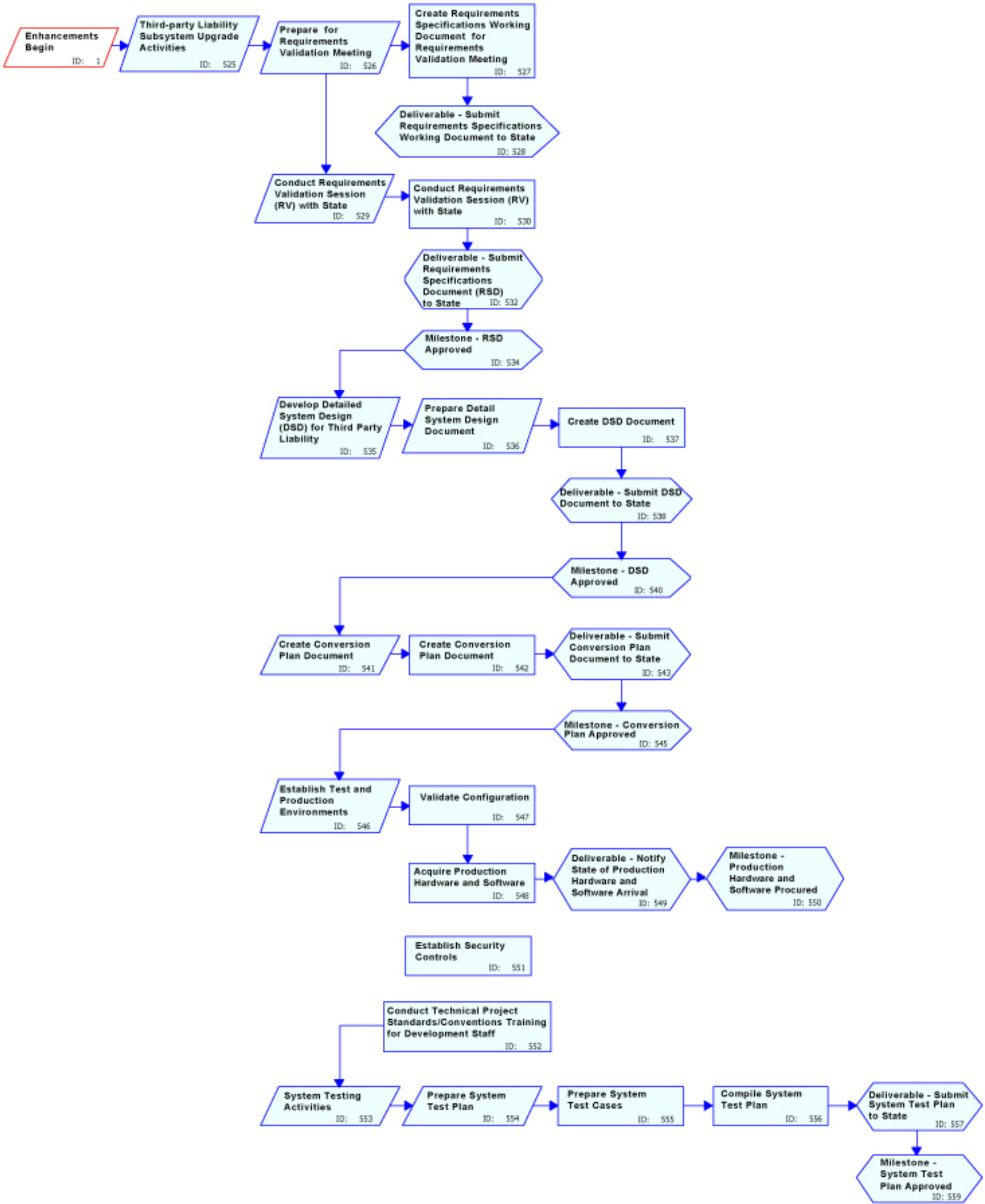
Critical Path Recipient Eligibility Verification Upgrade



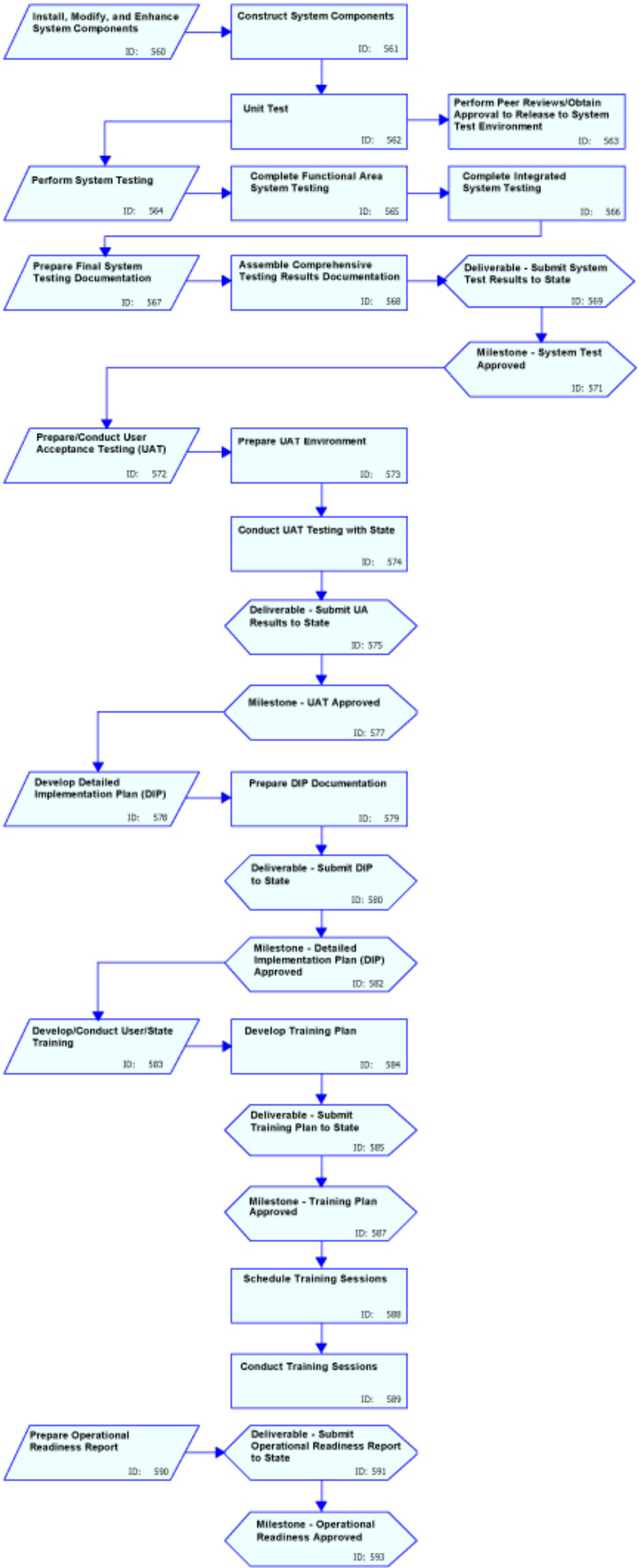
Critical Path Recipient Eligibility Verification Upgrade (continued)



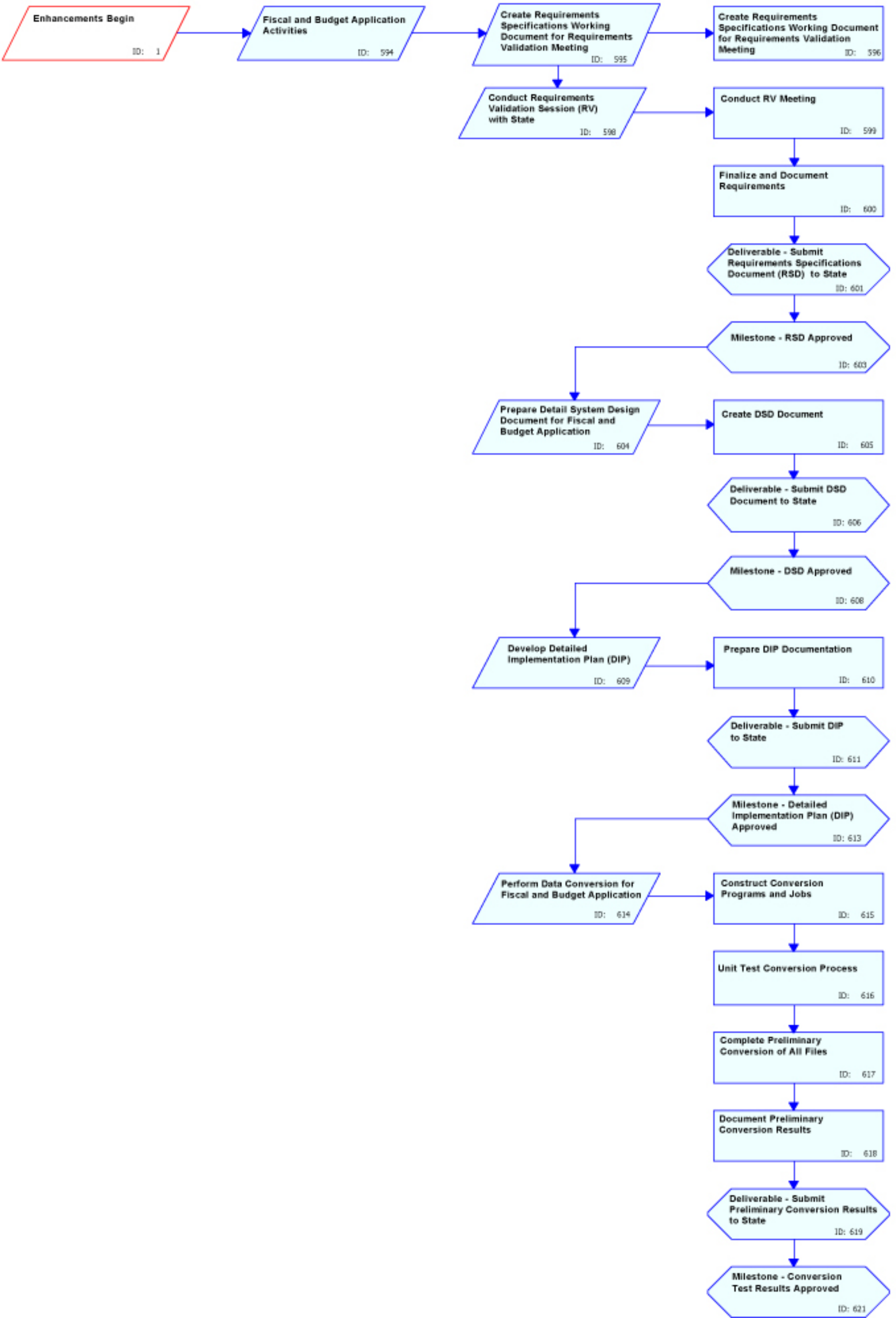
Critical Path Third-Party Liability



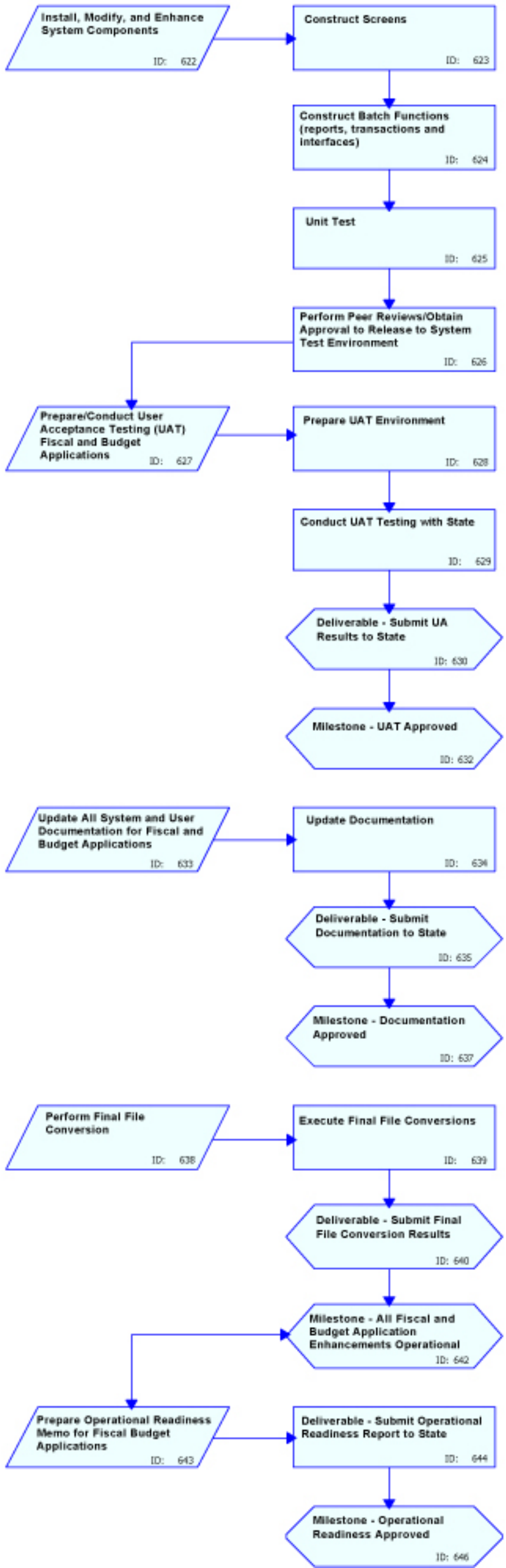
Critical Path Third-Party Liability (continued)



Critical Path Fiscal and Budget Applications



Critical Path Fiscal and Budget Applications (continued)



p. Gantt Chart

RFP Reference: 3.2.2.10(p), p.3-16

With this proposal, EDS has submitted a Gantt Chart graphically depicting the duration, relationship, and dependencies of each task, subtask, activity, and subactivity throughout the Enhancements/Modifications Phase, as well as all deliverables and milestones.

The following describes each column of the Enhancements/Modifications Gantt Chart.

Enhancements/Modifications Gantt Chart Descriptions

Column	Description
ID	This first column on the left of the Gantt Chart is a sequential series of numbers from one through to the last activity on the Gantt Chart.
WBS	Microsoft Project generates a WBS number that indicates the relationship between tasks, subtasks, activities, and subactivities. The WBS ID number is sequential within each task and identifies work plan elements. Inserting, moving, or deleting a Microsoft Project task or subtask automatically updates the related identification numbers and displays the current order of tasks. The WBS number provides a unique identifying value that accounts for work plan tasks and subtasks. The number, divided into segments, is separated by a decimal point. Segments correspond to a task outline level.
Task Name	The task name proves an English (textual) description of the task, subtask, activity or subactivity.
Duration	The number in the duration column indicates the number of days—exclusive of weekends and state holidays—required to complete the task, subtask, activity, or subactivity.
Start	The start column indicates the day the work is scheduled to begin for the task, subtask, activity, or subactivity.
Finish	The finish column indicates the day the work is scheduled to finish for the task, subtask, activity, or subactivity.
Task Bar	Lines in the main body of the chart depict the calendar duration of the work required to complete the task described on the same line.

The Enhancements/Modifications Gantt Chart is on the following pages, as well as on the proposal CD. Please note: You will need MS Project 2000 on your PC to open the Gantt Chart file.

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q. How the Work Plan Provides for the Handling of Potential and Actual Problems

RFP Reference: 3.2.2.10(q), p. 3-16

Enhancements/Modifications Manager Sean Daly and his dedicated team will use proven project management methodologies, a structured development and implementation procedure, and a proven approach to quality management to produce outstanding results.

Our proven project management methodology approach ensures a well-formulated MMIS project plan that reflects systematic processes for planning, monitoring, adjusting, and controlling work plan activities. These processes allow a complete and orderly implementation of the requested enhancements. It provides operational reliability and positions us to anticipate and prevent problems that may arise. We will proactively monitor and evaluate the progress of the work plan. Using weekly updates, meetings, and ongoing communications within EDS and with the Department of PATH, EDS addresses areas within the work plan that require adjustment and communicate this need to the Department.

The project's quality monitoring and improvement process will leverage current operational staff including Barbara Davis and Cherie Bergeron. This experienced staff will participate in regular status meetings and prepare timely project status reports that track and monitor the following items:

- Current issues
- Tasks and subtasks being performed ahead of schedule, on schedule, or behind schedule
- Corrective actions planned to resolve issues or implement modifications
- Time estimates to resolve issues or implement modifications.

Sean Daly has overall responsibility for maintaining the work plan. Prior to each weekly status meeting, the project planner will update the work plan based on progress made during the previous week, decisions made during the previous status meeting, or through communications with authorized Vermont staff. Vermont benefits from Sean's recent experiences and knowledge in assisting with the implementation of the Delaware MMIS.

The work plan is reviewed by Sean and the other account leaders. Any adjustments deemed necessary are then made, and the work plan is printed for the current week's status meeting. This process is repeated weekly throughout the Enhancements/Modifications Phase.

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r. How the EDS Approach to the Enhancements/Modifications Scope of Work Clearly and Unambiguously Accommodates Existing Technology and Meets Stated Technical Requirements

RFP Reference: 3.2.2.10(r), p. 3-16
2.9, p. 2-179
2.10, p. 2-184

EDS' approach to the Enhancements/Modifications Phase scope of work will clearly and unambiguously satisfy the state's requirements to:

- Accommodate Existing Technology
- Meet Stated Technical Requirements

Accommodate Existing Technology

The RFP requires a takeover of the current VermontAIM client/server "as is," without any enhancements or modifications in the Takeover Phase (September through December 2003). Because we are the current contractor, we can say that EDS' takeover is done on the first day of the contract.

We will continue to operate VermontAIM and provide uninterrupted service to Medicaid and other state programs that use the system**. Only by selecting EDS to continue providing your fiscal agent services can the state save staff time and effort and reduce the risk associated with an inexperienced bidder performing the required tasks to successfully take over the current VermontAIM client/server system.**

The Operations Phase of the new contract begins on January 1, 2004. During this first year of operations, the state is requiring the contractor to implement the following Mandatory Enhancements/Modifications:

- MMIS system modifications
- Platform conversion
- ClaimCheck and ClaimReview installation
- Provider enrollment data integration

At its own discretion, the state may also require the implementation of any or all of the following optional enhancements:

- Internet functionality
- Recipient Eligibility Verification System upgrade
- Third-party liability subsystem upgrade

By definition, the implementation of any of these Mandatory or Optional enhancements or modifications will require the replacement of current technology (for example, converting the current database platform from Ingres to DB2) or the addition of new technology (for example, implementing ClaimCheck and ClaimReview). However, these enhancements and modifications will be implemented within the framework of the existing VermontAIM system.

All of these enhancements and modifications are extremely complex and require an in-depth understanding of the VermontAIM system's existing technology. The technical personnel who will be responsible for implementing these enhancements, under the direction of Enhancements/Modifications Manager Sean Daly, have the necessary detailed knowledge of the system because they have been working with the VermontAIM for many years. This experience with the existing system will allow Sean and his team to rapidly implement the modifications that will further enhance the system's value to all the programs that use it.

Meet Stated Technical Requirements

The takeover and operation of the VermontAIM will meet the technical requirements stated in RFP sections 2.9 and 2.10, with additional detail in 2.11. In fact, EDS already meets the stated technical requirements because we operate the system today. The mandatory enhancements and the optional enhancements that the state selects for us to implement will build on this existing technology (using it as a solid foundation for growth) and meet any new technical requirements that are defined in the design process.

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