



August 19, 2011

Mr. Bill Clark  
Provider and Member Services Director  
RFP for Member Services for **Green Mountain Care**  
Department of Vermont Health Access  
312 Hurricane Lane, Suite 201  
Williston, Vermont 05495

**RE: Member Services for Green Mountain Care RFP No.: 03410-00001-12**

Dear Mr. Clark:

MAXIMUS Health Services, Inc. (MAXIMUS) a wholly owned subsidiary of MAXIMUS, Inc., and your proven partner, is pleased to present the State of Vermont, Agency of Human Services, Department of Vermont Health Access (DVHA) our proposal to provide Member Services for Green Mountain Care. As directed in the Request for Proposal (RFP), we provide the following affirmations:

- MAXIMUS is willing and ready to provide the services defined in the RFP
- MAXIMUS agrees to all terms contained in the RFP
- MAXIMUS does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, sexual orientation, marital status, political affiliation, national origin, or handicap and complies with all applicable provisions of Public Law 101-336, Americans with Disabilities Act
- The MAXIMUS person who will serve as the primary contact person for the State's Issuing Officer is:

Susan Bauer, Vice President  
101 Cherry Street, Suite 320  
Burlington, Vermont 05401  
Telephone Number: (802) 238-3489  
Fax Number: (703) 251-8240

MAXIMUS offers DVHA a comprehensive and intact solution along with the required expertise to appropriately execute the scope of services described for Green Mountain Care Member Services. We have the necessary local facility, equipment, technology platform, experienced and trained Vermont-based personnel, training materials and protocols, policies and procedures, as well as the cumulative knowledge and experience gained by providing these exact services in Vermont for more than 15 years. Our local team is supported by a complement of highly qualified health and human services professionals and corporate infrastructure that supports

similar services for more beneficiaries than any other contractor; serving two-thirds of the Medicaid population among states that outsource these services.

In the spirit of continuous improvement and innovation, we offer several enhancements to services for the upcoming contract term. Understanding the considerable budgetary constraints Vermont faces, we employed creative solutions and cost savings initiatives to offer the full scope of services outlined in the RFP, along with innovations, while reducing overall annual costs to DVHA for these services. The innovations we offer include:

- Refreshed notices developed by the MAXIMUS Center for Health Literacy designed to improve the effectiveness of the notice allowing beneficiaries to better understand and act on them
- A member satisfaction survey that can be completed by callers through the IVR enhancing our ability to measure satisfaction effectively and efficiently
- Enhanced reporting format adding "clickable" links allowing DVHA officials to easily navigate through the reports
- The MAXDash system innovation that streamlines access to multiple different systems, integrating data in real time, resulting in greater accuracy, quality, and productivity increasing first call resolution

Understanding that resources are limited, we also provide a number of Optional Enhancements for your consideration should DVHA wish to explore additional scope items for Green Mountain Care Member Services. Optional Enhancements include:

- Enhanced support for Medicaid transportation services
- Additional assistance for premium billing functions and/or alternate payment methods such as debit/credit card payments via the Interactive Voice Response (IVR) or web
- Expanded IVR functionality including new self-service options for beneficiaries
- Creation of a Green Mountain Care Member Services website and the utilization of social media to reinforce the branding of Green Mountain Care Member Services and facilitate ongoing communication to Vermonters as programs are modified and/or new initiatives are launched
- Enhanced data analysis to comply with Centers for Medicare & Medicaid Services (CMS) proposed reporting requirements related to enrollment trends and the churning effect between programs

We offer DVHA a no-risk solution and implementation at a time when your considerable talents and focus are needed for other critical initiatives. We are prepared and excited to offer you our support to bring these initiatives and whatever other needs that emerge, to bear.

MAXIMUS has completed the Bidder Information Sheet and it is attached to this Transmittal Letter for your consideration. As stated previously, MAXIMUS accepts all terms described in the RFP. In accordance with DVHA's response to Questions and Answers, MAXIMUS looks forward to discussion and negotiation of certain contract terms and conditions. We understand that such discussions are intended to focus primarily on additional language further clarifying the terms under which MAXIMUS will provide the services defined in the contract, and that such

discussions that will occur prior to contract signing. This request does not denote that our proposal is conditional in any way, but rather communicates an assumption as to the process through which any resultant contract will be finalized.

The Certificate of Compliance as required by the RFP is attached to this Transmittal Letter.

As instructed in the RFP Section 9.7: Disposition of Proposals, we wish to assert certain portions of our proposal as Proprietary and Confidential, and exempt from release. These pages are clearly marked "PROPRIETARY" at the bottom of the page. In addition, we have developed a matrix that provides Section and page numbers associated with the Proprietary and Confidential information, and the justification for requesting that this information remain proprietary. The matrix denoting MAXIMUS proprietary information is attached to this Transmittal Letter.

We wish to convey our thanks for your long term partnership with MAXIMUS. It has been our singular pleasure to provide enrollment broker and member services support for one of the most forward-thinking and innovative state health care programs in the nation. We share Vermont's vision of health care as a right, rather than a privilege, and it is our strong desire to continue to partner with DVHA into this next, exciting, era for Vermont as you implement federal health care reform and become the first state in the nation to establish a hybridized single payer health care system. Having worked by your side these past 15 years, and seen firsthand what you are capable of achieving, we have no doubt that this vision will not only become a reality but a model for the nation.

Sincerely,



Bruce L. Caswell

President

MAXIMUS Health Services, Inc.

Enclosures

- Bidder Information Sheet
- Certificate of Compliance
- Matrix of proposed exempted portions of the proposal

RFP/PROJECT: Member Services

DATE: August 19, 2011

### Certificate of Compliance

This form must be completed in its entirety and submitted as part of the response for the proposal to be considered valid.

**TAXES:** Pursuant to 32 V.S.A. § 3113, bidder hereby certifies, under the pains and penalties of perjury, that the company/individual is in good standing with respect to, or in full compliance with a plan to pay, any and all taxes due to the State of Vermont as of the date this statement is made. 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.

**INSURANCE:** Bidder certifies that the company/individual is in compliance with, or is prepared to comply with, the insurance requirements as detailed in Section 7 of Attachment C: Standard State Contract Provisions. Certificates of insurance must be provided prior to issuance of a contract and/or purchase order. If the certificate(s) of insurance is/are not received by the Office of Purchasing & Contracting within five (5) days of notification of award, the State of Vermont reserves the right to select another vendor. Please reference the RFP and/or RFQ # when submitting the certificate of insurance.

**CONTRACT TERMS:** The undersigned hereby acknowledges and agrees to Attachment C: Standard State Contract Provisions.

**TERMS OF SALE:** The undersigned agrees to furnish the products or services listed at the prices quoted. The Terms of Sales are Net 30 days from receipt of service or invoice, whichever is later. Percentage discounts may be offered for prompt payments of invoices, however such discounts must be in effect for a period of 30 days or more in order to be considered in making awards.

**FORM OF PAYMENT:** Would you accept the Visa Purchasing Card as a form of payment? \_\_\_ Yes  No

Insurance Certificate(s): Attached \_\_\_\_\_ Will provide upon notification of award

Delivery Offered: 75 days after notice of award Terms of Sale: N/A

Quotation Valid for: 180 days Date: 2/15/2012  
(If Discount)

Name of Company: MAXIMUS Health Services, Inc. Contact Name: Susan Bauer

Address: 11419 Sunset Hills Rd., Reston, VA 20190 Fax Number: (703) 251-8240

E-mail: susanbauer@maximus.com

By: Bruce L. Caswell  
Signature (Bid Not Valid Unless Signed)

Name: Bruce L. Caswell  
(Type or Print)

All returned quotes and related documents must be identified with our request for quote name.

### ATTACHMENT TO TRANSMITTAL LETTER

We have given careful consideration to which portions of the proposal we seek to deem proprietary in accordance with Vermont's "Public Records Law" Title 1, Chapter 5, Subchapter 3 of Vermont Statutes Annotated ([1 V.S.A. §§ 315-320](#)), and have marked these sections accordingly. We believe the sections which we mark as proprietary fits within your definition of Trade Secrets, in accordance with the public records exemptions found in 1 V.S.A. § 317:

- Trade secrets, including any formulae, plan, pattern, process, tool, mechanism, compound, procedure, production data, or compilation of information which is not patented, which is known only to certain individuals within a commercial concern, and which gives its user or owner an opportunity to obtain business advantage over competitors who do not know it or use it, except that the disclosures required by 18 V.S.A.

We further categorize each Trade Secret using the definitions below.

- A. Personnel:** Disclosure of personnel names and positions shows the types of qualifications and responsibilities of key individuals and reveals information about a specific approach to service delivery that may be economically advantageous to a competitor.
- B. MAXIMUS Innovations:** Information about innovations developed by MAXIMUS would cause economic loss if disclosed to competitors in this and future procurements.
- C. Technology Approach:** Disclosure of the MAXIMUS technology approach, including hardware, software, telephone systems, and the configuration of such would lead to economic loss.
- D. Corporate Management, Business Practices, or Policies:** Description of internal management principles and techniques, protected business practices, and corporate policies as applied to this proposal would create an economic loss for MAXIMUS if revealed.
- E. Costs:** Our cost models are known only to certain individuals within our commercial concern and disclosure would allow our competitors to have an unfair advantage in our commercial marketplace.

In the following matrix, we provide section and page numbers of those items which we request to have withheld from disclosure.

Section	Page Number	Reason Code
<b>3: Executive Summary</b>	3-3 through 3-5 3-6	B, D A
<b>4: Corporate Background and Experience</b>	4-5 through 4-6 4-13 through 4-28 4-31 through 4-32 4-33 4-35 through 4-52	B E D A A
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<b>6.3: Enrollment</b>	6-52 through 6-53 6-56 through 6-58 6-63 6-65 6-68 6-71	A B C D B B
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<b>6.7: Data Reporting Exchange</b>	6-152 through 6-157 6-159 through 6-160	B B
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	9-48 through 9-51	D
<b>9.7: Data Management and Use</b>	9-55 through 9-58	D
<b>9.8 Human Resources</b>	9-63 through 9-66	A
<b>9.9: Operations</b>	9-68 through 9-70	C
<b>9.10: Contract Provisions</b>	9-72	B, C
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<b>11: Optional Enhancements</b>	11-1 through 11-14	B
<b>Appendix B: Job Descriptions</b>	All Pages	A
<b>Appendix C: Resumes</b>	All Pages	A
<b>Appendix F: Information Security Policy</b>	All Pages	C, D

## 10. STATE RESPONSIBILITIES

The Department of Vermont Health Access has partnered with MAXIMUS since 1996, collaborating to provide member services to Vermonters. As your trusted partner, we offer flexibility, cooperation, adaptability, and responsiveness to your current and future needs.

RFP Section 8, page 28

Our Technical Proposal demonstrates the benefits of operational continuity, a knowledgeable and experienced management team, programmatic stability, and the lowest possible risk that can only come from having an established 15-year relationship with the Department of Vermont Health Access (DVHA). As part of the contract resulting from this procurement, MAXIMUS understands the State shall assume the responsibilities summarized in *Exhibit 10-1: Acknowledgement of State Responsibilities*.

Task	State Responsibilities
Notification	Notify in a timely manner, all pertinent changes in health care program or DVHA policy, procedures or operational systems that affect or depend upon operations or activities.
Notification	Provide, in a timely manner, information regarding State or federal regulations, policies or statutes, or changes thereof, which are relevant to performance.
Review and Approval	Review and approve or indicate necessary changes in all informational and enrollment materials within 15 business days of receipt of said material.
Notification	Provide other information that the State deems relevant in order to fulfill the duties required by this contract.
Monitoring	Designate a project manager to represent the State on all matters pertaining to the contract, including monitoring compliance with contract terms, monitoring progress and quality improvement initiatives, and resolving issues related to program implementation and operation.
Reimbursement	Reimburse on a monthly basis in accordance with procedures defined in the contract, upon receipt of a properly completed invoice.
Enrollment	Perform final determination for all requests for exemption from enrollment in managed care.
Enrollment	Process disenrollments.
Enrollment	Provide current Medicaid provider lists, as necessary.
Enrollment	Provide information and otherwise assist in responding to complex inquiries from clients regarding DVHA policies.
Enrollment	Provide on a daily or weekly basis an outreach list of beneficiaries who changed health care programs.
Monitoring	Provide monthly enrollment reports to track enrollment and performance indicators.

**Exhibit 10-1: Acknowledgement of State Responsibilities.** As your current contractor, MAXIMUS remains aligned with DVHA's vision and goals, meeting contract provisions and responsibilities now and in the future.

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### 3. EXECUTIVE SUMMARY

MAXIMUS is honored to have served Vermonters, and the Vermont health care programs, since 1996. As the scope and reach of the programs administered by the Department of Vermont Health Access have grown over the years, we have been a steady and reliable partner, meeting or exceeding our performance standards and showing flexibility, adaptability, and an unwavering commitment to the Vermonters who depend on your programs. Our proposal maintains the people and best practices that have met the State's needs for more than 15 years while laying the foundation for innovation and new ideas that align with Vermont's ambitious plans for health care in the future.

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For those Americans lucky enough to live in a State whose size is inversely proportional to its natural beauty and independent thinking, Vermont offers many attractions. From the Champlain Valley, to the heights of Mount Mansfield, Vermont has a long history of "marching to the beat of its own drummer." From the early history of Vermont as a Republic unto itself, to the historical and pivotal role played by its "Green Mountain Boys" in turning the tide of the American Revolution, to its prescient and precedent setting establishment of the first constitution in America that abolished slavery, Vermont has proven it does not shy away from bold moves. While Vermont's charms are many, among its greatest is its history as a laboratory of government solutions whose scope and ambition dwarf what many other States of considerably greater resources and wealth are willing to attempt or even consider.

Among the most notable of these, of course, is Green Mountain Care, both in its current form and as envisioned in Act 48. MAXIMUS is honored to have served the Department of Vermont Health Access (DVHA) during a period of time in which a suite of innovative and successful government programs have come together to form a health insurance continuum for most Vermonters who need a helping hand with their coverage. We respect, and share, Governor Shumlin's vision that health care is a right, and not a privilege, and are committed to doing whatever it takes to support



**Subject Matter Expertise.** As the only company that has served as Vermont's member services contractor since 1996, MAXIMUS brings comprehensive and unmatched understanding of DVHA's goals, program requirements, and future plans. We bring the kind of deep and relevant knowledge that can only be acquired through interactions with hundreds of thousands of Vermonters over a long period of time.

**A Seasoned and Knowledgeable Management Team.** Our team of talented professionals, all well known to DVHA and collectively possessing more than 85 years of combined project experience, will remain intact and fully engaged.

**Innovations Based on Best Practices.** While we have been a stable and high-performing contractor, we are pleased to bring a set of new operational innovations that reflect our experience and position as the nation's dominant company providing supporting services for public health care programs.

**A Foundation for the Future.** We have the infrastructure and solutions in place to meet all of your needs today, and the knowledge, commitment, and experience to help you achieve your ambitious plans for health care in the future.

**Lowest Risk.** Our personnel, infrastructure, technology, and community partnerships are in place to meet the RFP's scope of work and associated deadlines. We have no learning curve and have already demonstrated our reliability by meeting or exceeding all contractual performance standards.

you in the pursuit of realizing this vision for Vermonters. Our proposal is submitted with pride in what we have achieved on your behalf, continued admiration and respect for your commitment and creativity, and a sense of optimism and excitement about where the future may lead.

### 3.1 MAXIMUS OVERVIEW

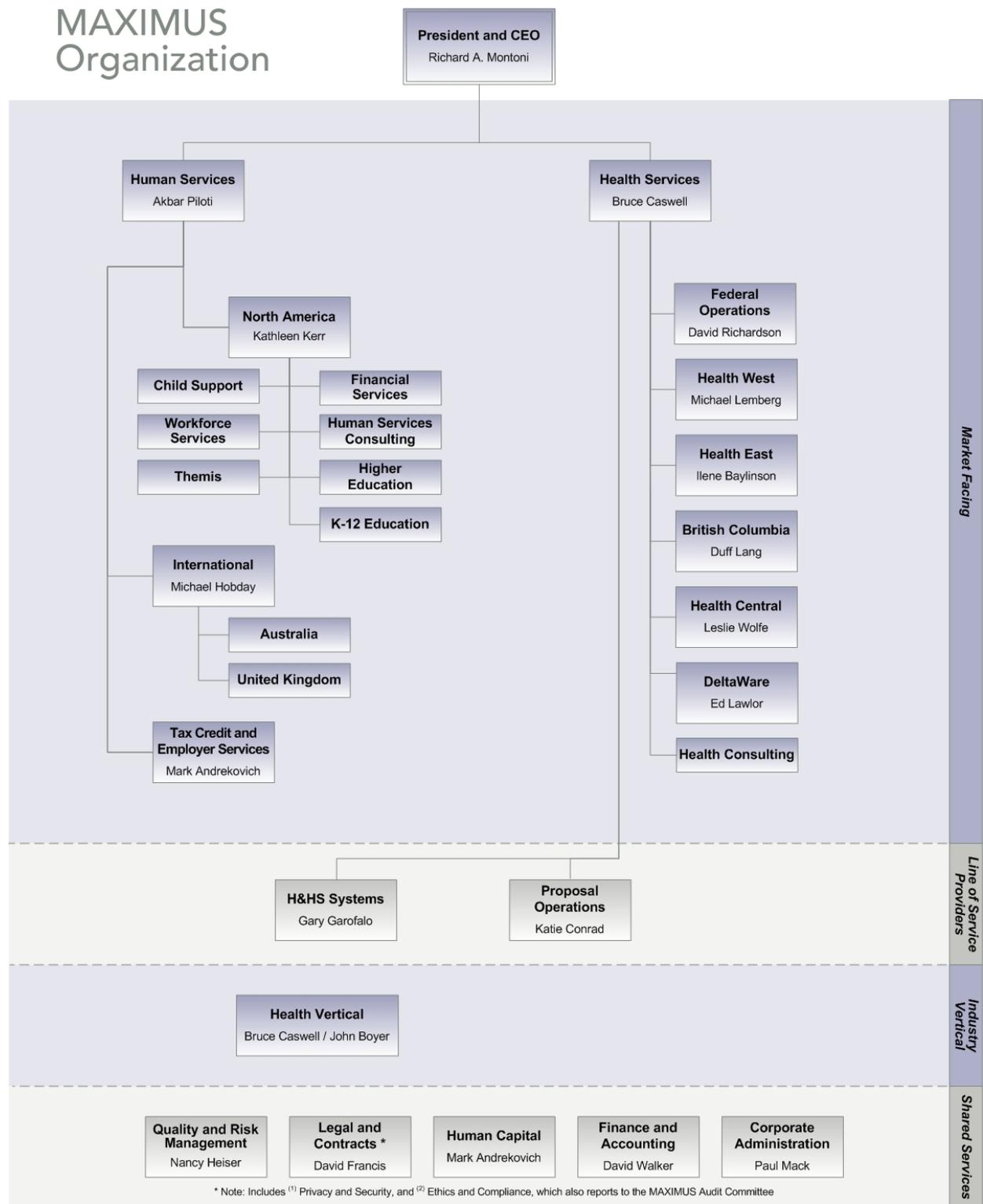
More state officials and decision-makers have selected MAXIMUS to support their Medicaid administrative services programs than any other company. We provide enrollment broker services to almost 15 million individuals in 13 states, representing almost two-thirds of the nation's Medicaid managed care participants. Our national experience in relation to the RFP's scope of work is dominant and unquestionable, including more than 47 million enrollments and reinstatements and 82 million customer service phone calls. We have the personnel, organizational capacity, and financial strength to produce more than \$800 million in annual revenue with no long-term debt. And we are increasingly being recognized as a national thought leader on how states can create practical and realistic solutions for their responsibilities under the Affordable Care Act (ACA).

But it is our track record in Vermont that is most relevant to our proposal because it demonstrates several attributes that we believe will be essential as the State moves toward the goals of ACA health reform and a new vision for Green Mountain Care:

- **Accountability.** During our current contract term, we have met or exceeded all performance standards, including an auto-assignment rate that is 40 percent better than the State's goal and a call center hold rate that is 75 percent shorter than the requirement. We have met our obligations and, in many cases, gone considerably beyond what was required of us. We commit to maintaining the same high level of services into the coming contract term.
- **Adaptability.** We have worked closely with DVHA to design and implement the *PC Plus* program, the redesigned premium collection process, the Dental Home initiative, the Catamount Health and Premium Assistance (CHAP) and the Employer-Sponsored Insurance Assistance programs. In relation to these efforts, we have performed special outreach, produced targeted mailings, triaged and referred callers, modified Interactive Voice Response (IVR) and educational messages, conducted research, modified reporting, extended hours of operation, and provided supplementary staff to assist DVHA in addressing various issues as raised. Changes to our contract have been, and will continue to be, developed in a spirit of helpfulness, accommodation, and goodwill.
- **Continuity.** Through three contract terms, we have developed the kind of knowledge, expertise, and trusted professional relationships with the State and its stakeholders for which there is literally no substitute. The positive outcomes that ACA and Act 48 offer can best be achieved by building on what has worked. MAXIMUS offers the kind of stability and steady-handedness that will be a virtual pre-requisite for success in the coming years.

### 3.2 GENERAL DESCRIPTION OF OUR APPROACH

MAXIMUS has established a reputation for serving Vermonters courteously, promptly, and effectively. We have mastered all facets of project operations including managed care education and enrollment, member services, materials creation and dissemination, and the proven capability to adapt and innovate to meet emerging needs. We offer DVHA a high quality, no



**Exhibit 3.3-2: MAXIMUS Organizational Chart.** As an organization, MAXIMUS is uniquely focused on only serving government and government programs and has the experience, technology, resources, and innovations to provide outstanding support for Green Mountain Care Member Services into the future.

## 4. CORPORATE BACKGROUND AND EXPERIENCE

The Department of Vermont Health Access administers one of the most complex member services projects in the nation, necessitating a partner with exceptional capabilities and qualifications that come from relevant, hands-on experience. As your partner for more than 15 years, MAXIMUS has successfully provided these services to Vermont's beneficiaries and met the State's evolving needs. We serve more than 18 million consumers of Medicaid and expansion programs. Our knowledgeable nationwide, dedicated staff is expert in serving beneficiaries and committed to providing excellent services for Vermonters. MAXIMUS is a trusted, experienced, and capable partner that is ideally positioned to assist the State of Vermont as it moves into the next phase of Green Mountain Care Member Services.

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The bidder should provide a brief description of contracting experience for projects of a similar scope and nature. The bidder should provide suitable evidence that the bidding entity has sufficient organizational and financial resources to provide the services offered. The bidder must include a copy of the most recent audited financial statement.

Additionally, bidder should provide a listing and description of all projects that involved one or more of the following activities as one of the project's major components:

- Medicaid Enrollment
- Managed Care Enrollment
- Managed Care Education
- Consumer Relations
- Outreach/Public Relations
- Data Systems and Operations

Project descriptions must include the client name; contact person and phone number, duration of the project, dollar amount, a description of the scope of services provided and a description of project components that are similar to the services defined in this RFP.

MAXIMUS has been privileged to serve the State of Vermont as a trusted partner in providing services for more than 15 years. Over that time, we have evolved to meet changes in State policies, programs, and priorities. As Vermonters themselves, our team in Vermont is proud of what we have been able to accomplish together through the years. From enrollment into managed care and the Catamount plans to the launch of Medicare Part D and VPharm and much more, we have seen Vermont take on many new initiatives and have been there to help you with each one of them. We hope to continue our partnership as you move forward to conquer new challenges, such as the implementation of ACT 48 and the Affordable Care Act (ACA) and upcoming changes to the Vermont Medicaid Management Information System (MMIS) and eligibility system. As the national leader providing these services to states,



**Experience.** A trusted partner for more than 15 years, we are experienced in helping Vermont through program changes and are equipped to help manage the innovations expected in the coming years.

**Continuity.** With our highly experienced team and our proven systems in place, MAXIMUS will maintain continuity in high quality service delivery.

**Strength.** Our financial and organizational strength and stability provide Vermont with the assurance that we can fully support our projects even in these times of economic turmoil.

**Best Practices and Innovations.** We continually invest in recognizing and developing best practices that inform and enhance the services we provide to Vermont, such as our recent implementation of the MAXDash portal and upcoming implementation of the IVR beneficiary satisfaction survey.

**Focus.** Our singular focus on health and human services government contracts means that every aspect of our organization will support the goals Vermont has for Green Mountain Care Member Services.

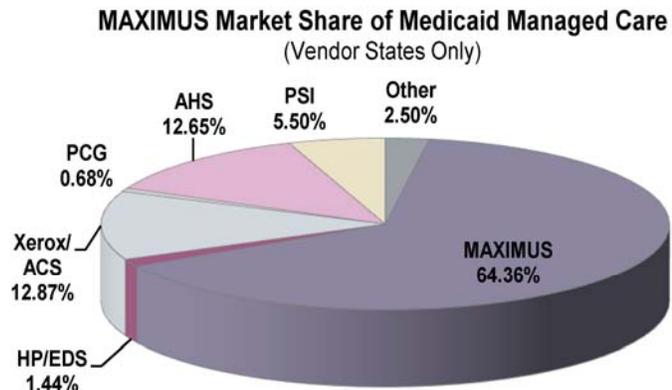
**Lowest Risk.** MAXIMUS represents the high-value, low-risk option for Vermont.

we are able to leverage innovative technologies and processes developed elsewhere, and do so for minimal cost, offering you the best value solution to meet both existing and emerging needs.

#### 4.1 EXPERIENCE WITH PROJECTS OF A SIMILAR SCOPE AND NATURE

MAXIMUS projects currently serve the majority of the nation's Medicaid and state health care program enrollees – more than 18 million people – making us the national leader in enrollment broker services. As a trusted ally to numerous states in providing enrollment broker services, we share our clients' mission and goals for serving their Medicaid enrollees.

Understanding and sharing our clients' goals for managed care enrollment are not enough, however; as Vermont is aware, experience matters. We are proud to note that we operate more Medicaid statewide call centers and process more applications and renewals for public sector programs than any other company. Having accumulated more than 100 program-years of experience over the past decade, and currently operating 13 Medicaid enrollment broker and member services projects, MAXIMUS is the national leader providing these services to states. Of those states enrolling through a third-party contractor, MAXIMUS serves nearly two-thirds of the nation's Medicaid managed care enrollees, as we show in *Exhibit 4.1-1: MAXIMUS Market Penetration in Medicaid Managed Care*.



**Exhibit 4.1-1: MAXIMUS Market Penetration in Medicaid Managed Care.** MAXIMUS is the leading contractor in the nation providing state Medicaid managed care enrollment.

Of our many and varied projects over the years, however, the experience of greatest relevance for this procurement is the work we are doing for you right now. Together we have forged a solid partnership for more than 15 years, evolving our services to meet your needs as they change and grow. We take great pride in this valued partnership and in the many things that together we have been able to accomplish.



Our partnership has been characterized by growth and change. At each turn, we have demonstrated our ability to adapt as your needs changed, an ability that we will carry forward to help you meet the new challenges and requirements to come. When our work with you began in 1996, the requirements focused primarily on managed care outreach and education. The next year saw the beginning of mandatory managed care enrollment, as well as program expansions for both VHAP and Dr. Dynasaur. MAXIMUS staff educated callers on the new mandatory managed care requirement, fielded calls to the toll free HelpLine, and made outreach calls to enrollees to choose a

health plan. In 1997 we also began preparing for the enrollment of the aged, blind, or disabled (ABD) populations, visiting provider sites to check for Americans with Disabilities Act (ADA)

compliance and providing feedback on needed improvements, revising enrollment scripts, developing and delivering specialized staff training, and working closely with the Department of Vermont Health Access (DVHA) and several other key stakeholders to achieve an efficient and effective managed care conversion process that met the unique needs of these enrollees. We began managed care enrollment for ABD populations in May 1998, placing more than 6,000 outreach calls to ABD enrollees in a two-month span. These project expansions were joined in April 1998, by the expansion to assume member services for all Vermont health care programs, and the enrollment for Social and Rehabilitative Services (SRS) children beginning in August. Collectively, these expansions resulted in a 69 percent growth in call volume, from 71,000 calls in 1997 to 120,000 in 1998. The following year was similarly eventful with the launching of **Primary Care Plus (PC Plus)**, enrolling persons with disabilities and seamlessly transitioning managed care enrollees.

As with the 1990s, the next decade further demonstrated the value of our partnership as the Vermont Member Services project underwent more change and growth. For instance, the establishment of the Healthy Vermonters Pharmacy Plan in 2002, along with changes to pharmacy plans and coverage, required the development and delivery of new training materials and new call scripts. The migration of eligibility notices from ACCESS to the Department of Children and Families (DCF) Intranet and changes in HIPAA confidentiality guidelines in 2003 similarly required new training. The premium collection process redesign in 2004 involved a lengthy, well-considered planning process for which we helped create overall policy surrounding the health care programs affected by premium changes. The selection of a new Pharmacy Benefit Management contractor in 2005 further necessitated changes in systems and service delivery processes, requiring us to develop and deliver new training and support for staff to ensure the proper utilization of an additional claims database.



Passage of the federal Medicare Prescription Drug, Improvement, and Modernization Act (MMA) presented new challenges to the project and brought new requirements for the rollout of Medicare Part D pharmacy benefits. The changes involved a new pharmacy benefit management system, new training, and new materials. Our staff adapted to accommodate a surge in call volume as beneficiaries sought information on this new program: the first quarter of 2006 saw an increase in call volume of 20 percent over the fourth quarter of 2005. During this time, we also assisted DVHA with their temporary Part D call center, deploying project staff to Williston to provide additional coverage seven days per week. Upon the passage of MMA, we were approached by DCF to assist with the new Citizenship and Identity requirement. Working closely with DCF, we negotiated and finalized an amendment to our contract and began to research and collect birth certificate application forms and websites for all 50 states and abroad, develop new training materials and staff training sessions, develop scripts to educate callers, and verify the status of proof submitted by beneficiaries. These efforts positioned Vermont well ahead of other states in progress toward compliance with MMA requirements.



In 2007 and 2008, we assisted Vermont with several new programs. When Green Mountain Care was established, we helped with the rebranding effort by providing feedback to DVHA on notices and website content. Our team assisted the State with determining policies, procedures, design, and operations for the new Catamount Health Plan and Premium Assistance programs. Further, we worked with DVHA's Coordination of Benefits staff to establish a cost-effectiveness test screening for beneficiaries with access to employer-sponsored insurance. These new programs, along with the Dental Home program in 2008, represented increases in our responsibilities that required new training and procedures for our staff and resulted in higher call volumes. Also in 2008, the Application Tracking effort began. This initiative tracked new applicants that did not complete the process or otherwise did not respond. We tracked more than 117,000 applications for this effort.

In 2009 we were pleased to be able to assist the State when the DCF Modernization effort's Economic Services Division (ESD) Benefit Services call center faced a significant challenge presented by a sudden and daunting increase in call volume; the number of calls we handled jumped 59 percent in one month, from 23,955 in August to 37,986 in September. To further support the DCF effort, we offered to provide other types of assistance such as support of the data entry of applications, assistance with additional calls, and other general support. Following the decision to return our toll free number to health care eligibility notices, we devised creative measures to ensure that we could promptly and effectively serve the escalated volume without adding costs for DVHA. These measures included implementing a call triaging process and instituting overtime hours for staff to ensure that beneficiaries with pressing needs could reach us immediately and that all beneficiaries would be served promptly and appropriately.

Also in 2009, we pursued new, more effective approaches to support Catamount Health Plan enrollment. We observed that the paper-based method had resulted in backlogs and proposed to support a paperless, phone-based process to streamline the overall enrollment process for beneficiaries. This innovation resulted in more than 16,000 paperless Catamount enrollments or transfers to date and no additional costs for DVHA.

When the DCF/ESD call center began experiencing significant challenges last year, we again were glad to assist the State. Changes at DCF caused a large increase in call volume at MAXIMUS as members sought to resolve issues with their applications and update their case files. After tracking the trends and consulting with both DVHA and Administrative Operations (AOPS), we created a triage process with message-taking to make sure callers with urgent issues could get through to their caseworkers. We employed an "all hands on deck" approach, bringing on additional temporary workers and asking staff members to work overtime for three months until the backlog was processed. Working collaboratively and placing a priority on clear communication, we documented and tracked concerns and complaints for DVHA in our weekly reports, allowing us to assess whether the changes were proving effective.



*Exhibit 4.1-2: Partnership Milestones in Vermont Green Mountain Care Member Services* summarizes a number of the significant events in the history of our work together.

in these systems can result in greater efficiency and effectiveness in program management, but the process of change presents the potential for disruption in operations. While system design, development, and implementation are covered by the selected technology vendor, our projects inevitably serve as the public face of the roll-out, so we make it our priority to ensure that changes roll out smoothly. This is an area where directly relevant experience makes all the difference. Our clients in Michigan, Georgia, and Massachusetts also have gone through a significant overhaul of their MMIS systems. We worked side-by-side with our state partners to anticipate issues and take all necessary steps to minimize the impact on members, resulting in a smooth transition to the new systems. We played an active role in documenting the "as is" processes and developing the "to be" processes and performed extensive User Acceptance Testing (UAT) to ensure that the end product was successful. Just as in those states, we can be an indispensable partner in helping to manage these changes for Vermont.

Throughout our tenure as your Member Services contractor, Vermont has been at the forefront of health care reform and will continue to be in the coming years. Reform efforts represent another area where change is already anticipated and will require capable and effective management. Our experience in helping other states move forward with health care reform can benefit Vermont. For instance,

- We helped Indiana set up its Healthy Indiana Plan, which covers otherwise uninsured single adults. We were able to create a call center to answer questions and distribute applications within two months of contract award by our client.
- In Massachusetts, the State expanded our MassHealth contract to include health reform populations covered by the State's universal health reform legislation. Within six weeks of first meeting with the Massachusetts Connector Authority, we were taking calls about health reform from the general public. Three months later, we partnered with Massachusetts to enroll the first members in the program known as CommCare.
- In New York and California, MAXIMUS was selected as the contractor to enroll members in the Pre-Existing Condition Insurance Program mandated by the federal Patient Protection and Affordable Care Act. MAXIMUS is the only company in the private sector in the country performing these services, and it has given us a significant head start on understanding federal health reform initiatives, especially with respect to members with complicated health needs that would have otherwise been uninsurable.

**MAXIMUS is the only company in the private sector in the country performing these services, and it has given us a significant head start on understanding federal health reform initiatives.**

Over the years, we have valued the opportunity to help Vermont achieve its ambitious, forward-thinking health care goals. Vermont has big plans for the future of its health care programs; with the expertise we've gained in Vermont and elsewhere, we look forward to helping you realize your goals both effectively and efficiently.

## 4.2 ORGANIZATIONAL AND FINANCIAL RESOURCES

MAXIMUS provides Vermont with the full scope of expertise needed to continue to operate Green Mountain Care Member Services effectively. Our singular focus on government

programs and our unwavering commitment to health and human services operations enable us to devote substantial corporate personnel and financial resources to a strong infrastructure supporting our projects. This reduces risk for our clients, as we can implement new programs and expand existing ones while drawing on company-wide resources, expertise, and knowledge.

#### 4.2.1 Corporate Organizational Resources

Our corporate organizational structure is presented as *Exhibit 3-2: MAXIMUS Organizational Chart* in *Section 3: Executive Summary*. Vermont is part of our Health East Division under the leadership of our Division President, Ilene Baylinson. Ms. Baylinson is a highly experienced professional with more than 25 years supporting government health care programs. Reporting to Ms. Baylinson is Vice President Susan Bauer. Ms. Bauer, who is a longtime Vermont resident, has been responsible for the direct oversight of our Vermont operation since it was established in 1996 and is well versed in government health care programs in general and the Vermont programs specifically.



Our corporate structure makes certain that Vermont will continue to have the advantages that come with our broad array of health and human services experience. Every aspect of our corporate organization – finance, quality and risk management, human capital, systems, administration – supports the projects we operate. This allows us to focus on quality and best practices for the type of opportunities we seek, constantly monitoring our current projects to anticipate needs and helping projects meet the expectations of our clients.

Our ability to draw on company-wide expertise and knowledge results in better program outcomes and reduced risk for our clients. MAXIMUS experts around the country are available exactly when your project needs their expertise. For instance, our business process modeling experts are available to design or refine process flows as needed. Our systems experts around the country are available to address system needs. Our infrastructure experts for technology and facilities are available to install systems and telephony and build out facilities as necessary. Because these experts are in-house, they are already known and trusted members of our team and can be deployed precisely when and where needed. We know the quality of their work, and we know they can deliver exactly what our clients need.

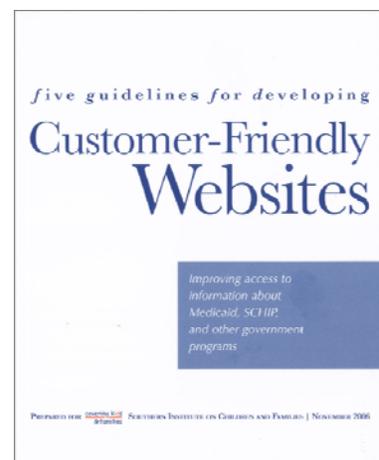
Two key benefits flow from our exclusive focus on government health and human services projects. First, as mentioned, it has allowed the supporting organizational resources to develop significant experience and expertise in meeting the needs of this kind of project. Second, this focus means that our corporate leadership's efforts are not divided between government health and human services projects and other lines of business. As such, we stay clear of conflicts that arise from business relationships with health care providers as a matter of corporate policy, and we are not distracted by commercial business. This allows us to ensure the delivery of choice counseling and enrollment services in an impartial and objective manner.

MAXIMUS invests in an array of corporate services and best practices to support our projects across the country. Our Center for Health Literacy, the Office of Quality and Risk Management,

and the Center for Employee Development each help us provide exceptional service delivery to our clients.

#### 4.2.1.1 Center for Health Literacy

To better serve customers with limited literacy or linguistic barriers, MAXIMUS established our nationally recognized Center for Health Literacy (the Center) in 2000. MAXIMUS understands that a key element to empowering public health and human service customers is the development and dissemination of accurate, timely, and easily understood information. The Center creates consumer-tested, accessible materials that are linguistically and culturally appropriate to further education and outreach. The Center provides our projects with information, publications, and design expertise to support the development of an array of easily understood and visually appealing program materials. Additionally, the Center provides expert translation services, developing forms and materials in languages needed by projects to serve segments of their populations. Furthermore, the Center developed and published *Five Keys to Developing Customer-Friendly Websites* under a contract funded by the Robert Wood Johnson Foundation in 2006. This manual offers practical guidelines for making user-friendly public program websites. The Center has been involved in the development of member handbooks and other materials throughout the past 15 years of our work with Vermont. We discuss the Center in greater detail in *Section 6.1: Outreach, Question 4*.



#### 4.2.1.2 Office of Quality and Risk Management

The Office of Quality and Risk Management (QRM) coordinates our company's quality efforts, sponsoring independent oversight for selected projects and monitoring adherence to performance standards on all contracts. QRM reports any instance of contract noncompliance to the CEO and the Board of Directors, which provides the highest levels of accountability and response for any project that is in need of additional support or problem-solving. To facilitate this role, each business segment within the company maintains, revises, measures, and reports to QRM a business-specific quality plan designed to align with the overall corporate Quality and Risk Management Plan. QRM provides a communication channel across the different business segments and projects, facilitating knowledge sharing among our projects and making certain that project directors and managers receive accurate and effective training and support related to quality best practices and initiatives. QRM also administers annual surveys of our government clients and performs follow-up meetings as appropriate to fully understand any issues and concerns of our clients. In each of the annual surveys conducted in the last three years, MAXIMUS Health Services clients rated project services overall at 4.6 on a five point scale. Please refer to *Question 26 (Section 6.6.8)* for more information on QRM.

#### 4.2.1.3 Center for Employee Development

We routinely support our project training staff with a dedicated team of trainers at our corporate office via our Center for Employee Development (CED). MAXIMUS created the CED to further enhance the ability of our projects' staff to offer effective, thorough training that results in high quality service delivery for our clients. With a cadre of instructional designers, classroom

trainers, and training coordinators, the CED oversees the design, development, and delivery of a core business curriculum designed to instill in our employees the knowledge and skills necessary to serve our customers and grow with the company. The CED also serves as a unifying agent in promoting integration, collaboration, and knowledge sharing among our geographically dispersed workforce. To this end, the CED supports locally delivered training programs, provides project trainers with electronic toolkits, coordinates off-site meetings for our management staff, and shares best practices across the organization. The CED also provides MAXIMUS University (MAXU), our enterprise web-based Learning Management System (LMS), to administer and manage corporate training activities and to deliver web-based training to our projects. We use the LMS to track staff participation and attendance in all courses, enabling us to be aware of which training modules are used most frequently and which seem to be most challenging for participants. We discuss the CED in greater detail in *Question 23 (Section 6.6.5)*.

Our orientation toward identifying best practices and using that knowledge when designing solutions for our clients means that the solutions we propose for Vermont today are informed by years of lessons learned from providing services to numerous clients, designing and refining solutions that respond to a wide array of policy directives and budgetary challenges, and addressing the changing needs of our clients quickly and effectively.

#### **4.2.2 Corporate Financial Resources**

MAXIMUS is publicly traded on the New York Stock Exchange (symbol: MMS) and is headquartered in Reston, Virginia. As such, our financial strength and stability are independently verifiable. We have accrued the financial and organizational capacity to oversee large-scale, highly visible projects, having grown to more than \$830 million per year in revenue with no long-term debt. Our financial strength provides our government clients with the confidence that we can fulfill contractual responsibilities and provide high quality, uninterrupted services to their citizens.

Effective government contracting requires a capacity to manage risk – for example, risk from changes in policy at the state or federal level. Smaller or more leveraged companies present their clients with the additional risk that one of the company's other projects might experience difficulties, potentially forcing a difficult decision about where to allocate limited corporate resources. Our publicly filed financial statements provide Vermont with the assurance that we have the financial resources to support all of our projects simultaneously as well as continue to develop the innovations that improve the services being offered to Medicaid members. Moreover, our financial stability and prudent, thoughtful leadership mean that Vermont can count on us to be here for the long haul.

**Vermont can be sure that in these uncertain times, MAXIMUS has the corporate capacity and financial strength to perform to the standards required for Green Mountain Care Member Services.**

We provide our most recent audited financial statement in *Appendix A: MAXIMUS 2010 10K Annual Report*.

Our understanding of and experience in Vermont, the depth of our experience nationwide, our financial strength and stability, and the depth of our organizational resources all offer significant benefits for Vermont and position us as the best choice for the continued operation of Green Mountain Care Member Services. We summarize these strengths and capabilities in *Exhibit 4.2-1: Why MAXIMUS?*

Key Factor Required	MAXIMUS Accomplishments
Understanding Vermont	<ul style="list-style-type: none"> <li>■ Experience providing these services for Vermont for more than 15 years</li> <li>■ Active participant in the Vermont Health Access Team (VHAT) workgroup that has evolved into the recently established health care reform workgroup</li> <li>■ Worked collaboratively with the State in creating new and modified programs such as the <b>PC Plus</b> program, the revised premium payment system, and the implementation of Green Mountain Care</li> <li>■ Unmatched understanding of the intricacies of all of Vermont's health care programs</li> <li>■ Demonstrated flexibility and responsiveness to changes in State policy and program requirements</li> </ul>
Experience with Medicaid Enrollment, Managed Care Enrollment, Managed Care Education, and Member Services	<ul style="list-style-type: none"> <li>■ More than 100 program-years of related experience in the last decade</li> <li>■ Medicaid managed care education, enrollment, and member services contractor in 13 states currently serving more than 18 million individuals</li> <li>■ Provide PCCM enrollment services in Vermont, Colorado, Virginia, and Massachusetts</li> <li>■ Currently provide managed care education and/or enrollment through 14 separate customer service call centers</li> <li>■ Operate member services and eligibility support HelpLine services in Vermont, Massachusetts, and Michigan</li> </ul>
Data Systems and Operations	<ul style="list-style-type: none"> <li>■ Successfully designed and implemented sophisticated enrollment and eligibility systems for all our Medicaid managed care enrollment and CHIP projects</li> <li>■ Ability to partner "high tech" solutions with our "high touch" values of service delivery</li> </ul>
Depth of Organizational Resources	<ul style="list-style-type: none"> <li>■ With more than 6,500 staff members nationwide, our in-house experts are ready to assist your project where and when needed</li> <li>■ We constantly strive to recognize and develop best practices, such as the work we do through our Center for Health Literacy, our Office of Quality and Risk Management, and our Center for Employee Development, in order to better serve our clients</li> </ul>
Corporate Financial Resources	<ul style="list-style-type: none"> <li>■ Revenue of \$830 million in 2010</li> <li>■ Free of long-term debt</li> </ul>

**Exhibit 4.2-1: Why MAXIMUS?** *As the current contractor for Green Mountain Care Member Services, MAXIMUS has direct experience in all required areas. This experience is supplemented by our operation of similar programs in other states around the country and is supported through our organizational strength and financial stability.*

### 4.3 RELEVANT MAXIMUS PROJECTS

In addition to Green Mountain Care Member Services, MAXIMUS currently operates 21 projects that provide services similar in scope to the needs of Vermont's beneficiaries. We summarize these projects and the services they provide in *Exhibit 4.3-1: MAXIMUS Medicaid, CHIP, Eligibility, and Disability Support Program Experience.*

Projects	Number of Years in Operation	Services Provided					
		Medicaid Enrollment	Managed Care Enrollment	Managed Care Education	Consumer Relations/Call Center Services	Outreach/Public Relations	Data Systems and Operations
<b>Medicaid Managed Care Enrollment Broker and Provincial Administrator Projects</b>							
Vermont Health Access Member Services	15.5	✓	✓	✓	✓	✓	✓
California Health Care Options	15	✓	✓	✓	✓	✓	✓
Michigan Enrollment Broker Services	14	✓	✓	✓	✓	✓	✓
Texas Enrollment Broker Services/Health Steps	14	✓	✓	✓	✓	✓	✓
MassHealth Customer Services	13.5	✓	✓	✓	✓	✓	✓
HealthColorado	13.5	✓	✓	✓	✓	✓	✓
New York Medicaid CHOICE	13	✓	✓	✓	✓	✓	✓
Virginia Enrollment Broker Services	8.5	✓	✓	✓	✓		✓
Health Insurance British Columbia	6.5		✓	✓	✓		✓
Iowa Member Services	6	✓	✓	✓	✓	✓	✓
Georgia Families (includes managed care enrollment for CHIP)	6	✓	✓	✓	✓	✓	✓
South Carolina Healthy Connections Choices	4		✓	✓	✓	✓	✓
Indiana Enrollment Broker Services	3.5	✓	✓	✓	✓		✓
Pennsylvania Enrollment Assistance Program	2	✓	✓	✓	✓	✓	✓
<b>CHIP, Eligibility, and Disability Support Projects</b>							
Michigan Enrollment Broker Services – CHIP component	13	✓	✓	✓	✓	✓	✓
Social Security Administration Ticket to Work and Self-Sufficiency Program	12				✓	✓	✓
Iowa <i>hawk-i</i>	11		✓	✓	✓	✓	✓
California Healthy Families	7.5		✓	✓	✓	✓	✓
Texas CHIP/Eligibility Support Services	6.5		✓	✓	✓		✓
Colorado EEMAP	1	✓			✓		✓
Pennsylvania Independent Enrollment Broker	<1				✓	✓	✓
New York Health Options	<1			✓	✓		✓

**Exhibit 4.3-1: MAXIMUS Medicaid, CHIP, Eligibility, and Disability Support Program Experience.** *Our successful management of projects providing services similar to those required by Vermont demonstrates our strong capability to continue to support Vermont for the new contract term.*

The project descriptions that follow contain the information required by the RFP response including project name, client name, contact person and phone number, duration of project, cumulative contract value, similar project components, and a description of the scope of services provided. We have arranged the project descriptions in the following order:

- 4.3.1 Vermont Health Access Member Services
- 4.3.2 California Health Care Options
- 4.3.3 California Healthy Families
- 4.3.4 HealthColorado

care organizations (MCOs) under the Medallion II program. Program choices vary in each of the Commonwealth's 135 jurisdictions (counties and cities). Project staff members provide accurate and complete information on managed health plan choices, educate members on their rights and responsibilities under managed care, provide educational materials (available in both English and Spanish) that assist members in making managed care choices, conduct health status assessments with all members enrolling into managed care health plans, assist members who request exemptions from managed care, and assist members who wish to file a complaint.

MAXIMUS works closely with DMAS, their fiscal agent, and the MCOs to ensure the success of the Virginia Enrollment Broker Project. Program responsibilities are implemented in a cooperative and complementary manner, consistent with the Commonwealth's goals and objectives. Frequent meetings take place regarding a variety of topics including systems interfaces, marketing materials, enrollment procedures, and provider file issues.

#### **4.4 PROPOSED STAFF**

RFP Section 5.8, page 21 and Section 10.6, page 33

The bidder must identify all staff that will be assigned to the project, describe the role of each staff member in completion of this project, and provide a brief description of each person's experience in performing similar services. If a person has not yet been hired, a detailed position description should be submitted. Identified staff positions should be consistent with those identified in Section 4.2.6 and those listed in the budget.

The Department of Vermont Health Access (DVHA) views health care as an essential public service and leads the way nationally with a hands-on, can-do approach to addressing the challenge confronting Vermont and the people of every state: providing accessible and affordable health care for our citizenry. As Vermont continues the process of fully implementing its revolutionary plans for Green Mountain Care, MAXIMUS maintains our ongoing commitment to serving as your reliable resource and support.

Our Green Mountain Care Member Services team is the established first contact for anyone interested in information about Vermont health care programs. We employ project staff capable of meeting the needs of people in all areas of the State and have developed collaborative working relationship with our government partners, community organizations, and program stakeholders, including providers. We provide a no-risk staffing solution to the State, as our employees are already trained on the existing program rules and are poised to implement any future programs—no other vendor can offer this to DVHA.

During our tenure as your member services contractor, we have demonstrated a deep commitment to Vermont health care programs. We truly love what we do, as evidenced by more than 60 percent of our staff having worked with the project for two years or more and several supporting Green Mountain Care Member Services for as long as 15 years. We are properly staffed with highly skilled, dedicated, and thoroughly trained personnel who are eager to provide a totally seamless and risk-free transition to a new contract.

**We are proud and gratified to offer a team that collectively brings a strength that no one else can offer—years of direct experience with and knowledge of Vermont's health care programs and the thousands of people they serve.**

MAXIMUS believes that knowledge is key, and we effectively respond to member services requests for information regarding applicable DVHA programs. Recognized as the definitive resource for Vermont health insurance program information by many state and community agencies, our team knows that delivering accurate and meaningful information to a variety of program constituents is what good customer service looks like.

Through years of program evolution—in which the size, scope, and reach of program services has continuously evolved and expanded—our managers and front-line workers have shown their ability to provide unbiased professional services to program participants. We offer a multi-faceted education and outreach strategy through phone, mail, and in-person channels to make certain that enrollees and beneficiaries have multiple mechanisms for receiving information and the resources they need to successfully complete the eligibility and enrollment process. Qualified and committed individuals at all levels of the project, and comprehensive training backed by a strong quality assurance component, have combined to produce programmatic outcomes that reflect well on DVHA.

We are proud and gratified to offer a team that collectively brings a strength that no one else can offer—years of direct experience with and expansive knowledge of Vermont's health care programs and the thousands of people they serve. This provides several obvious and significant advantages to DVHA: the lowest possible implementation risk, no "learning curve" that must be backfilled by DVHA resources, and a cohesive operational structure that is optimally scaled to program scope and requirements now and ready for the future.

As the incumbent contractor, our team is in place and fully dedicated to this effort. We are prepared to continue to successfully operate Green Mountain Care Member Services with no risk of disruption, unlike those that must hire and train new teams. A new contractor will bring a new management style and must forge new relationships with program stakeholders and DVHA. Even those with experience in other states must master Vermont's unique health care services business knowledge before they can effectively perform to DVHA requirements. MAXIMUS has no learning curve and can immediately focus on continuous improvement and innovation, not basic skills acquisition. Even those who claim a high incumbent capture rate cannot guarantee staff retention. DVHA knows the passion and commitment of the MAXIMUS

**"I enjoy working for MAXIMUS for several reasons. The work environment is wonderful, my supervisors are all very knowledgeable and approachable, and I always feel like I have ample resources to do my job confidently and efficiently.**

**I enjoy having the opportunity to assist beneficiaries so that they feel as though their questions have been thoroughly answered and their experience enjoyable. There's no greater feeling than getting to help people."**

*- Jasmine Francis,  
Member Services Representative*

A number of our staff members have been working for the project for many years and several have been with the project since its inception in 1996. The veteran staff we propose offer beneficiaries and enrollees superior service in that they have an unmatched understanding of Vermont and its health care programs.

Many of our proposed staff members have served in a variety of positions in the project, resulting in a broad understanding of the complexities surrounding Vermont's health care programs, policies, and systems. All proposed staff are fully trained and effectively serving in their current positions, eliminating the risk associated with recruiting, hiring, and training untested staff during the new contract term. The benefits of this combination of deep experience and broad program knowledge are apparent in the project's record of excellence in customer service, consistency in meeting established performance standards, and flexibility to adapt to meet new and changing requirements.

We are pleased to have a Project Director in place who brings more than 12 years experience working with the project. If at some future date MAXIMUS would need to identify an alternate Project Director, MAXIMUS is prepared to promptly notify DVHA.

We have included job descriptions and resumes for each of our key personnel assigned to the project in *Appendix B: Job Descriptions* and *Appendix C: Resumes*. The resumes for our proposed staff provide the unique details of each individual's professional experience. At this time, the project is fully staffed, with no vacant positions. It is important to note that we are not proposing promised qualifications or asking DVHA to assume we will fill critical positions with competent individuals. Instead, we are proposing in-place, highly qualified staff already known to and trusted by DVHA and program stakeholders.

#### **4.4.1 Highlights of Proposed Staff**

All of our proposed staff members are deeply invested in the success of Green Mountain Care Member Services. The project employs staff in appropriate numbers with the proper qualifications to handle contractual requirements, including call center and member services activities. In the following section, we provide the name, role, and summary of each person's experience relevant to performing the services required in completion of this project.

**"I am proud of the Vermont MAXIMUS project because at any stage of employment an employee or member of management can assess exactly where a staff member stands in terms of productivity or individual progress.**

**This transparency fosters an environment of trust between staff and management that I have never seen in another employer, and which promotes accountability and personal growth."**

*- Rachel Stillwell,  
MSR Supervisor*

## 6.1 OUTREACH

Effective outreach is the cornerstone of educating potential beneficiaries, enrollees, and the general public regarding Green Mountain Care programs. These programs are accessible and promote positive health outcomes when individuals understand eligibility requirements, enrollment methods, available benefits, pharmacy programs, member services call center resources, and the availability and responsibilities of the Health Care Ombudsman Office. We anticipate that effective outreach strategies will be particularly crucial during the upcoming contract period as Vermont moves to a single payer model and changes associated with federal health care reform are implemented.

We recognize that the requirements to conduct marketing and outreach activities at local Department of Children and Families (DCF) offices, Department of Health (DOH) offices, community action agency locations, and organized outreach events across the State of Vermont were removed from the RFP in Amendment #1 issued by the Department of Vermont Health Access (DVHA) on July 28, 2011, and responses to Questions and Answers provided by DVHA on August 4, 2011. We understand that requirements and questions related to community outreach will not be evaluated and scored. As the result, our response to the questions in the remainder of this section focus on outreach and education activities conducted via written materials, the telephone, and in-office sessions. As instructed by DVHA, we do not provide a written response to those questions pertaining to former community marketing and outreach. However, we remain poised to work with DVHA to reinstitute community outreach in the future as needed.

### 6.1.1 Outreach Strategy

**Question 1:** *Provide a description of the proposed outreach strategy, including methods that will be used to inform the public regarding health care programs and efforts to coordinate with the State. Describe proposed outreach strategy for those to be enrolled into managed care.*

RFP Section 5.4, page 15, Section 10.9.1, page 34

We have found, through serving as your partner for the past 15 years and performing similar services in several other states, that well-designed outreach and education strategies make a



**Experience.** Having performed community outreach throughout the State of Vermont for more than a decade, we have the knowledge and experience to effectively reach and connect with beneficiaries and stakeholders.

**Innovations Based on Best Practices.** We propose to leverage our nationally recognized MAXIMUS Center for Health Literacy (the Center) to refresh Green Mountain Care notices and forms to institute a cohesive look and feel, and messaging for Green Mountain Care.

**Established Linkages.** We have longstanding relationships with Vermont state agencies, community based organizations, and stakeholders that we could draw upon to establish a comprehensive community outreach program as we have done successfully in the past.

**Adaptability to Meet Future Needs.** While we understand that community outreach is not a current requirement, we have the ability to launch an effective statewide community presence should DVHA decided to reinstate this component in the future.

significant difference in how well beneficiaries understand the health insurance options available to them and how appropriately they access services. The most effective outreach approaches involve communicating key program information using a variety of methods. Our outreach focus for Green Mountain Care Member Services goes hand-in-hand with our proposed education initiatives, offering beneficiaries the opportunity to receive program information and enrollment assistance through multiple channels – culturally sensitive written materials, high-touch services through the HelpLine, and readily available in-person assistance at the Green Mountain Care Member Services office location.

As described in greater detail in our response to *Question 5 (Section 6.2.1)* through *Question 9 (Section 6.3.6)*, MAXIMUS performs a variety of functions to provide program information and assistance for beneficiaries. Activities include but are not limited to the following.

- Completing outreach calls to **PC Plus** enrollees to capture primary care provider (PCP) information and educate individuals about managed care rules and requirements, program benefits, cost sharing, and other key messages
- Flagging pending enrollees via the MAXDash portal to maximize the number of beneficiaries that voluntarily enroll and/or are provided with a **PC Plus** program overview
- Performing welcome calls for **PC Plus** enrollees
- Creating and mailing individuals a variety of educational materials including notices, enrollment booklets, and program handbooks
- Coordinating efforts with DVHA and other State agencies to ensure messages are up-to-date, accurate, and complete
- Maintaining an easy-to-navigate and detailed Knowledge Base (KB) system to ensure staff have quick access to accurate program information, covered services, eligibility criteria, and other key messages
- Providing face-to-face assistance for individuals at our Burlington, Vermont facility



In addition, we have proposed to design and implement a transactional Green Mountain Care Member Services website and social media tools as Optional Enhancements for the next contract term. By promoting a strong internet presence for Green Mountain Care programs, we increase our accessibility to the community and expand upon our ability to help beneficiaries understand their health insurance options and make informed decisions by keeping pace with the changing ways in which people obtain health care information. Because we make outreach and education available through multiple methods and media, beneficiaries from communities in all areas of the State have the ability to access information at times and locations convenient to them. We describe our proposed multimedia Optional Enhancement in further detail in *Question 5 (Section 6.2.1)*, and in *Section 11: Optional Enhancements*.

### 6.1.2 Utilizing Community Resources for Outreach

**Question 2:** *Describe how the bidder will use existing community resources to perform outreach. Describe other means by which the bidder will ensure that outreach activities are efficiently, yet effectively, conducted.*

RFP Section 10.9.2, page 34

As instructed by Amendment #1 and Questions and Answers provided by DVHA on August 4, 2011, bidders are not required to provide a response to this question as it relates to the former Marketing and Outreach functions that are no longer part of the Member Services contract. Therefore, it is our understanding that this question will not be scored.

### 6.1.3 Strategies to Reach Individuals in Remote Areas

**Question 3:** *Describe innovative strategies that will be employed to inform and educate individuals in the most remote regions of the State or the most difficult to locate (i.e., individuals living on farms, individuals residing in Vermont's most rural areas of the state, Vermonters without telephones, those working during non traditional business hours, and the homeless.)*

RFP Section 10.9.3, page 34

As instructed by Amendment #1 and Questions and Answers provided by DVHA on August 4, 2011, bidders are not required to provide a response to this question as it relates to the former Marketing and Outreach functions that are no longer part of the Member Services contract. Therefore, it is our understanding that this question will not be scored. However, as an Optional Enhancement, we do offer DVHA detailed information on our innovative strategies to inform and educate a broad spectrum of individuals on a statewide basis in our response to *Question 5 (Section 6.2.1)*, and in *Section 11: Optional Enhancements*.

### 6.1.4 Written Materials to Inform Green Mountain Care Beneficiaries

**Question 4:** *Describe examples of the types of written materials that will be distributed in order to inform the public about DVHA health care programs. Provide samples of actual materials you have developed with other accounts.*

RFP Section 10.9.4, page 34

Written materials have historically played a critical role in conveying information about the Green Mountain Care programs to Vermonters. We have worked closely with you for the past 15 years to develop, produce, and continually refine high quality materials that have proven effective at educating beneficiaries on their health insurance options and the key tenets of managed care. Since 2008, MAXIMUS has distributed more than 200,000 mailings to Vermonters annually.

We already have an array of notices, enrollment materials, handbooks, and envelopes currently in place to inform Vermonters about Green Mountain Care health care programs, managed care, and the enrollment process. We list these written materials in *Exhibit 6.1-1: Green Mountain Care Written Materials*.

Green Mountain Care Written Materials	Used for Current Contract	Proposed for Use in Next Contract
<b>Notices</b>		
Initial Medicaid/VHAP Mandatory Notice	✓	✓ (redesign proposed)
Medicaid/VHAP Reminder Notice	✓	✓ (redesign proposed)
<b>PC Plus</b> Auto Assign Confirmation Notice	✓	✓ (redesign proposed)
<b>PC Plus</b> Enrollment Confirmation Notice	✓	✓ (redesign proposed)
<b>PC Plus</b> PCP Transfer Notice	✓	✓ (redesign proposed)
<b>PC Plus</b> Reinstatement Notice	✓	✓ (redesign proposed)
Disenrollment Notice	✓ (per DVHA ended February 2004)	
Dental Home Confirmation Notice	✓ (began February 2008)	✓ (redesign proposed)
Dental Home Transfer Notice	✓ (began February 2008)	✓ (redesign proposed)
PCP Gone Special Notice	✓	✓ (redesign proposed)
PCP Moved Special Notice	✓	✓ (redesign proposed)
<b>Enrollment Materials</b>		
<b>PC Plus</b> and Dental Enrollment Form (Plan/PCP Preference Form)	✓	✓ (redesign proposed) (revision to add option for no preference)
Enrollment Handbook (Enrollment Booklet)	✓	✓
Health Care Programs Handbook ( <b>PC Plus</b> Handbook)	✓	✓
Pharmacy Programs Handbook	✓	✓
Premium Assistance Handbook	✓	✓
<b>Envelopes</b>		
Enrollment Packet Outer Envelope	✓	✓
Postage Paid Business Reply Envelope	✓	✓
Application Document Processing Center Envelope	✓	✓

**Exhibit 6.1-1: Green Mountain Care Written Materials.** Over the past 15 years, MAXIMUS has worked closely with DVHA to produce and refine the menu of mailings sent to beneficiaries.

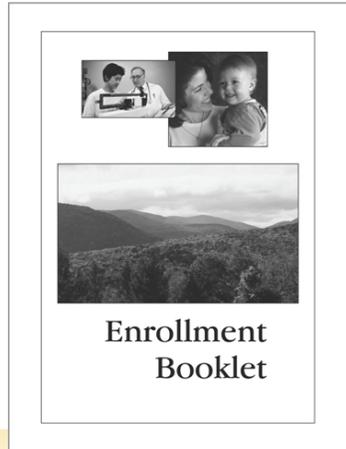
#### 6.1.4.1 Enrollment Packet

Central to our educational materials is the enrollment packet, which is mailed to beneficiaries identified as needing to choose a PCP and/or dental home. The current enrollment packet includes a systems-generated enrollment form, pre-populated with the beneficiary's contact information, date of birth, and redacted social security number (last four digits only); the web address for the online provider directory; an enrollment booklet explaining the basic principles of managed care, available methods to enroll, contact information for our HelpLine in 20 languages on the back page; and a postage paid business reply envelope with the return address for our Burlington office to complete the enrollment by mail. We display these items as *Exhibit 6.1-2: Current Green Mountain Care PC Plus Enrollment Packet.*

**Pre-Populated Enrollment Form  
(with Provider Directory Web Address)**

The form is titled "PRIMARY CARE (PC) PLUS ENROLLMENT FORM" and includes fields for State Number, Social Security Number, Date of Birth, and Family Member Name. It also contains sections for "Welcome to PC Plus", "You must choose a PCP", and "Do you own a premium?". At the bottom, it asks for the PCP name, address, and phone number, and includes a checkbox for "Check this box if you do not want to choose a PCP".

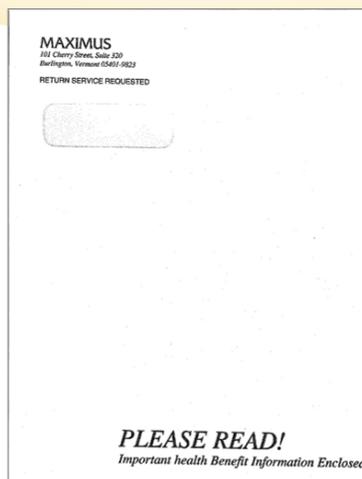
**Enrollment Handbook**



**Postage Paid Return Envelope**



**Enrollment Packet**

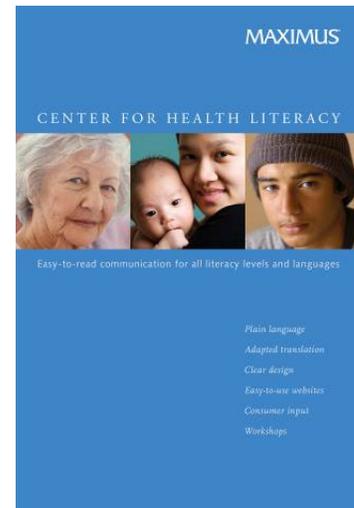


**Exhibit 6.1-2: Green Mountain Care PC Plus Enrollment Packet.** The contents of the enrollment packet have been developed over the years in collaboration with DVHA and the MAXIMUS Center for Health Literacy.



The MAXIMUS Center for Health Literacy (The Center) has reviewed the PCP/Preference Form and proposed new text and formatting. For the upcoming contract term, we propose to modify the PCP/Plan Preference Form to add the option for enrollees to indicate they prefer not to choose a provider, update the text, and add the Green Mountain Care Member Services name and logo. As a further HIPAA security measure, we propose to remove the redacted social security number entirely along with the date of birth and instead only list beneficiary names and ages. We illustrate this change in Exhibit 6.1-3: Proposed Refresh for PCP/Plan Preference Form.

The Center is uniquely qualified to design, compose, revise, print, and produce easy-to-read and culturally appropriate materials. The Center is staffed by a skilled group of writers, designers, and researchers with many years of experience developing high quality materials for low literate and culturally diverse beneficiaries. The Center supports virtually all MAXIMUS Health Services projects by producing materials that can be understood by the specific populations we serve, and it has played an integral role in the development of Vermont's Green Mountain Care handbooks in coordination with DVHA.



In 2001, the Center for Medicare & Medicaid Services (CMS, then HCFA) contracted with the Center to analyze Medicaid and CHIP notices and applications in both English and Spanish for all states. We tested more than 300 low-literate English and Spanish beneficiaries to determine if the CMS models could be easily read and understood. Using what we learned, we developed simplified models for states to use in rewriting their materials (Medicaid, Medicaid/CHIP, Medicaid/Food Stamp/TANF notices and applications). Under that contract, the Center also wrote and produced the *"Notices and Applications Handbook: A Guide for Simplifying,"* included in *Appendix D: Sample Materials*.

Over time we have identified and developed best practices for creating plain language materials, shown in *Exhibit 6.1-5: MAXIMUS Center for Health Literacy Best Practices*.

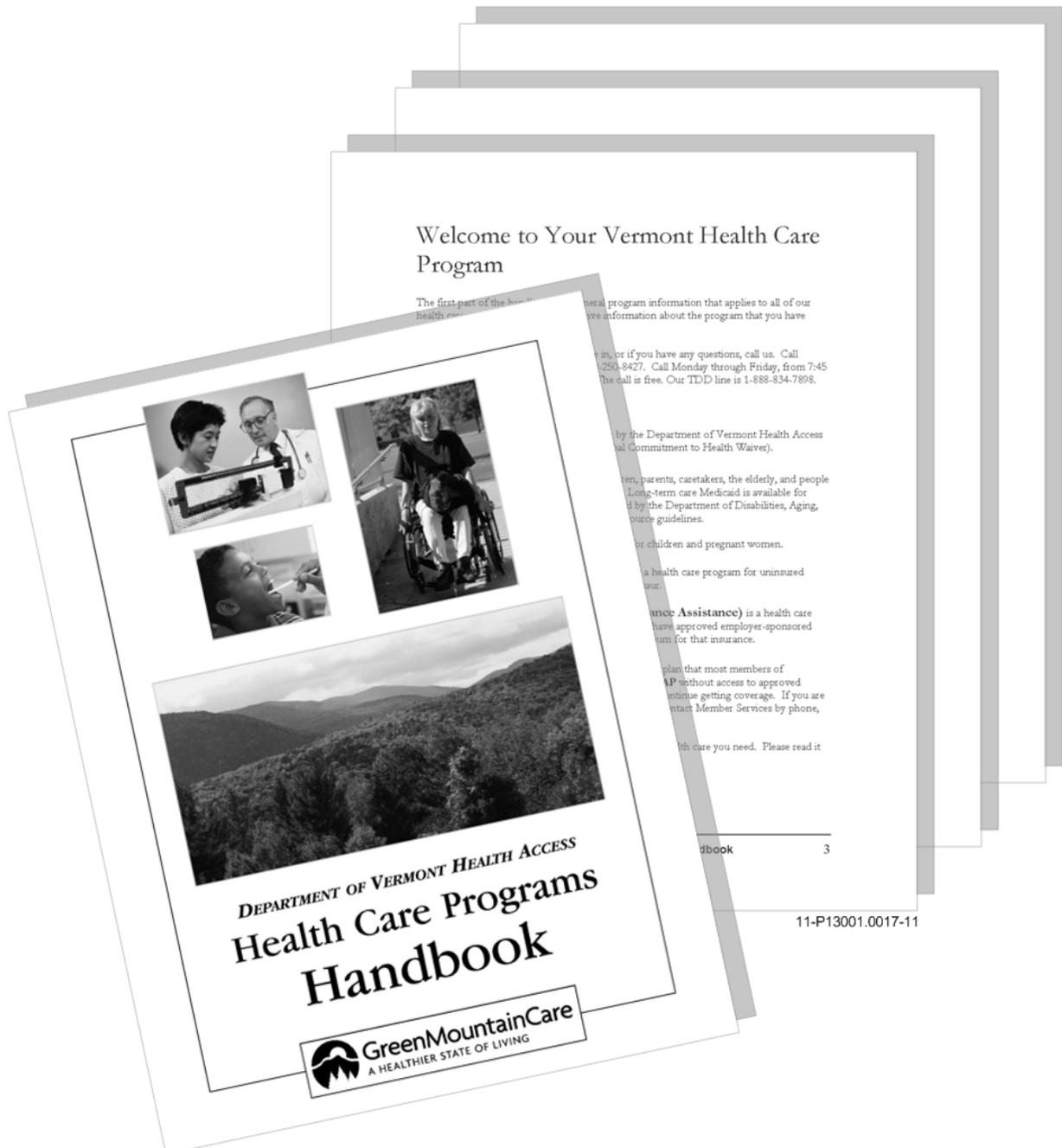
Best Practices: Writing for Readers with Limited Literacy Skills	
<b>1</b>	Organize the content so that it is logical from the readers' point of view
<b>2</b>	Write in plain language, using simple vocabulary <ul style="list-style-type: none"> <li>✓ Write in a polite and conversational tone</li> <li>✓ Use short sentences and short paragraphs</li> <li>✓ Feature only two or three key messages per page</li> <li>✓ Explain new and/or difficult words and concepts</li> <li>✓ Streamline the text, so that key messages stand out and are not buried in unnecessary verbiage</li> </ul>
<b>3</b>	Choose a clean and uncluttered design, and use it consistently throughout the document <ul style="list-style-type: none"> <li>✓ Select easy-to-read fonts</li> <li>✓ Use a readable print size</li> <li>✓ Create headings, sections, and other navigational aids to help readers follow along</li> <li>✓ Illustrate the text with relevant graphics or photographs to make the document friendlier and more appealing</li> </ul>
<b>4</b>	Field test draft materials to be sure consumers can read and understand them

11-P13001.0017-28

**Exhibit 6.1-5: MAXIMUS Center for Health Literacy Best Practices.** *The Center has developed and tested strategies and guidelines for producing materials that are easy to read.*

### 6.1.4.3 Handbooks

In addition to the enrollment packet and notices, we have worked with DVHA to develop and maintain a set of health care program handbooks to help beneficiaries understand the various health care programs offered by DVHA, such as the general health care programs overview booklet shown in *Exhibit 6.1-6: Health Care Programs Handbook*, and included in *Appendix D: Sample Materials*.



**Exhibit 6.1-6: Health Care Programs Handbook.** Through collaboration with DVHA and our Center for Health Literacy, we developed program handbooks to assist beneficiaries understand the various health care programs and offerings.

We typically mail these handbooks along with confirmation letters for new beneficiaries, as well as upon request for those seeking more detailed program information. Designed in collaboration with DVHA and our Center for Health Literacy, independent auditors for CMS have praised our program handbooks as a model for other states because they are clearly written and easy to understand and could serve as a model for other states.

In addition to the materials we have developed in collaboration with DVHA for the Green Mountain Care programs, we regularly work with our state partners nationwide to design, produce, and distribute written materials aimed at informing beneficiaries of the health care programs available to them. We include a sampling of these materials, each of which has been designed in coordination with our Center for Health Literacy, as *Appendix D: Sample Materials*. We also have included additional materials describing the capabilities and qualifications of our Center.

**"Our EQRO auditors were here last week auditing us for CMS as an MCO. They've done 100s of audits. They had great praise for the handbook, saying it was exemplary—clearly written and easily understood—and even said if they were asked to supply a model for other states, this would be it."**

*- DVHA Contract Monitor, 2008*

## 6.2 EDUCATION

Working as your partner since 1996, we have implemented an array of education strategies that have increased program understanding among Green Mountain Care beneficiaries, promoted positive perceptions of the managed care program, and motivated individuals from a variety of backgrounds to make informed PCP and dental home choices. As DVHA programs have continued to evolve, MAXIMUS has refined our education strategies to support the changing needs of DVHA and the beneficiaries we collaboratively serve. The foundation we have established, and continue to build upon, positions perfectly to continue to meet DVHA's goals for beneficiary education in the coming contract term.

Looking ahead to the next contract term, continued beneficiary education remains of critical importance as federal health care reform is implemented and as Vermont establishes the platform for a hybridized single payer health care system. Vermonters need to easily understand the health care options available to them and/or the impact of impending changes on their health care programs and how they receive care.

As your current Green Mountain Care Member Services contractor, we have already begun to experience some early impacts of these changes. In May of this year, as documented in our monthly report, we received increased calls from beneficiaries with questions about health care reform and its impact on the Green Mountain Care programs. Given that there are likely to be extensive changes to the Vermont health care programs in the future, the need for effective and compassionate beneficiary education will only continue to grow. Effectively supporting beneficiaries through this considerable transition requires a contractor with the right experience, knowledge, processes, tools, technology, and staff. MAXIMUS possesses all of these capabilities and more, and we are positioned to aid beneficiaries through any future transitions seamlessly as programs are modified or created in the future. Effectively educating beneficiaries remains among our top priorities.



**Capacity to adapt to future needs**

**MAXIMUS... Vermont's proven partner to achieve its goals; yesterday, today, and tomorrow**

**Commitment.** We have developed and maintain extensive and detailed staff reference materials and resources, including community resource and up-to-date dental provider lists, in order to provide the greatest possible assistance for Vermonters for every aspect of their well-being.

**Proven Strategies.** We know from our direct experience that beneficiaries have different learning styles; therefore we continue to offer multiple channels through which beneficiaries can receive education and enroll – mail, telephone, and in person at our Burlington office.

**Technology.** Our systems, already in place, have been crafted to support the specific needs of Vermont and promote effective beneficiary education.

**Adaptability to Meet Future Needs.** We have the capability to adapt our beneficiary education strategies to support changes to programs and new programs as DVHA migrates to a hybridized single payer model and implements federal health care reform.

## 6.2.1 Approach to Ensuring Enrollees Receive Sufficient DVHA Health Care Program and Policy Information

**Question 5:** *Provide a brief description of the bidder's approach to ensuring that individuals receive sufficient and understandable information regarding DVHA health care programs and their policies.*

RFP Section 10.6.5, page 34

Health insurance programs and concepts are not simple to understand under typical circumstances, but they can be particularly challenging amidst an array of complex program information and an ever-changing health care landscape. As we have demonstrated throughout our 15 year partnership with you, we have a broad based approach to beneficiary education and view every contact with Vermonters as opportunities to inform and empower them to better navigate DVHA health care programs and policies.

"I appreciate the hard work that you do. You make navigating confusing health insurance issues that much easier."

*-Green Mountain Care member,  
January 2008*

Our experienced staff is trained regarding all aspects of the Vermont programs, as well as techniques such as active listening and customer service skills, so that they can best respond to the wide range of inquiries and issues related to the various programs that fall under the Green Mountain Care umbrella. The outcome of our educational process is a beneficiary population that understands the health care program(s) for which they are eligible, the scope of services and benefits for those programs, and other health, social, or community resources that are available to them.

### 6.2.1.1 DVHA Program Education through Written Materials

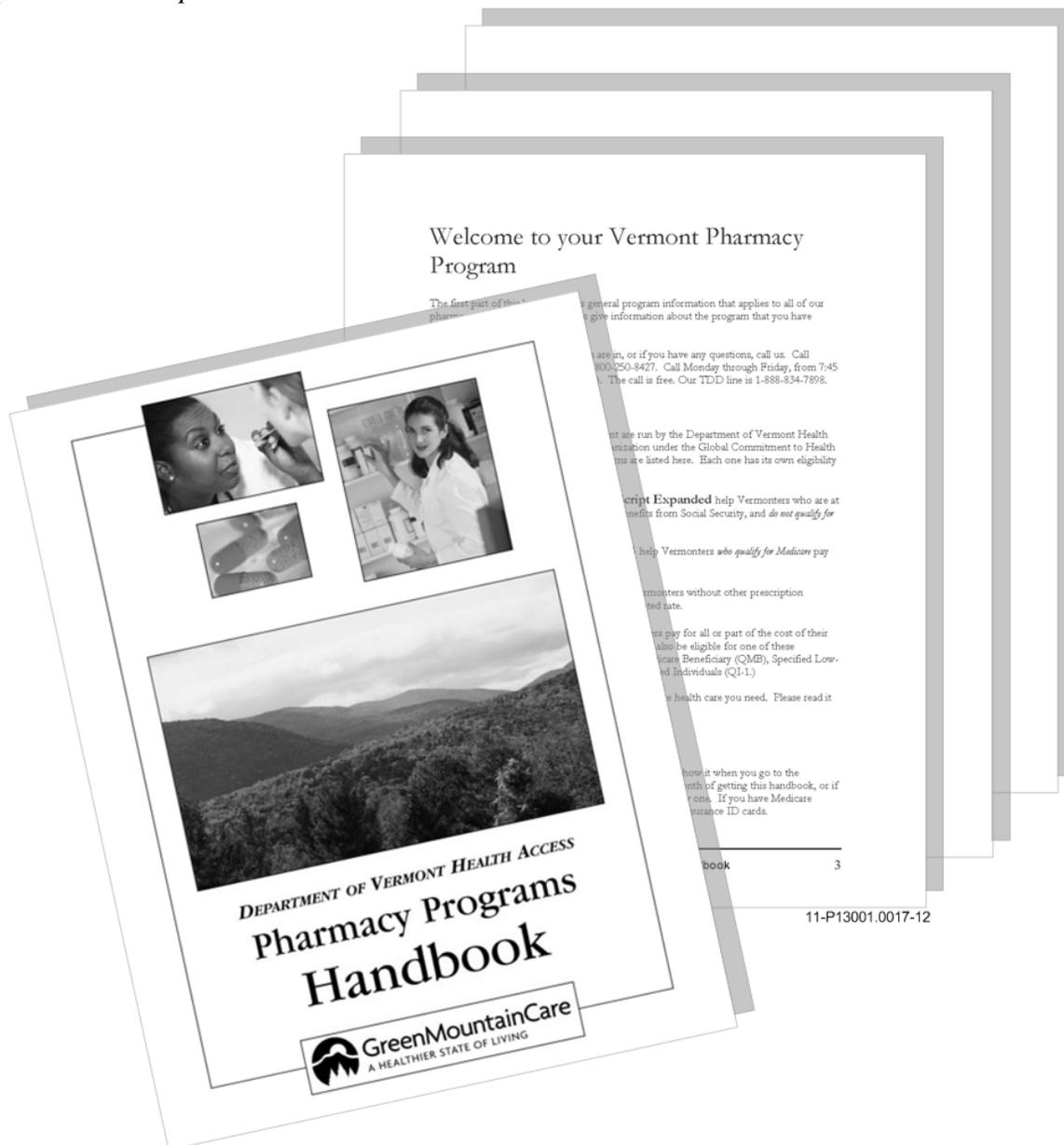
We use written materials to provide an additional opportunity for new beneficiaries to receive education about DVHA programs in which they are interested or active and the policies associated with these programs. In collaboration with DVHA, we have developed and maintain a number of handbooks explaining key information regarding Green Mountain Care program policies and procedures, including:

- Covered services and benefits
- How to locate and access providers
- Premiums and co-payments, if applicable
- Member rights and responsibilities
- How to file grievances and request appeals
- Additional programs available in the State

Vermonters have the opportunity to request copies of these handbooks any time, and we fulfill requests for program education materials within one business day of receipt of the file from DVHA, in accordance with DVHA guidelines, and to ensure beneficiaries have ready access to information necessary to appropriately navigate programs and utilize services on a statewide basis.



New **PC Plus** enrollees receive a Program Handbook, in addition to the appropriate enrollment confirmation letter, to inform them of covered benefits and key information specific to **PC Plus**. Beneficiaries that are new to other programs are sent handbooks specific to their program within one business day of receipt of the file from DVHA to ensure all beneficiaries are armed with the information needed to appropriately access services. We also regularly mail program handbooks to beneficiaries that either request them, or whom we identify as requiring additional information, via our HelpLine interactions. We provide an example of one of our non-managed care related program handbooks as *Exhibit 6.2-1: Pharmacy Programs Handbook* and in *Appendix D: Sample Materials*.



**Exhibit 6.2-1: Pharmacy Programs Handbook.** To promote and ensure beneficiary education, MAXIMUS routinely mails four different program handbooks to new beneficiaries and individuals identified as needing information or requesting handbooks via the HelpLine.

resources and adding new information as we gather and verify the information, to ensure we provide "above and beyond" Member Services for Vermont beneficiaries.

### **6.2.1.3 Meeting the Unique Education Needs of All Vermonters to Promote Proper Service Utilization, Wellness, and Positive Outcomes**

The strategies that represent the component parts of our approach to educating Vermonters as to DVHA programs are all designed and implemented with the unique needs of Vermont in mind. We understand that our audience is diverse and includes low-income families with children, pregnant women, seniors, and persons with disabilities. Many of the individuals we serve face a variety of social and personal challenges, in addition to managing complex health care issues. To provide the best, and most appropriate, service for a wide range of beneficiaries, we have taken established protocols and guidelines regarding effective communication in a variety of circumstances.

- **Elderly and Beneficiaries with Disabilities:** We know from experience, both in Vermont and nationwide, that older adults and persons with disabilities often face significant barriers when attempting to navigate the health care system, access important program information, and obtain the information and education needed to maximize the effectiveness of services and supports. Throughout more than 15 years serving Vermonters who have a disability and/or are elderly, we have established close working relationships with individuals and organizations serving these individuals. We regularly communicate with and/or assist a plethora of organizations and entities that serve these vulnerable populations such as the Northeast Health Care Quality Foundation (NHCQF), the Vermont Centers for Independent Living (VCIL), Vocational Rehabilitation, Area Agencies on Aging (AAAs), Vermont Association for the Blind and Visually Impaired, Social and Rehabilitation Services (SRS), the Vermont Department of Health (DOH), the Vermont Department of Children and Families (DCF) District Offices, community mental health centers, local community actions agencies, and community health centers.
- **Healthy Babies and WIC Participants:** Through our previous outreach work on behalf of Green Mountain Care programs, we have become very familiar with WIC centers and other establishments that disseminate program and policy information to beneficiaries. We frequently explain these programs to Vermonters and refer individuals to them, providing beneficiaries with contact information for locations near them as appropriate.
- **Recipients of ANFC-related Medicaid:** Many of the individuals we serve in Vermont not only receive health care services but also qualify for additional services via TANF and related programs. In our experience, these individuals are often single and/or unemployed parents with young children who are experiencing financial distress and receiving critically needed temporary cash and medical assistance. It has been our experience that outside pressures; such as the lack of financial resources, permanent housing, transportation, and child care; have a downstream negative impact on an individual's ability to understand, and appropriately access and manage critical health care services. In addition, varying educational levels and socio-economic and cultural differences often negatively impact access to needed services such as the ability to adhere to scheduled appointments, understand complex program rules and requirements, and meet cost-sharing obligations. Our approach in Vermont is to educate and sensitize our staff as to the impact income distress and other

for member services helps expand our ability to communicate with a larger consumer population and reach those individuals we may not have otherwise.

#### **6.2.1.5.1 Green Mountain Care Interactive Website**

Based upon our experiences with similar programs nationwide, we have found that the Internet is responsible for many new means of communication amongst public health program beneficiaries, providers, and community members. Websites provide a means of reaching an array of program stakeholders at times and locations that are convenient to them. They can browse information with ease, spend their time learning about program elements most relevant to them, and engage with a variety of resources while maintaining individual control of their education process.

Studies continue to show that the general public is accessing health care information using electronic resources at increasing rates. For example, recent research by the Pew Institute shows that about eight in ten Internet users look online for health information, making it the third most popular online pursuit (following email and using a search engine). The growing adoption and usage of websites to access health care information is consistent with the overall trend across all demographic groups toward online transactions for many everyday tasks, such as paying bills, booking travel, and doing research. For these reasons, as well as our experiences developing and deploying highly successful government health program websites in numerous states including California, Georgia, Michigan, Pennsylvania, South Carolina, and Texas, we believe it is the appropriate time to develop an interactive website for the Green Mountain Care programs to make sure that beneficiaries are able to reap the benefits of these new technologies. Although the State currently operates an informational website that allows eligibility prescreening and "contact us" functions that are fielded by MAXIMUS, developing a transactional website through which beneficiaries can enroll, change PCPs, and complete other activities on their own would provide an additional source of consistent, up-to-date information that incorporates what we have learned about how to best serve Vermonters through 15 years of experience working with you.

Through our Enrollment Broker work across the nation, MAXIMUS has gained extensive experience creating and maintaining informational and transactional websites aimed at supporting Medicaid managed care beneficiaries. This competence is complemented by the MAXIMUS Center for Health Literacy, which brings multi-lingual and low-literacy level content and design skills to produce websites that are easy to read, visually attractive, inviting, and simple to navigate for low-literate and culturally diverse individuals. The Center also provides the necessary up-to-date knowledge of federal website accessibility standards to keep our websites compliant for users with disabilities.

We understand the importance of creating websites that are uniformly clean, readable, inviting, and easily navigable while incorporating design elements, photographs, and color schemes that give each site a look and feel that is uniquely appropriate to the respective program. Even for programs as multi-faceted as Green Mountain Care, we could design a website that is easy to use and filled with useful information, downloadable forms, and interactive capabilities to put virtually every aspect of the program at the hands of beneficiaries, providers, and the community at large. This approach is a convenient and consumer-friendly way for Vermonters to connect to health care resources outside of traditional business hours. We include a preliminary mock-up of the type of site we could design for Green Mountain Care in collaboration with DVHA as

## 6.2.2 Approach to Ensuring Enrollees Receive Sufficient Enrollment and Managed Care Information

**Question 6:** *Provide a brief description of the bidder's approach to ensuring that enrollees receive sufficient and understandable information regarding enrollment, managed care programs, their policies and benefits.*

RFP Section 5.5, page 16, and Section 10.9.6, page 34

One of the most important tenets of our Green Mountain Care educational strategy is to emphasize the importance of beneficiary understanding of managed care programs, policies, and benefits. We know from experience, both in Vermont and nationwide, that voluntary selection of a health plan, PCP, and/or dental home improves beneficiary satisfaction with, and willingness to use, managed care services, and this in turn supports improved health outcomes.

We afford beneficiaries the opportunity to make informed health care choices through a well-planned and proactive educational process that makes certain enrollees receive sufficient and understandable information regarding enrollment, managed care programs, and their policies and benefits. As part of this process, we ensure that beneficiaries receive and understand the information necessary to make an informed choice, and the channels through which they can do so – by mail, over the telephone, and in person.

- We mail initial enrollment packets to heads of households of family members eligible for managed care enrollment that include an enrollment booklet explaining the key concepts of managed care and how beneficiaries can enroll
- We use every telephone contact with individuals as opportunities to educate them on managed care program enrollment
- For Vermonters visiting our Burlington office for assistance, we explain to them the importance of active managed care decisions and how to access services as appropriate

Because there are multiple ways in which beneficiaries are able to enroll and receive education, the educational approach for Green Mountain Care Member Services must help ensure that individuals receive sufficient, understandable, and consistent information. We strive to handle their inquiries efficiently and concisely, providing them with complete and accurate information without overwhelming them with too much detail that may detract from their ability to understand the information and act upon it.

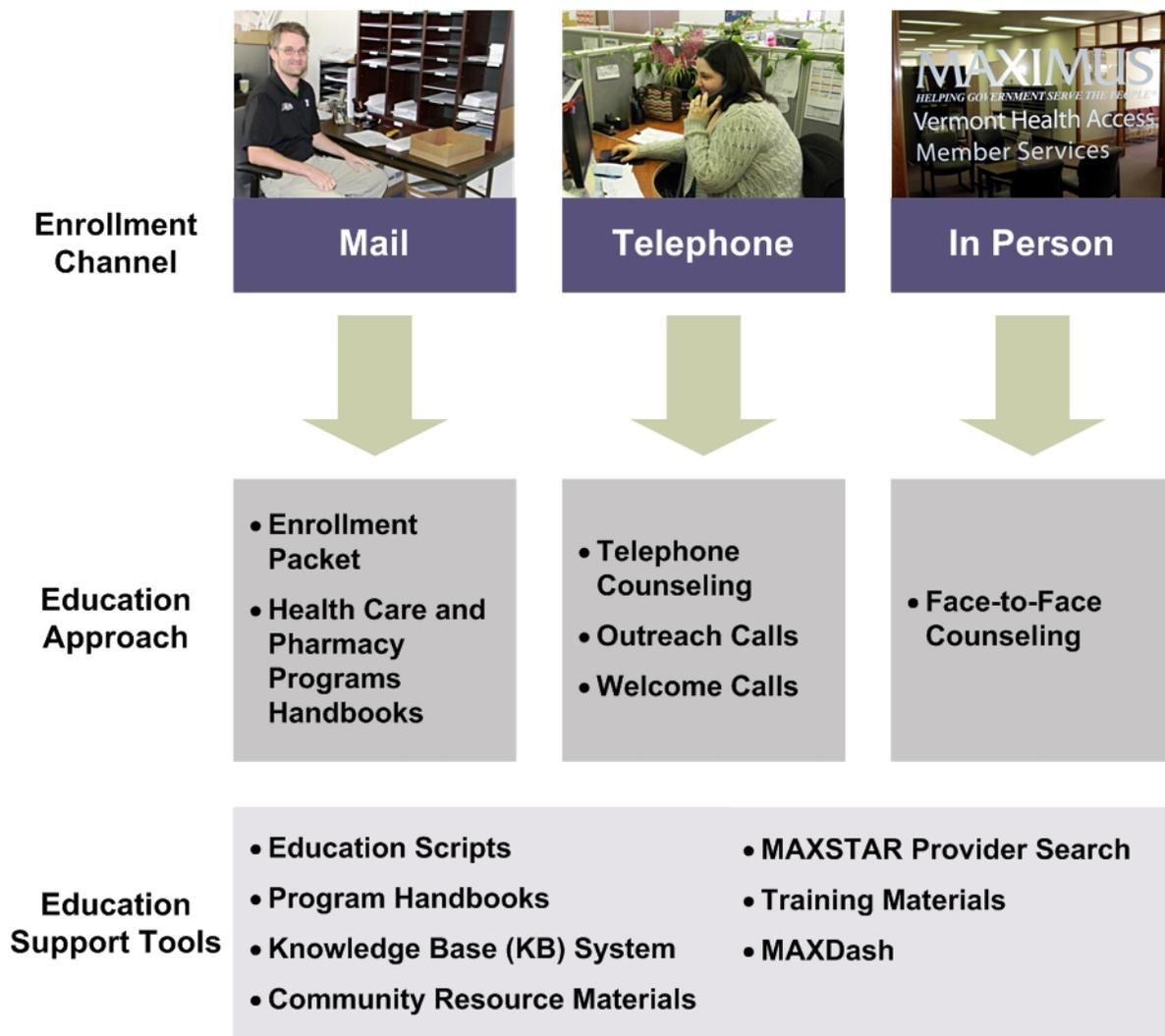
We view beneficiary education as an ongoing process that occurs not only at the time of enrollment, but throughout the various points of the member lifecycle when questions regarding Green Mountain Care programs, policies, and procedures arise. Our staff remains available through each of these channels to assist beneficiaries with an array of issues ranging from assisting them with completing necessary forms to helping them understand and resolve enrollment problems that arise regarding health plan policies, their PCP, premiums, billings, or any additional challenges they face.

We illustrate the various methods through which Green Mountain Care beneficiaries can enroll and our corresponding educational approach for each channel, as well as the tools we have in

**"Each MSR patiently explained the process using layman's terms and really helped me through it."**

*-New Green Mountain Care member  
with children in Dr. Dynasaur,  
August 2008*

place to support the provision of consistent program and policy information, in *Exhibit 6.2-9: Member Services Education Approach*.



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**Exhibit 6.2-9: Member Services Education Approach.** *Through our years of experience working with Vermonters, we have tailored our strategy to address the diverse educational needs of beneficiaries throughout the State of Vermont.*

Through each of these channels, we help individuals understand all facets of managed care enrollment, programs, and policies, including but not limited to:

- General concepts about health care programs such as eligibility, managed care plans, and Primary Care Case Management (PCCM) service delivery models
- How to access services
- Services covered under VHAP, Medicaid, Dr. Dynasaur, and other programs and services not covered by Medicaid
- How to use the Beneficiary Request for Coverage Exception (formerly M108 exception process) for services not covered by Medicaid/Dr. Dynasaur

- Information on how to access other State health care and social service programs, such as pharmacy programs, transportation, or other services
- Program policies under pharmacy programs, including cost-sharing through premiums
- The role and responsibilities of primary care providers (PCP)
- The importance of selecting a health plan and PCP, as appropriate
- Consumer rights, including appeal and fair hearing rights, confidentiality rights, availability of the Office of Health Care Ombudsman, and client-initiated disenrollment
- Member responsibilities, including the need to obtain prior authorization and proper utilization of the emergency room
- Cost-sharing responsibilities, such as premiums and co-payments, for expanded eligibility populations
- Responsibilities of beneficiaries to follow health plan procedures for seeking emergency and non-emergency services; making, keeping, and canceling appointments with PCPs and specialists; seeking hospital admissions; and understanding circumstances in which self referral is appropriate
- Information about the automatic assignment process to a health plan and PCP

#### 6.2.2.1 Education Strategy for Mail Enrollments

All eligible beneficiaries receive an enrollment packet that includes an enrollment form listing the provider directory web address, an enrollment booklet explaining the basic principles of managed care and the various channels through which they can enroll, and a postage paid envelope with the return address for MAXIMUS. We have found the enrollment packet highly effective at facilitating initial education for beneficiaries newly eligible for Green Mountain Care programs.

For beneficiaries choosing to enroll by mail, we perform the requested enrollments and then conduct welcome calls to educate them on the managed care program in general, the benefits associated with their plan, and how to access services. Each month, DVHA provides MAXIMUS with a list of new beneficiaries of **PC Plus** who have not been previously educated, including those who have enrolled by mail, and we conduct our welcome call campaigns based upon this list. We have developed a simple and direct script used by our staff when conducting these calls, illustrated in *Exhibit 6.2-10: Welcome Call Script*.

#### Welcome Script

"I'm calling from Primary Care Plus to welcome you to your new health care plan. Please call us at 1-800-250-8427 if you have any questions about the plan. We can be reached Monday – Friday 7:45 a.m. – 4:30 p.m. Our phone number is also on the back of your insurance ID card.  
Thank you."

**Exhibit 6.2-10: Welcome Call Script.** *Our welcome call script supports consistency in the delivery of key program information and education for newly enrolled beneficiaries.*

Working in collaboration with you, we have found welcome calls highly effective at reaching and educating new beneficiaries. In May 2011, for example, we achieved a 92 percent success rate, welcoming 176 of 191 households attempted through outbound calls. On average, we are able to reach approximately 90 percent of newly enrolled households using this approach. For individuals who do not respond to mailed enrollment materials by selecting a PCP and/or dentist through any available enrollment channel and are approaching automatic assignment or

manual enrollment, our MSR/Outreach Supervisor oversees outreach call campaigns aimed at educating and enrolling these hard-to-reach beneficiaries. Once per month, our MSR/Outreach Supervisor generates a list of beneficiaries who have yet to make a PCP and/or dental home selection using ACCESS. The MSR/Outreach Supervisor then assigns MSRs to make one outreach call to each of these individuals to try to obtain a choice prior to following through with the manual enrollment or auto-assignment processes. This is a time not only to obtain active provider selections from newly eligible beneficiaries; we also use these calls as opportunities to educate beneficiaries about Green Mountain Care programs and the benefits of managed care. In May 2011, we were able to successfully enroll and educate 232 individuals through this process.

#### **6.2.2.2 Education Strategy for Telephone Enrollments**

We view every call we receive from Vermonters as an opportunity to educate them on Green Mountain Care programs and policies, and the concepts and benefits of managed care. Through the toll free line, MAXIMUS assists enrollees with understanding policies and respond to their questions. We educate beneficiaries regarding Green Mountain Care programs during every HelpLine enrollment, using scripts and reference materials to make certain that managed care enrollments are accurate, thorough, and understood by beneficiaries.

We make outreach calls to obtain PCP/dental home selections and educate beneficiaries facing automatic assignment or manual enrollment, welcome calls to educate newly enrolled beneficiaries who have not yet received education because they enrolled by mail/email or they were manually and automatically enrolled. We also initiate outbound call campaigns through our toll free line to provide effective member services in special circumstances. We use these opportunities to foster better client understanding and awareness of Green Mountain Care programs and managed care services as appropriate.

An example of an outbound call campaign we recently conducted in collaboration with DVHA was initiated when a physician treating Suboxone patients lost his license in the State, leaving 65 beneficiaries with immediate health care needs and without a health care provider. We initiated the campaign to assist these individuals with finding alternate providers in their areas and called providers to verify their ability to take new patients. We also used this opportunity, as appropriate, to educate beneficiaries about available programs and services under Green Mountain Care. We perform similar ad hoc outreach calls to beneficiaries if their designated PCP become unavailable or a beneficiary is discharged from the practice to facilitate a PCP transfer.

**"I consider myself someone who needs a bit of extra help these days, and Dustin (MSR) had no problem repeating when I needed him to or being patient with me through the entire call. I had a great experience today."**

*-Green Mountain Care member,  
March 2009*

#### **6.2.2.3 Education Strategy for In-Person Enrollments**

MAXIMUS makes every effort to meet caller needs during HelpLine encounters, but on occasion individuals request a face-to-face enrollment and managed care education. We encourage in-person meetings for these beneficiaries, inviting them to visit our Burlington office for assistance at any time during business hours with no need for an appointment. In addition, because we are centrally located, we often experience beneficiaries walking in for enrollment assistance. We treat these encounters the same way we would over the telephone, taking any

opportunity we have to educate beneficiaries about Green Mountain Care programs and policies, the benefits of managed care, and the enrollment process.

#### 6.2.2.4 Education Training and Support

Regardless of how beneficiaries prefer to contact us, we use a three-pronged approach to managed care education and enrollment that is founded upon these major concepts:

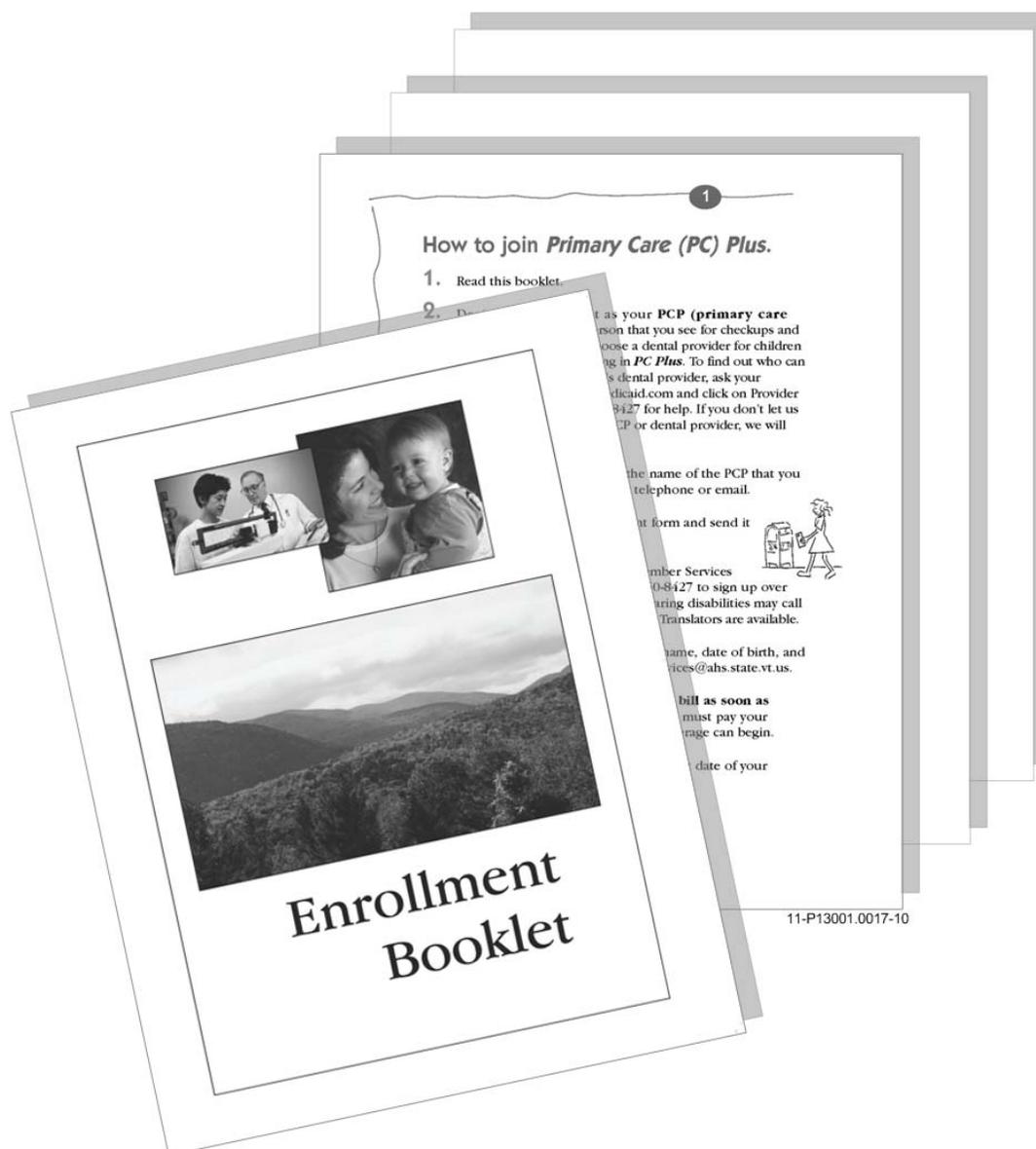
- **Encourage** beneficiaries to select a PCP and/or dental home by listening to their individual concerns and addressing them in a considerate, respectful, and culturally sensitive manner
- **Empower** beneficiaries by giving them all the information they need to make well-informed choices in easy-to-understand formats
- **Enable** beneficiaries to effectively use their health care resources by helping them fully understand how managed care programs operate

We have implemented a number of strategies to make certain enrollees receive sufficient and understandable information regarding enrollment, managed care programs, and their policies and benefits. We train staff on the particulars of managed care via our training modules, helping them to understand the benefits of managed care, how to enroll, and how to explain these concepts consistently and accurately to callers.

Our training program for MSRs, which has been used as a model for other programs in the State, emphasizes the purpose and role of the **PC Plus** program as well as the managed care enrollment process, as shown in *Exhibit 6.2-11: PC Plus Training Module and Enrollment Process Flow*.

"I want to commend the person I was working with for her thoughtful and thorough assistance. She was patient, provided clear answers to my questions, and made sure I understood the answers before going on to the next point."

-Green Mountain Care member



**Exhibit 6.2-14: PC Plus Enrollment Booklet.** *This enrollment booklet informs beneficiaries that enrollment may be performed via mail on an enclosed enrollment form, over the phone by calling the hotline, in person, or via email through Green Mountain Care member services.*

To help answer specific covered services questions during the managed care and enrollment education process, we maintain a variety of matrices, as well as policies and procedures for program and sample beneficiary notices, in our KB system for quick access by MSRs. This system serves as the warehouse for all MSR reference materials, including education scripts, program eligibility information sheets, system application quick guides, community resources for callers, and answers to caller's frequently asked questions. Our staff is well trained as to the effective use of the KB system, and how to best access the hundreds of references contained within, complementing our intensive training program focused on content and a quality customer experience. We illustrate some of the vital program information contained in our KB system as *Exhibit 6.2-15: Green Mountain Member Services KB System.*

Visitors are greeted warmly by our Receptionist, and we maintain a private and secure office for staff, specially trained for this purpose, to provide face-to-face assistance in a confidential and respectful manner. During this time, we supply beneficiaries with appropriate materials, such as the enrollment booklet, and educate them on program benefits and managed care. Individuals with speech difficulties or those who are not comfortable receiving assistance over the telephone have expressed thanks that they have the option to meet with us in person as needed.

#### 6.2.4 Fostering Client Understanding and Education

**Question 8:** *Describe how the toll-free line will be used to foster client understanding and education.*

RFP Section 10.9.8, page 34

As it has since 1996, our Burlington office houses the Member Services HelpLine that supports all DVHA health care programs, and supporting the education and enrollment process. We have found that our toll free line is the most efficient and effective way to educate



Vermonters regarding the programs available to them, covered services, eligibility guidelines, the managed care process, and how to enroll. Our robust telephone-based strategy is the primary way we foster client understanding, serving as the backbone of our approach to education. During May 2011 alone, we received more than 1,100 calls related specifically to enrollment and handled more than 12,000 calls regarding program overviews and managed care. We view every call to the HelpLine as an opportunity to foster better beneficiary understanding of DVHA programs and policies.

MAXIMUS takes full advantage of these opportunities by providing our staff with carefully prepared beneficiary education scripts, up-to-date resource materials, and reliable technology. Staff undergo rigorous training regarding health care programs, including all aspects of program eligibility, covered services, third party liability, fair hearings, prior approval for services, health department special programs, managed care education and enrollment, and how to deliver exceptional customer service. They educate beneficiaries on their rights and responsibilities under managed care, assist those requesting exemptions from managed care, and help those who wish to file a complaint. Through the HelpLine, MAXIMUS performs the following key functions.

- **Provide Managed Care Education for New Enrollees:** As a matter of practice, our staff checks the managed care education status of each caller to the HelpLine and provides a managed care overview to those callers who have not yet been educated
- **Explain Program Notices:** Many beneficiaries call the HelpLine requesting further explanation of notices generated by DVHA or DCF. Upon receiving these calls, our staff researches and identifies these notices and make every effort to provide a full and satisfactory explanation to the beneficiary. Many of these notices are housed for quick reference in our KB system
- **PC Plus Welcome Calls:** Individuals who have enrolled in *PC Plus* by mail or email, and those who have been auto-assigned or manually enrolled, often have not yet received a thorough managed care overview. In addition to mailing each newly enrolled member a member handbook, we conduct outbound welcome calls to these beneficiaries by telephone to help them receive proper education

#### 6.2.4.4 Community Resources

Our Green Mountain Care Member Services philosophy consistently has been to provide Vermonters with information on community agencies they can turn to for help, even for those who are not able to receive that help through DVHA-administered programs. To support this philosophy, over time we have compiled a large array of information on available community resources to support beneficiary education and their ability to access the various services they require.

Our KB system contains approximately 25 lists of community resource information separated into categories such as clinics, dental services, medication assistance, food shelves, HIV/AIDS supports, and family resources. We keep this information up-to-date, regularly verifying that community resources are correct and adding any additional supports that may have become available. The creation of these resources stems from our experiences and encounters from the past 15 years – we know the State and what resources are available to Vermonters. Most of these resources have been given to us by callers, researched by our staff, and discovered by our field personnel in years past. One example of how our community resources are useful is reflected in a common call scenario when a VHAP member who desperately needs dental services is told they have no dental coverage. Staff are able to reference our dental clinic resource list and provide the caller with an alternative to just saying "not covered." Through this level of customer service, program beneficiaries are assured that someone on the other end of the phone cares. We provide a sample of our home-grown community resource information as *Exhibit 6.2-16: Community Resources*.

"I appreciate you being here to answer my questions. Although I am not currently eligible for your programs, I appreciate your referring me to community resources and being so helpful."

-Green Mountain Care member,  
 November 2008



Category : Comm Resources		Search this Category: <input type="text"/>	Search
All Articles			
	Article	Modified	
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	<a href="#">Waivers Resources</a>	4/8/2011	
	<a href="#">Vision Resources</a>	9/1/2010	
	<a href="#">VA Resources</a>	8/24/2010	
	<a href="#">RX P&amp;P Resources</a>	8/24/2010	
	<a href="#">Prescription Resources</a>	7/5/2011	
	<a href="#">Phone Resources</a>	8/24/2010	
	<a href="#">Other Resources</a>	7/1/2011	
	<a href="#">Mental Health and Substance Abuse Resources</a>	8/24/2010	
	<a href="#">Medical Clinic Resources</a>	8/24/2010	
	<a href="#">LGBTQ Resources</a>	8/24/2010	
	<a href="#">Housing and Shelter Resources</a>	8/24/2010	
	<a href="#">HIV and AIDS Resources</a>	8/24/2010	
	<a href="#">Food Shelves southwest-vermont</a>	10/8/2008	
	<a href="#">Food Shelves southeast-vermont</a>	10/8/2008	

Results : 1 - 15 of 25

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**Exhibit 6.2-16: Community Resources.** The Community Resources lists we maintain are available electronically through the KB system to each member services staff member.

The array of community resources are presented by category, such as Family Resources and HIV/AIDS Resources, so we can quickly identify sources of assistance for HelpLine callers. Through this level of service, we are able to foster a greater understanding of the resources available to Vermonters both inside and outside of Green Mountain Care programs. We provide sample community resource lists we have compiled and maintain as *Exhibit 6.2-17: Sample Community Resource Lists*.

VERMONT HEALTH ACCESS MEMBER SERVICES		MAXIMUS	
FAMILY RESOURCES			
Organization	Area Served	Phone/Fax #	
<b>Camp Agape</b>	Statewide  <b>Camp Agape Vermont</b> P.O. Box 596 Charlotte, VT 05445	802-425-5533	They provide a free week of Christian camping for children ages 7-11 who have a parent under the supervision of the Department of Corrections. 8/3/10
<b>Red Cross</b>	Statewide	Southern Vermont (Green Mountain Chapter) (802) 254-2377 Central Vermont (802) 223-3701 Northern Vermont 800-660-9130	The Red Cross helps people prevent, prepare for, and respond to emergency situations. They offer blood donation, training, classes and volunteer opportunities 8/3/2010
<b>State Health Insurance Assistance Program (SHIP)</b>	Statewide	1-800-642-5119 (Senior HelpLine) <a href="http://www.medicarehelp.vt.net">www.medicarehelp.vt.net</a> Judith Crawford – State SHIP Director	This program is designed to provide help with questions or concerns about Medicare related issues to those 65 and over or with disabilities. Trained counselors and volunteers are located in the Area Agencies on Aging. They help with any questions or problems consumers have with Medicare or other health insurance, including the Vermont State programs. Refer callers to the Senior Helpline ph#, it will connect them to their nearest Area Agency on Aging. MSR: See your AOA breakdown list for local office ph# and addresses. 8/3/10

FAMILY RESOURCES PAGE 1  
Last Updated on 10/20/10

VERMONT HEALTH ACCESS MEMBER SERVICES		MAXIMUS	
HIV AND AIDS RESOURCES			
Organization	Area Served	Phone/Fax #	
Bennington Area AIDS Project	Bennington And Brattleboro	Brattleboro office 802 254-4444  Bennington office Phone 802 447-8007	An all-volunteer organization that provides speakers, educational seminars, training, support groups and direct assistance for families & those living with HIV/AIDS. 8/6/10
Vermont Cares <a href="http://www.vtcares.org">www.vtcares.org</a>	Statewide	800-649-2437 toll free 802-864-7730 fax PO Box 5248 Burlington, VT 05402	Vermont CARES provides direct supportive services to people living with HIV/AIDS and prevention outreach to people at risk of HIV/AIDS in an interconnected continuum of programs. 8/6/10
Aids Medication Assistance Program (AMAP)	Statewide	802 951 4005	Provides medication assistance with individuals having a HIV diagnosis. 8/6/10
Dental Care Assistance Program (DCAP)	Statewide	802 951 4005	Provides financial assistance to HIV patients' w/dental expenses. Other dental coverage does not impact eligibility. 8/6/10

HIV AND AIDS RESOURCES PAGE 1  
Last Updated on 10/20/10

11-P13001.0017-20

**Exhibit 6.2-17: Sample Community Resource Lists.** Through internally developed and maintained community resource lists, we are able to assist HelpLine callers with finding help for services not covered under Green Mountain Care programs.

## 6.3 ENROLLMENT

RFP Section 5.6, Page 17

Enrollment activities are performed with an understanding of how Vermont has transformed its managed care program from one that initially provided services using managed care organizations to one that today delivers services through contracted providers who participate in *PC Plus*. As your enrollment contractor since 1996, we have adapted to program changes demonstrating our flexibility and commitment to accommodating program growth. We offer our enrollment solution by bringing unmatched knowledge and expertise of Vermont's programs, targeted use of technology to augment the State's current investment in its own enrollment system, and efficient business processes. Our solution for enrollments highlights these benefits.

The Department of Vermont Health Access (DVHA) has been proactive and forward thinking in its approach to finding new and innovative ways to extend health care coverage to uninsured Vermonters. Starting in October 1996, the State turned to managed care to deliver cost-effective and coordinated quality care to beneficiaries through low-cost and free health care programs, which now operate under the broader name of Green Mountain Care. Since the introduction of managed care, the number of individuals receiving services under this framework has grown. This success has allowed Vermont to emerge as a national leader in reducing the number of uninsured children and adults through effective use of managed care. While Vermont is at the forefront in providing managed health care for Medicaid and other publically funded programs, the State continues to pursue new and innovative ways to further improve services and provide universal coverage to its citizens. As DVHA moves Vermont along the continuum of providing affordable and cost-effective health care, we anticipate that the Green Mountain Care Member Services contractor will have an important role in supporting these efforts. As your partner since 1996, we have successfully worked with you to implement the changes shown in *Exhibit 6.3-1: Managed Care Program Changes from 1996-2011*.

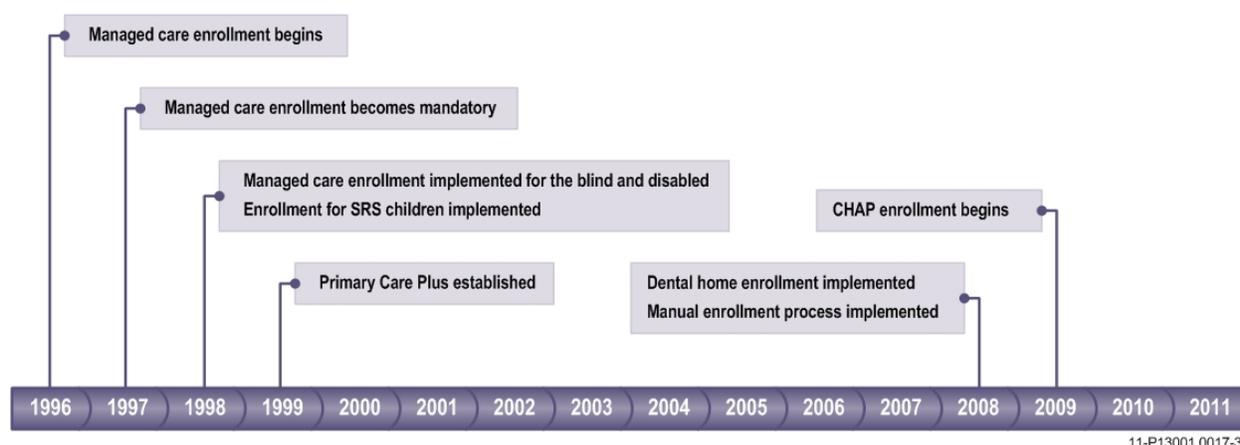


**Proven Capacity to Process New Enrollments.** Since the first full year of operations in 1997, MAXIMUS has handled an average of 37,000 new enrollments annually and is poised to continue providing services with capacity to accommodate future program growth and expansion.

**Proven Ability to Help Vermonters in Choosing a Health Care Provider.** With a low auto-assignment rate of 16 percent over the last 15 years, MAXIMUS has helped 84 percent of Vermont's health care beneficiaries in choosing a provider which demonstrates an ability to continue assisting Vermonters in a similar capacity in the future.

**MAXIMUS Provides a Cost-effective Solution to Accommodate Program Growth.** Since 2008, MAXIMUS processed 23 percent more HelpLine enrollments without having to increase staffing levels demonstrating capacity to offer cost-effective and scalable services.

**Capacity to Adapt to Program Change.** Since 1996, the project successfully accommodated six major program changes that impact enrollment processing providing assurance to DVHA of our ability to support future program change and growth.



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**Exhibit 6.3-1: Managed Care Program Changes from 1996-2011.** *MAXIMUS has partnered with DVHA to help roll out new programs and expand services, experience that is beneficial for the next contract period.*

When managed care was first implemented in Vermont in 1996, beneficiaries had the option of enrolling in one of two health plans. During the initial implementation we worked with DVHA to design materials and create enrollment scripts and resource guides for use by our staff in helping beneficiaries enroll in a health plan and to choose a PCP. When health plans withdrew from the program, we worked with DVHA to help implement the new Primary Care Case Management (PCCM) program, called **PC Plus**. As part of this effort, our staff was able to draw on the MAXIMUS knowledge and experience from operating managed care enrollment programs in other states to assist DVHA in creating the new PCCM program in Vermont. In addition, we supported DVHA in making the transition for beneficiaries easy and with minimal disruption by converting members from health plans and enrolling them with a **PC Plus** provider. When DVHA changed its program branding to Green Mountain Care in 2007, MAXIMUS worked with the State to devise new protocols, revise resource materials, and develop new training aids to support service delivery. In 2008 we again accommodated program changes that were required to begin processing dental enrollments and in 2009 we further updated our scripts, protocols, training materials and procedures to provide enrollment services for the Catamount Health and Premium Assistance Program (CHAP). As Green Mountain Care was further modified to accommodate Act 48 and federal health care reform, we adjusted our operations without causing an interruption of services.

An understanding of the history and vision of Vermont's managed care program is important because it allows service delivery to occur with sensitivity to Vermont's needs and an appreciation for its political and social environment. Our Member Services Representatives (MSRs) are knowledgeable about Vermont's health care programs, experience that is unique to MAXIMUS. This experience is important to beneficiaries and DVHA because our staff is already knowledgeable about enrollment policy, and is trained, and adept in providing enrollment services. Vermonters and DVHA can continue to receive the same high level of managed care enrollment services they already receive today without incurring the costs associated with a new implementation and a new vendor. In addition, we offer these services while leveraging existing infrastructure that is proven, reliable, and capable of accommodating the program growth and change we expect to occur. Our solution minimizes risk to DVHA and provides benefits to Vermonters and the State as shown in *Exhibit 6.3-2: The MAXIMUS Solution Provides Benefits to DVHA and Vermont's Managed Care Beneficiaries.*

<b>Contractor's Enrollment Responsibilities</b>	<b>MAXIMUS Approach</b>	<b>Benefits to DVHA and Vermont's Beneficiaries</b>
<ul style="list-style-type: none"> <li>• Provide managed care outreach and enrollment education for <b>PC Plus</b></li> <li>• Conduct provider searches to assist beneficiaries in choosing a provider for <b>PC Plus</b></li> <li>• Enroll CHAP beneficiaries into Catamount Plans</li> <li>• Enroll <b>PC Plus</b> beneficiaries with a dental provider</li> <li>• Process <b>PC Plus</b> and Catamount enrollments and transfers</li> <li>• Maintain a low auto-assignment rate for <b>PC Plus</b></li> <li>• Process and send all notices required for enrollment processing</li> </ul>	<ul style="list-style-type: none"> <li>• Import daily files into MAXSTAR to generate all notices</li> <li>• Use existing project staff with Vermont-specific enrollment experience</li> <li>• Use our MAXDash desktop integration tool to identify enrollees and streamline enrollment processing tasks</li> <li>• Use existing HelpLine and mailroom facilities and infrastructure for providing services</li> </ul>	<ul style="list-style-type: none"> <li>• Managed care notices and forms refreshed and rebranded by the MAXIMUS Center for Health Literacy</li> <li>• Existing staff continues providing services without interruption, delay, or a lengthy training period</li> <li>• MAXDash desktop integration leads to greater accuracy and first call resolution and efficiency in enrollment processing by reducing manual tasks and the need to switch between numerous systems</li> <li>• Use of existing infrastructure lowers startup cost</li> </ul>

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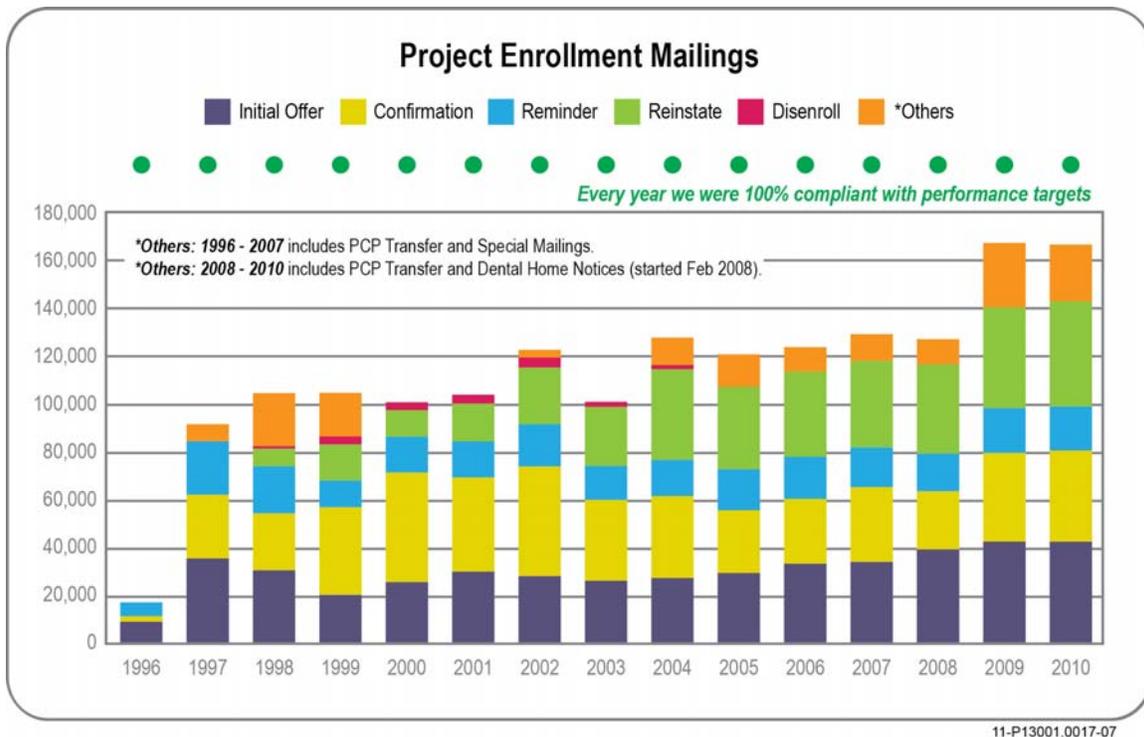
**Exhibit 6.3-2: The MAXIMUS Solution Provides Benefits to DVHA and Vermont's Managed Care Beneficiaries.**

*Our proven and tested enrollment processing solution has the existing capacity and functionality to meet DVHA's needs today and into the next contract period.*

In RFP Section 5.6: Enrollment Activities, DVHA has identified a series of requirements that the contractor must perform. We present our solution to meeting each of these specific requirements in our answers to RFP questions. The following lists the requirements in Section 5.6: Enrollment Activities and the specific question where our solution is presented.

- Initial enrollment into a health plan – *Question 10 (Section 6.3.2) and Question 12 (Section 6.3.4)*
- Activities related to transfers, reinstatements, and disenrollments – *Question 9 (Section 6.3.1) and Question 12 (Section 6.3.4)*
- Process enrollment files from the State and mail enrollment packages – *Question 9 (Section 6.3.1)*
- Assist beneficiaries with choosing a PCP – *Question 11 (Section 6.3.3) and Question 12 (Section 6.3.4)*
- Provide unbiased choice counseling information for selection of a PCP – *Question 10 (Section 6.3.2)*
- Notify consumers in writing to confirm enrollments and transfers – *Question 9 (Section 6.3.1)*
- Process PCP enrollment choices in the ACCESS system or any successor system should a replacement system become available – *Question 9 (Section 6.3.1) through Question 12 (Section 6.3.4)*

In addition all RFP requirements in Section 5.6.1: Enrollment Process are addressed in our answers to *Question 9 (Section 6.3.1) through Question 13 (Section 6.3.5)* and are organized topically by the specific question. For example, any specific requirement in RFP Section 5.6.1: Enrollment Process pertaining to auto-assignment is addressed in our answer to *Question 13 (Section 6.3.5)*.



**Exhibit 6.3-3: MAXIMUS Has Experienced a Steady Increase in the Volume of Outbound Mail.** While the volume of outbound mail has progressively increased, MAXIMUS continued to meet performance targets.

### 6.3.1.3 First Class Postage Helps Promotes Timely Delivery

We send all notices using first-class postage, which provides the least expensive but most efficient option for mailing documents. First-class postage helps make sure potential enrollees receive their mailing timely and with sufficient time to choose their provider.

### 6.3.1.4 Notices and Related Processing

As the existing contractor, we have responsibility for notifying members in writing of various enrollment activities. In meeting these obligations we currently generate and mail the following:

- Initial Enrollment Notification which includes the PCP Preference Form and enrollment handbook: daily and monthly
- 21 Day Enrollment Reminder: daily
- Enrollment (PCP and dental)/Auto-assignment Confirmation: daily
- Reinstatement Notification: daily
- **PC Plus** PCP Change Notification and Dental Transfer: daily
- Health Care Programs, Pharmacy Programs, and Premium Assistance Programs handbooks: weekly

The enrollment process begins with the State identifying those who are eligible for managed care by sending us a file listing individuals who are to receive an enrollment package. The initial enrollment notification packet is mailed to all beneficiaries who are required to enroll into managed care and includes the following information:

- Initial enrollment notification letter and pre-printed, personalized PCP Preference Form (combined form)

- Enrollment handbook
- The web address of the online provider directory ([www.vtmedicaid.com](http://www.vtmedicaid.com))
- Business reply return envelope

While the RFP requires that a provider directory be included in the initial mailing, this directory is no longer printed and mailed with the packet because beneficiaries have access to the online provider directory. The online version of the provider directory is easier to keep updated than the printed directories and avoids the cost of producing updates. Those who do not have access to the internet or require assistance in finding a



provider can contact the HelpLine for personalized services. Should DVHA require inclusion of the directory during the next contract, MAXIMUS is able to meet this requirement. Similarly should health plans be included in the program, MAXIMUS will include health plan directories and summaries.

The enrollment package provides potential members with enrollment instructions and information about managed care. The enrollment letter and form are combined as shown in *Exhibit 6.3-4: PCP Preference Form*. This form includes all of the required elements including the beneficiary's name, address phone number, age, and the HelpLine toll free telephone number. As shown in the exhibit we have modified the PCP Preference Form with a refreshed design, which also allows potential members to indicate when they do not have a PCP preference. When a member does not have a preference we contact them by telephone to help them identify a suitable provider as discussed in *Question 12 (Section 6.3.4)*. Information from the PCP Preference Form is entered into the ACCESS system. We acknowledge this system is due for replacement in 2013.

The pre-printed PCP Preference Form lists all members who must enroll and allows each member of the case to choose a different provider. The form also allows beneficiaries to list their dentist. Inclusion of the dental provider information is intended to encourage use of dental services among school-aged **PC Plus** beneficiaries in support of DVHA's Dental Dozen Initiative. If a dentist is not indicated on the **PC Plus** Preference Form the project manually assigns a dentist by selecting one within close proximity to the beneficiary's residence. In addition to the enrollment letter, the initial packet lists the web address of the online provider directory for those who wish to use this tool to find an appropriate provider.

Although the project has rigorous quality assurance protocols in place to prevent any mailroom HIPAA violations from occurring, the enrollment form has built in a safeguard against possible identity theft by replacing social security numbers and date of birth with the beneficiary's age. This extra safeguard was an adaptation made by the project to align itself with the State's unique identification number initiative.

Members who do not enroll within 21 days of eligibility receive an enrollment reminder as shown in *Exhibit 6.3-5: Enrollment Reminders Are Used to Encourage Individuals to Choose a Provider*.

This notice contains all of the information required by DVHA including the member's name, address, member services number, Office of the Health Care Ombudsman telephone number/address, and PCP name. The confirmation notice is used by members as a temporary I.D. card to show eligibility for services. The RFP indicates that the plan member's handbook is mailed with the confirmation notice. Under the current contract the health care programs handbook is sent weekly in a separate mailing. MAXIMUS is able to include the health care programs handbook with the confirmation mailing should this be required during the next contract period. Additionally, the project will include a health plan questionnaire if the State requires this as part of the confirmation mailing. Finally, should the State contract with health plans for managed care we can send any detailed health plan materials and a confirmation notice that includes the name of the member's health plan.

When **PC Plus** members transfer to another PCP they receive a notification listing their new PCP. In addition to transfers, the project handles activities surrounding reinstatements. Individuals who temporarily lose benefits but regain eligibility within six months are automatically reinstated by the State's ACCESS system with their prior provider. The project is notified in the daily file of those who are reinstated and our responsibility is to send a notice to these members.



The RFP identified "health plan" specific notices, such as a pre-printed Plan Form as well as other notices for enrollment cancellation, open enrollment, and disenrollment that are no longer produced by the project. These notices are no longer needed because of the current requirements for Green Mountain Care enrollment services. For example, while enrollment is at the health plan level for CHAP beneficiaries DVHA has elected to not use enrollment forms for this program. In addition, when multiple health plans were offered as managed care options in Vermont for Medicaid, Dr. Dynasaur, and VHAP, and the program had a specific open enrollment period, MAXIMUS created and sent health plan and open enrollment notices. Now that managed care enrollment in Vermont for these programs is with a **PC Plus** provider and members can make PCP changes monthly, the health plan and open enrollment notices are no longer required. Should DVHA include health plans in addition to **PC Plus** or institute an open enrollment period MAXIMUS is able to create and send the required notices. In addition, DVHA no longer requires a disenrollment notice because the ACCESS system was unable to distinguish between those who disenrolled from **PC Plus** and went to another program from those who were disenrolled due to a loss of eligibility for benefits. The inability to distinguish these groups caused confusion among beneficiaries leading DVHA to discontinue use of the disenrollment notice in February 2004. Again, should DVHA request that disenrollment notices be sent, MAXIMUS is able to comply with the request.

### 6.3.2 Ensuring Unbiased Benefits Counseling

**Question 10:** *Describe how the bidder will ensure unbiased benefits counseling for beneficiaries.*

RFP Sections 10.9.10, Page 35 and 5.6.1, Page 17

A primary reason many states have turned to an independent enrollment contractor for managed care is to help make sure beneficiaries receive unbiased information on enrollment options. Over

the years as your contractor we have instituted rigorous and proven procedures to make sure the project helps beneficiaries in understanding their provider options and that benefits counseling is provided in an objective, non-biased fashion that does not favor or discriminate against any health care provider. Our ability to deliver this service rests on having an effective training program, providing MSR's with tools to provide information to beneficiaries about their choices, and closely monitoring service delivery to ensure compliance with benefits counseling standards.

### 6.3.2.1 Training to Make Sure MSR's Deliver Objective and Unbiased Benefits Counseling

MAXIMUS has developed and refined an effective three-tiered training program for Green Mountain Care Member Services that focuses on enabling staff to present all available provider options to **PC Plus** beneficiaries based on their geographic location and individual preferences or CHAP beneficiaries selecting a plan. We also follow this same approach when helping families identify a dentist for their children. When potential enrollees contact us to receive enrollment services either through the HelpLine or in-person, MSR's follow detailed system quick guides and enrollment scripts to assist them during the education and enrollment process. These quick guides and scripts help make sure enrollment processing and education follows established procedures, is unbiased and objective, and does not favor or discriminate against any health plan or provider. We present a summary of our guidelines in *Exhibit 6.3-7: MSR's Provide Unbiased Benefits Counseling by Following MAXIMUS Guidelines for Choosing a Provider.*

Guidelines for MSR's to Follow When Helping Beneficiaries in Selecting a Provider
<p><b>Catamount Health and Premium Assistance Program (CHAP) Provider</b></p> <ul style="list-style-type: none"> <li>■ Ask the beneficiary if he/she has decided on a Catamount Health Plan</li> <li>■ If the beneficiary has not made a decision, instruct him/her to contact each health plan to obtain more information about available services</li> <li>■ Provide the beneficiary with the telephone number for each health plan or offer to mail plan information sheets</li> </ul>
<p><b>Dental Provider</b></p> <ul style="list-style-type: none"> <li>■ Ask the member if the children in the case have a dentist they see regularly. If the answer is yes, ask the member if he/she would like to enroll his/her children with that dentist</li> <li>■ If the member identifies a preferred dental provider for any adult member in the case, then record their provider choice</li> <li>■ If the beneficiary cannot identify a dentist for the children in the case, ask the beneficiary if they have any preference for a dentist (such as location) and use the Dental Providers list to identify possible dental providers</li> <li>■ If the beneficiary asks for written information you can email or mail the Vermont Dental Dozen Initiatives Brochure to the requestor. Inform the beneficiary that the brochure also is available online by visiting the DVHA website: <a href="http://www.dvha.vermont.gov/for-providers/dentaldozenbrochure.pdf">www.dvha.vermont.gov/for-providers/dentaldozenbrochure.pdf</a>.</li> </ul>
<p><b>PC Plus Provider</b></p> <ul style="list-style-type: none"> <li>■ Ask the beneficiary if he/she or any member of the case has a doctor or provider</li> <li>■ Use the MAXSTAR Provider Application to search for the provider to determine if the provider participates in <b>PC Plus</b> and is accepting new patients</li> <li>■ If the beneficiary does not have a prior provider or is unable to identify one, offer to search for a suitable provider using any of the following criteria: provider name, city, county telephone number, gender, handicap access score, or group number</li> <li>■ Do not recommend any provider and do not advocate on behalf of the beneficiary or his/her family members</li> </ul>

**Exhibit 6.3-7: MSR's Provide Unbiased Benefits Counseling by Following MAXIMUS Guidelines for Choosing a Provider.** MSR's have tools and guides to follow to make sure they provide unbiased benefits counseling services.

It is important to note that in recording enrollments for CHAP, MSR's provide minimal education, assistance, and information about the plans. If members request extensive information they are instructed to contact the appropriate health plan for more information. The interview scripts include reminders and information so that MSR's inform potential members of

their rights and responsibilities under the program including premiums and co-payment amounts. MSRs are instructed to provide information on grievance and fair hearing procedures as well. We do not currently inform members about co-insurance amounts because this requirement is not applicable under the current program. If DVHA modifies the program and co-insurance amounts become relevant we agree to provide beneficiaries with this information.

MAXIMUS uses a multi-phased training program to make sure MSRs are ready to provide services. Training includes conventional classroom sessions, which are interspersed with job-shadowing and hands-on activities. Assessments are administered weekly to gauge trainee proficiency. This systematic approach allows management to make sure those who complete training are assigned to the appropriate phone queue. We train new staff to always adhere to the script as this provides the best way to avoid showing bias during benefits counseling. Individuals who demonstrate their ability to provide unbiased benefits counseling during training are assigned to the enrollment phone queue. At the conclusion of training MSRs are enabled to:



- Take enrollments for CHAP
- Determine if **PC Plus** beneficiaries have an existing or prior relationship with a provider and determine if the preferred provider participates in the program
  - If a preferred provider does not participate we submit a request so that the provider can be recruited to join the **PC Plus** network
  - Help the beneficiary enroll with another PCP
- Conduct a search for **PC Plus** providers if the beneficiary cannot identify a provider with whom they wish to enroll
- Provide information so families can choose a dental provider
- Provide information without making recommendations or advocating on behalf of a beneficiary or provider.

### 6.3.2.2 Tools to Assist MSRs in Providing Unbiased and Objective Benefits Counseling

During enrollment counseling, our staff has access to the online tools and information to make sure protocols are followed in presenting unbiased information. These tools are listed as follows:

- **Online Knowledge Base (KB) System:** The KB stores interview scripts, answers to frequently asked questions, policies and procedures, Quick Reference Guides, community resources, and other enrollment and benefits material
- **MAXSTAR Provider Application:** Allows MSRs to search for available providers (more detailed information is listed in our answer to *Question 11 (Section 6.3.3)*).

### 6.3.2.3 Monitor MSRs to Make Sure Benefits Counseling is Unbiased and Objective

Our project uses internal standards of quality to make sure that enrollment assistance is unbiased, accurate, and appropriate. Live call monitoring is used when staff members are new to the project or when past performance requires greater attention while recorded call monitoring is conducted monthly to assess compliance among all MSRs. Supervisors listen to at least three recorded calls per MSR per month and will increase the number of monitored calls when necessary, such as if an MSR's performance is not at the required levels. During the review, supervisors use a checklist to document performance and compliance with customer service standards including making sure MSRs provide unbiased information as shown in *Exhibit 6.3-8*:

*Supervisors Monitor to Ensure Benefits Counseling is Unbiased.* The exhibit shows that we check to make sure health plan, dental, and **PC Plus** benefits counseling is unbiased. The customer service portion of the tool allows supervisors to score MSRs on their professionalism and general demeanor and provides an indication of their performance in providing unbiased services. If our supervisors detect that an MSR is not providing unbiased provider information this is immediately addressed with the staff member either through one-on-one coaching or by requiring refresher training. When conducting call monitoring, our supervisors are able to listen to the call and view the on-screen actions taken by the MSR at the same time. The ability to hear and see what actions were taken allows us to ensure that appropriate caller education occurred and that enrollment information is entered correctly into the State's ACCESS system.

In addition to monitoring HelpLine calls, supervisors monitor quality of in-person enrollments conducted in the Burlington office. They are able to observe and listen to interviews because benefits counseling takes place in a conference room surrounded by glass. MSRs leave the door open for security and accessibility. Supervisors perform quality control checks using the same standards that are used to assess HelpLine calls. Supervisors use the checklist to indicate if benefits counseling was unbiased and objective. They also note if the MSR was appropriately positioned in relation to the client and if the door was left open to secure safety.

Section C. Enrollment/Education
<b>CHAP Enrollments</b>
If the beneficiary did not know what plan they wanted, did the MSR refer to plans for more info?
<b>Dental Enrollments</b>
Did the MSR ask if they have a current dentist?
If no current dentist, did the MSR search for dentists and provide choices?
<b>Primary Care Plus Enrollments</b>
Did the MSR ask if they have a current doctor?
If no current doctor did the MSR ask for demographic and gender preference?
Did the MSR conduct a search in MAXSTAR for possible doctors?
Did the MSR recommend a doctor?
Explain provider roles
Managed Care rules
Covered Services
Services not requiring a referral
Will get handbook, etc.
Total Correct
Total Incorrect
Total Possible
<b>SECTION C SCORE</b>

**Exhibit 6.3-8: Supervisors Monitor to Ensure Benefits Counseling is Unbiased.** Our supervisors document compliance with requirements for providing unbiased enrollment services.

(Catamount Blue or MVP Catamount Choice) and enter their plan selection into ACCESS. It does not require a PCP selection. All benefits and services questions are referred to these two plans. Occasionally, we may have beneficiaries contact us to say that their Catamount plan does not show them as active. We may reach out to either plan to confirm coverage on behalf of these beneficiaries, and we may communicate with them to resolve eligibility and status issues for beneficiary cases in conjunction with State AOPS staff.

If DVHA introduces health plans for *PC Plus* in the future, MAXIMUS acknowledges that enrollment will be conducted at the health plan level and that the health plan will follow-up to obtain the PCP choice after enrollment.

### **6.3.4 Encouraging Enrollees to Select a PCP**

**Question 12:** *Describe bidder's approach (including innovative strategies) to encourage individuals to select a PCP.*

RFP Sections 10.9.12, Page 35 and 5.6.1, Page 17

As your partner in providing managed care enrollment services since 1996 we have had the opportunity to refine and continuously improve operational procedures to encourage beneficiaries to select a PCP and maximize choice rates. In working directly with beneficiaries we have received feedback and information that has allowed us to understand the potential barriers that might prevent an individual from selecting his/her own PCP. We use this information to improve our business processes to overcome enrollment barriers and empower beneficiaries in choosing a PCP. Our approach, centers on the following:

- Implementing efficient business processes for enrollment processing and providing multiple enrollment channels
- Making sure MSRs are trained and well-equipped to assist beneficiaries in selecting a PCP

#### **6.3.4.1 Efficient Business Processing Includes Multiple Enrollment Channels**

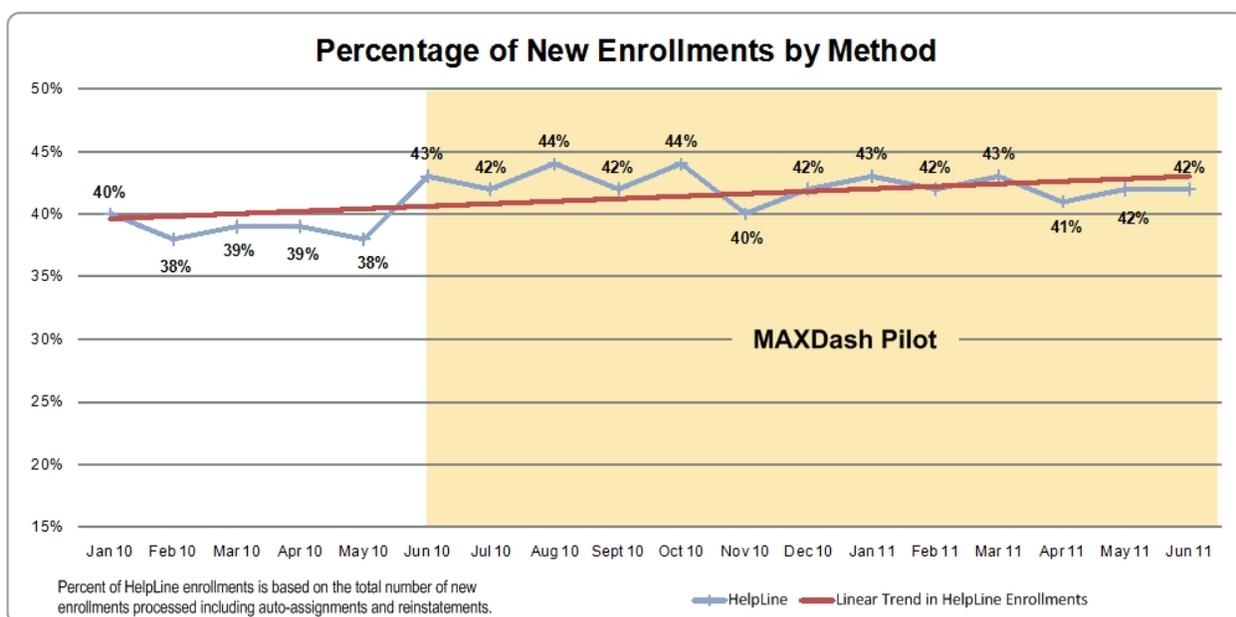
Having efficient business processes are critical in making sure beneficiaries make a PCP selection. In *Exhibit 6.3-10: MAXIMUS Approach to Enrollment Processing for PC Plus*, we present our solution for handling beneficiaries at various points in the enrollment cycle. One of the key features of our business process is we allow individuals to submit their enrollment by mail, telephone, and in-person. This same approach can be used for processing health plan enrollments should they become part of *PC Plus* in Vermont. We have found that offering different enrollment channels is important because each person has his/her own individual preference, comfort level, and needs when it comes to enrolling. Some prefer to speak to an MSR, while others find it more convenient to send their enrollment form to us. From 2001 to 2010, 63 percent of "choice" enrollments were handled by telephone, 37 percent were sent by mail, and less than one percent of enrollments were submitted in-person. This demonstrates the importance of having highly trained and experienced MSRs who can provide HelpLine enrollment services.

When beneficiaries contact the HelpLine they have the option of indicating the purpose of their call is for enrollment by selecting the appropriate queue. This provides efficiency because MSRs know right away that beneficiaries in this queue wish to submit their enrollment choice. While the exhibit is specific to *PC Plus*, CHAP beneficiaries also use the HelpLine to enroll in a health plan. Our enrollment scripts guide MSRs in conducting the enrollment interview to help the beneficiary identify and choose an appropriate provider. As mentioned previously in our answer to *Question 11 (Section 6.3.3)*, MSRs use MAXSTAR to help search for potential providers. The search is based on preference criteria identified by the caller such as location or gender and the tool allows us to tailor the search to meet each beneficiary's specific needs. For example, we can search for female providers, or female providers in Burlington, who are in a specific group practice. By altering the criteria on any number of factors we can help beneficiaries identify a suitable provider. Although many callers select the enrollment queue when they contact the HelpLine, we know from experience that some individuals, who have not yet enrolled, select another reason for their call, such as to get information about where to go for services. It is important for our staff to know that these callers, while having another purpose for their call, must still enroll. When our MSRs search for a beneficiary's case in the enrollment system, our MAXDash desktop integration tool displays the names of all members in a household or case who must enroll. The advantage of this tool is that even when someone calls for a non-enrollment reason, our MSRs know if he/she or any members of the case must enroll. Our innovative use of desktop integration allows us to take a proactive approach to identifying those who must enroll so that we can assist them in selecting a PCP. More information about MAXDash is presented in *Question 13 (Section 6.3.5)* and in *Section 6.5: Member Services*.

We have experienced an upward trend in the percent of enrollments processed by the HelpLine. Since 2008, the percent of HelpLine enrollments has increased by 23 percent. With the addition of our pilot of MAXDash, we have further increased the percent of beneficiaries who make a PCP selection via the HelpLine as shown in *Exhibit 6.3-11: Number of HelpLine Enrollments Shows an Upward Trend*. Our business processes and use of MAXDash have contributed to our ability to encourage individuals to select a PCP and improve on one of DVHA's desired program outcomes.

**A beneficiary wanted to express her gratitude for the assistance she received in getting her kids on Dr. D. She said that not only is the program wonderful, but everyone she has dealt with has been friendly, courteous, and exceptionally helpful. To quote: "Keep up the wonderful work! You are appreciated!"**

*- Member Services Representative*



11-P13001.0017-09

**Exhibit 6.3-11: Number of HelpLine Enrollments Shows an Upward Trend.** *Our business processes and introduction of the MAXDash pilot have helped to increase the number of PCP enrollments.*

Potential members for **PC Plus** may also enroll by returning the PCP Preference Form in the business reply envelope provided in the initial enrollment packet. Clerical staff counts and records the number of forms and reviews them for completeness and accuracy. Complete forms are entered into the ACCESS system daily. Those that contain any of the following issues are categorized as problem forms and require additional attention:

- PCP is not listed
- A group practice rather than a specific PCP is identified
- Provider listed is not available

Problem forms are identified and set aside so that MSRs can contact the potential enrollee to obtain the correct or complete information. MSRs first attempt to contact potential members by telephone to obtain a valid enrollment. If contact by telephone is unsuccessful, the enrollment form is returned by mail with a note requesting that the beneficiary contact the HelpLine for further assistance. This type of outreach is also conducted when the beneficiary indicates he/she does not have a PCP preference on the returned form. If outreach is not successful we acknowledge that the beneficiary is at risk for an automatic assignment as indicated in RFP Section 5.6.2.

In our experience a small number of beneficiaries prefer in-person enrollment assistance. Individuals have the option to visit our office in Burlington to enroll by meeting with an MSR. Our office, which is conveniently located in downtown Burlington and near the local shopping mall and bus station, makes it easy and convenient for those in Chittenden County who wish to take advantage of this enrollment option. MAXIMUS intends to retain this office under the new contract term. Those who live outside of Chittenden County can contact us via the HelpLine to receive assistance.

effective on the first day of the month following enrollment as long as beneficiaries enroll before the first of the next month as listed in the Questions and Answers issued August 4, 2011.

Under DVHA policy, members are permitted to transfer PCPs monthly, but the timing of when the transfer occurs will impact when the member can begin accessing services with the new PCP. If the change is made within the first five business days of the month, enrollment with the PCP is effective within the same month. Transfers occurring after the first five business days of the month are effective on the first of the following month. These rules also apply to transfers initiated by a provider or the State, and when this occurs, MAXIMUS works with beneficiaries to help them enroll with another provider. By processing changes or selections timely, we promote a positive impression of the program. This, in turn, increases the likelihood that any member who leaves medical assistance but returns at a future date will be empowered and willing to select a PCP.

While RFP Section 5.6 indicates the contractor is responsible for a variety of activities which include disenrollment processing, the Questions and Answers indicate that this is not a required function. The project performs some tasks related to disenrollment processing primarily focused on helping to document requests. Many disenrollments are handled directly in the ACCESS system when a beneficiary loses eligibility for **PC Plus** or moves to another program. These types of disenrollments do not involve Green Mountain Care Member Services staff. Some beneficiaries contact us to close their program participation. When this occurs we document the request in ACCESS and send a message through the system to the eligibility worker. When a beneficiary requests either an early enrollment or they issue a deferred/exempted request our staff gathers the information and emails the request to DVHA staff for final determination. We will continue to provide these services as required by DVHA.

### 6.3.5 Approach to Minimize Assignments

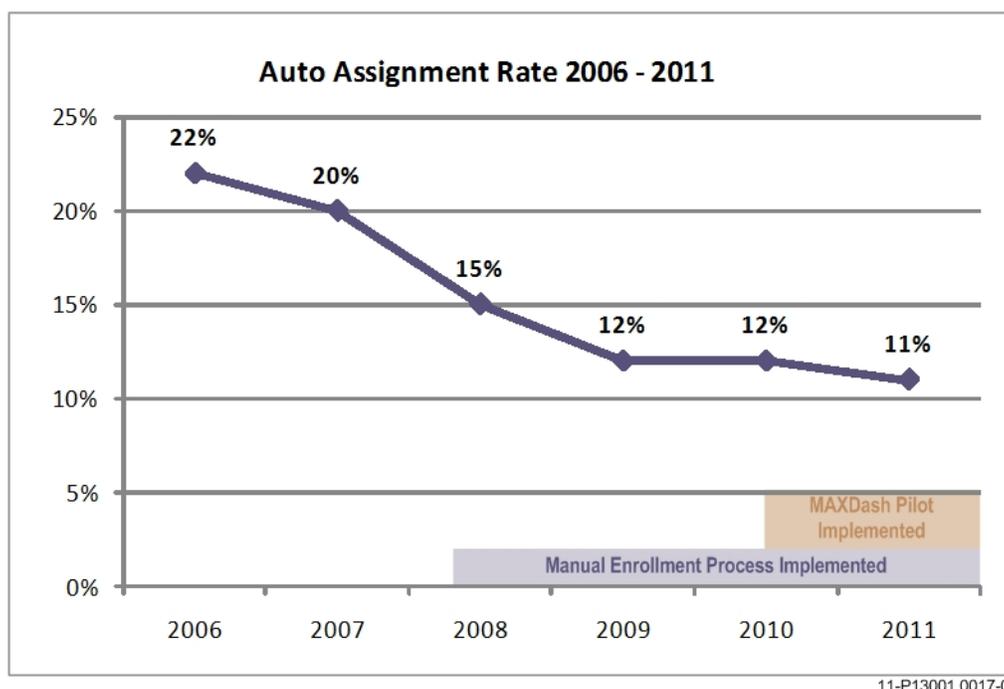
**Question 13:** *Describe the bidder's approach to minimize the number of auto-assignments.*

RFP Section 10.9.13, Page 35; 5.6.1, Page 17; and 5.6.4, Page 19

As a measure of our ability to provide effective and appropriate enrollment counseling we closely monitor the number of members who are auto-assigned to a provider. When individuals are informed and take an active role in their health care by choosing a provider, they have a greater chance of establishing a medical home and a better chance of receiving preventive and coordinated health care. The importance of working with beneficiaries in getting their active participation in health care decisions is critical so that they know how, when, and where to receive care and they have the best opportunity to remain healthy.

As your partner in first helping beneficiaries choose a health plan when managed care was new in Vermont to today where enrollment is into the **PC Plus** program, we have consistently made sure the number of auto-assignments was kept to a minimum. If a beneficiary has not made a PCP selection within 30 days, the State will execute its automatic assignment algorithm. It is important to note that auto-assignment occurs at the provider level for **PC Plus** because this program no longer includes health plans as a managed care option. The algorithm follows State criteria including PCP availability in the member's region. Over the life of the project we have maintained a low auto-assignment rate of just 16 percent which means that an estimated 84 percent of individuals have made a managed care decision when receiving benefits counseling

from MAXIMUS. In the current year, we have maintained an even lower auto-assignment rate of just 11 percent with 89 percent of beneficiary's choosing a PCP as shown in *Exhibit 6.3-12: MAXIMUS Has Consistently Reduced Auto-Assignment Rates*. In maintaining a low auto-assignment rate of 11 percent we are outperforming DVHA's standard which requires us to maintain an auto-assignment rate of no more than 25 percent.



**Exhibit 6.3-12: MAXIMUS Has Consistently Reduced Auto-Assignment Rates.** All of the activities we undertake to minimize the auto-assignment rate have been successful as illustrated by the consistent drop and current low rate of just 11 percent.

Our ability to minimize the number of auto-assignments is enabled through use of:

- Targeted outreach and conducting manual enrollments based on claims data
- Technology to help our staff quickly identify beneficiaries who have not selected a provider
- A motivational program that provides incentives to MSRs who are successful in getting members to choose a provider
- Ongoing monitoring of auto-assignment rates

The previously mentioned procedures that have led to our success in minimizing the auto-assignment rate are the ones we propose for the next contract period and are discussed in the sections that follow.

### 6.3.5.1 Outreach to Beneficiaries to Minimize the Auto-Assignment Rate

We use the monthly report from the State, which identifies individuals who have not made a health care choice, to initiate outbound telephone calls to members to encourage them to select a PCP. We find that telephone outreach is effective because an estimated 63 percent of "choice" enrollments are submitted by telephone. When a member has not made a choice by the 21<sup>st</sup> day of the enrollment cycle, we send the 21 Day Enrollment Reminder notice. If the beneficiary has not enrolled with a provider after receiving the reminder letter, our Outreach Coordinator manually assigns beneficiaries to a provider with whom they have had a prior relationship. Our

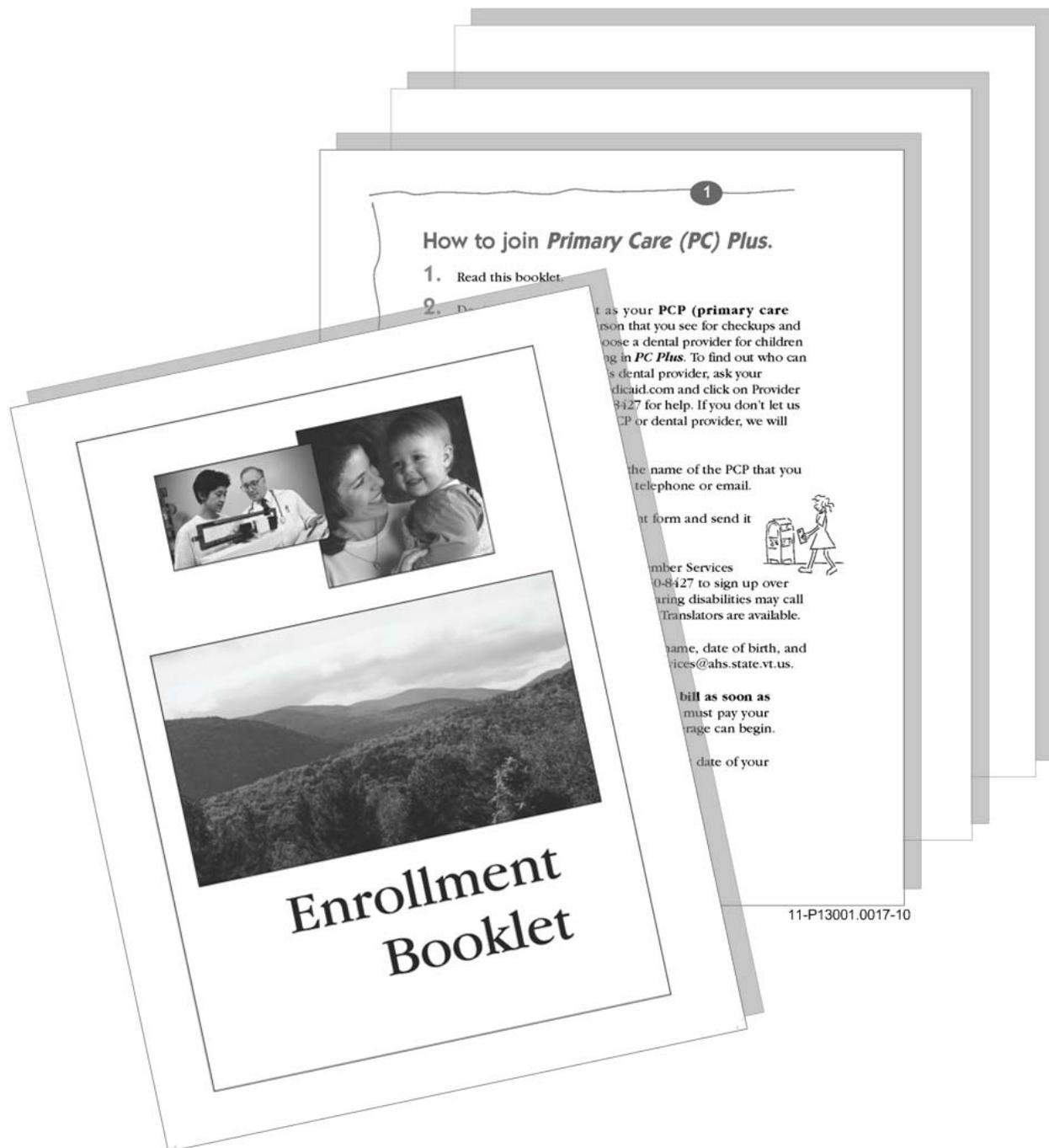
### 6.3.6 Approach to Updating and Producing Materials

**Question 14:** *Describe bidder's approach to updating and producing the required written materials listed in RFP; also describe any additional materials that the bidder intends to develop.*

RFP Sections 5.2, Page 15; 5.6.6, Page 19; and 10.9.14, Page 35

Because we have had the opportunity to serve as your Member Services contractor for more than 15 years, we have an established and proven approach to producing and updating written materials for Green Mountain Care. We understand that written materials are dynamic and must be updated when modifications to program occurs. MAXIMUS currently produces, maintains, updates, prints, and distributes a broad range of beneficiary enrollment and education materials. These materials have been continually refined over time to reflect ongoing program changes and are designed to maximize communication with beneficiaries. The materials we produce as the Green Mountain Care Member Services contractor include the following:

- The PCP Preference Form has been revised over time to reflect programmatic changes such as the Dental Home requirement in 2008. We have proposed to update the design of the form to provide a refreshed appearance and format as discussed in answer to *Question 9 (Section 6.3.1)* and as shown previously in *Exhibit 6.3-4: PCP Preference Form*.
- A collection of member handbooks which have been designed in coordination with DVHA and our Center for Health Literacy. The handbooks have received recognition from CMS independent auditors for their clarity and ability to be easily understood.
- A set of notices that convey key program information to potential enrollees, members, and their representatives about their enrollment. We updated the format and design of all of our notices as discussed in *Question 9 (Section 6.3.1)* with samples of the notices.
- The Enrollment Booklet and inserts, which helps beneficiaries understand terms, conditions, rights and responsibilities, benefits, and other applicable program information, illustrated in *Exhibit 6.3-13: Enrollment Booklet*.



**Exhibit 6.3-13: Enrollment Booklet.** *The enrollment booklet describes the various ways that a consumer may enroll, as well as their rights and responsibilities.*

A full list of the materials we produce for Green Mountain Care Member Services is shown in *Exhibit 6.3-14: Enrollment Materials for Green Mountain Care*. In collaboration with DVHA and our Center for Health Literacy, we designed each piece of written material so they are easily understood by the intended audience and are unbiased regarding available providers and health care options. These documents are written at or below the sixth grade reading level. As mentioned previously, the notices have been updated, with a refreshed design and easy-to-read

format and are part of our solution for the next contract period. Should DVHA institute health plans as part of **PC Plus**, we will make sure materials pertaining to health plan enrollment are also unbiased as required in the RFP, are written at the sixth grade reading level and are easily understood by beneficiaries.

Green Mountain Care Written Materials	
Notices	Enrollment Materials
Initial Medicaid/VHAP Mandatory Notice	<b>PC Plus</b> and Dental Enrollment Form (Plan/PCP Preference Form)
Medicaid/VHAP Reminder Notice	Enrollment Handbook (Enrollment Booklet)
<b>PC Plus</b> Auto Assign Confirmation Notice	Health Care Programs Handbook ( <b>PC Plus</b> Handbook)
<b>PC Plus</b> Enrollment Confirmation Notice	Pharmacy Programs Handbook
<b>PC Plus</b> PCP Transfer Notice	Premium Assistance Handbook
<b>PC Plus</b> Reinstatement Notice	Enrollment Packet Outer Envelope
Disenrollment Notice (ended per DVHA in February 2004)	Postage Paid Business Reply Envelope
Dental Home Confirmation Notice	Application Document Processing Center Envelope
Dental Home Transfer Notice	
PCP Gone Special Notice	
PCP Moved Special Notice	

**Exhibit 6.3-14: Enrollment Materials for Green Mountain Care.** *Over the past 15 years, MAXIMUS has worked closely with the State and our own Center for Health Literacy to produce and refine the collection of beneficiary materials.*

In addition to more traditional written materials, MAXIMUS is sensitive to the need to provide materials in alternative formats. These materials are designed to accommodate our beneficiaries with special needs. For our visually impaired beneficiaries we make information available in large print and Braille translations upon request.

### 6.3.6.1 Materials Production

As part of our responsibilities as your Member Services contractor, we have an established process to produce and print enrollment materials including notices, enrollment booklets, and member handbooks. Since 2008, we send an average of more than 200,000 mailings annually to Vermont health care beneficiaries. As mentioned previously in our response to *Question 9 (Section 6.3.1)* we import State-provided mail files to initiate mailings to those who are newly eligible for **PC Plus**, to newly enrolled members to confirm their enrollment and to members who transfer providers or are reinstated for benefits. MAXIMUS also sends enrollment mailings upon request by a member. These files are prioritized in accordance with mailing deadlines to ensure that enrollment materials are mailed in compliance with contractual performance standards. MAXIMUS maintains a copy of every mail file imported from DVHA. This historical data is frequently utilized to confirm individual mailings in response to queries from DVHA or other agencies, and also allows us to resend notices at the request of DVHA or beneficiaries.

Since 1996, we have provided cost-effective and efficient mailing services using our project's internal mailroom to handle incoming and outgoing mail. We plan to continue using this same approach during the next contract period including using our Mailing Coordinator, Tim Bard to coordinate all enrollment related mailings. This approach is proven and cost-effective because it avoids the time and resource expenditures that occur when a new contractor implements services for the very first time.

### 6.3.6.2 Materials Updates

Since first implementing enrollment and member services we have worked collaboratively with you to revise written materials to reflect changes in programs, policies, and available benefits. In a state as dynamic as Vermont, where leaders are constantly looking for new and better ways to provide its residents with health care services, having a tested process in place to quickly and accurately reflect programmatic changes in written beneficiary materials is critical.

Each time a programmatic change necessitates updates, we modify all related materials promptly and in accordance with the process we have established with DVHA. Our Project Director, Sonia Tagliento, oversees the materials update process, which begins internally with input from the Center for Health Literacy and our management team. Through our KB system, designated team members identify all materials that may be impacted by the change and make preliminary edits, submitting them to our Project Director for review. Depending upon the change, staff members in various positions have the opportunity to provide input on the change to make certain that those spending the most time working one-on-one with Vermonters have the opportunity to weigh in.



Once this internal review is complete, our Project Director then submits suggested materials changes to DVHA for review and approval prior to their distribution. We understand that the State will review and approve or indicate necessary changes in all informational and enrollment materials within 15 business days of receipt of said material.

Upon completing any additional changes requested by DVHA and obtaining final approval, our Project Director oversees the introduction of these changes to production to make certain Vermonters receive accurate, up-to-date written program information. Any time materials updates are made, we notify MSRs through our KB system to familiarize them with the changes so that they can modify the information they provide through our toll free line instantaneously. Historically, this update process occurs frequently for mailed notices, and at least annually for member handbooks.

### 6.3.6.3 Additional Materials and Innovations

We recognize that clearly written, easy-to-understand, and visual appealing materials will remain of critical importance to ongoing member education as we move into the next contract term. As discussed and shown in our response to *Question 9 (Section 6.3.1)*, we propose to refresh existing notices and the enrollment form for the next contract period. Our innovative approach to materials development includes using the MAXIMUS Center for Health Literacy and designing materials that are appealing and presented in an easy-to-read format. The project will undertake these changes with input from DVHA making sure that information in the refreshed materials continues to engage and educate members while reflecting Vermont's health care program messaging and branding. Upon your approval, our process for refreshing these existing Green Mountain Care materials includes:

- Meeting with DVHA so that we understand specifically what you desire in terms of content and style
- Developing a graphic theme for the materials that is relevant and appealing to Vermonters and helps them recognize Green Mountain Care communications
- Organizing the proposed content so that it makes sense to readers, flows logically, and serves to highlight important messages
- Writing the text so that it is easy to read, following the best practice guidelines in our *Health Literacy Style Manual*
- Designing the materials so that the formats enhance readability and beneficiaries can find key messages easily
- Choosing illustrations and graphics that aid comprehension because they relate to the particular backgrounds and experiences of Vermonters
- Testing all draft materials with consumers so that we are sure they are easy to read and understand
- Revising our drafts in accordance with test results and input from DVHA
- Receiving approval from DVHA on final materials prior to distributing them to the public

## 6.4 COORDINATION

RFP Section 10.9.15, page 35

**Question 15:** *Describe the bidder's plan to coordinate its education, outreach, and enrollment functions with those performed by other parties, including State agencies and community groups.*

Working together with the Department of Vermont Health Access (DVHA), we have implemented an array of outreach strategies that have increased program awareness and created positive perceptions of Green Mountain Care programs among general and targeted populations. As the Vermont health care programs have grown and evolved since their inception, MAXIMUS has revised and refined our outreach strategies to support the changing demands of DVHA and the people we collaboratively serve. For more than 15 years, we have demonstrated our ability to partner with you through a variety of program and policy changes, including the addition of new populations, plans, and programs. In each instance we have worked with local organizations and stakeholders to understand and respond to the needs of the community. Through these experiences, MAXIMUS offers unique advantages to the project outreach and education requirements that are unmatched by our competitors:

- Trust-based relationships with all stakeholders, including local Department for Children and Families (DCF) offices, community based organizations (CBO), Catamount plans, other contractors, the Office of Health Care Ombudsman, and Area Agency on Aging offices
- Knowledge of effective strategies to reach all uninsured Vermont residents and encourage them to apply and enroll
- Hands-on experience and a deep understanding of the unique characteristics and needs of Vermont's communities
- A demonstrated ability to work seamlessly and effectively within the State's Green Mountain Care eligibility and enrollment process

### 6.4.1 Experience with Vermont Stakeholders

Successful performance of health care education, outreach, and enrollment functions depends on the formation and maintenance of effective working relationships with a host of involved entities and organizations that have a stake in the operation of the programs. It is vitally important that there is connectivity between all stakeholders. We recognized the need for these alliances and established informal partnerships with several State and community agencies throughout our



**Capacity to adapt to future needs**

**MAXIMUS... Vermont's proven partner to achieve its goals; yesterday, today, and tomorrow**

**Understanding.** Our long term and successful history with Vermont programs and beneficiaries, along with the fact that all of our proposed staff live and work in Vermont, ensures that we have the knowledge to impart information in an effective and supportive manner.

**Partnership.** We continually demonstrate our ability to cooperate with a wide range of Vermont state agencies and community organizations to successfully convey information.

**Social Media.** MAXIMUS has the capability to support DVHA in creative ways, such as via web and social media outreach campaigns.

**Expertise.** We offer unmatched Vermont experience providing face-to-face education gained from delivering more than 2,000 in person presentations to Vermonters between 1996 and 2006.

time in Vermont to better serve our clients. *Exhibit 6.4-1: Vermont Green Mountain Care Stakeholders*, highlights the entities that we have partnered with to reach various populations regarding changes to programs and processes. These joint efforts took the form of presentations to provide information that could be passed on to enrollees, presentations directly to beneficiaries, and participation in training sessions. Following the cessation of contracted marketing and outreach functions in 2006, MAXIMUS continues to maintain close professional ties with these entities and remains a critical resource for health program information.

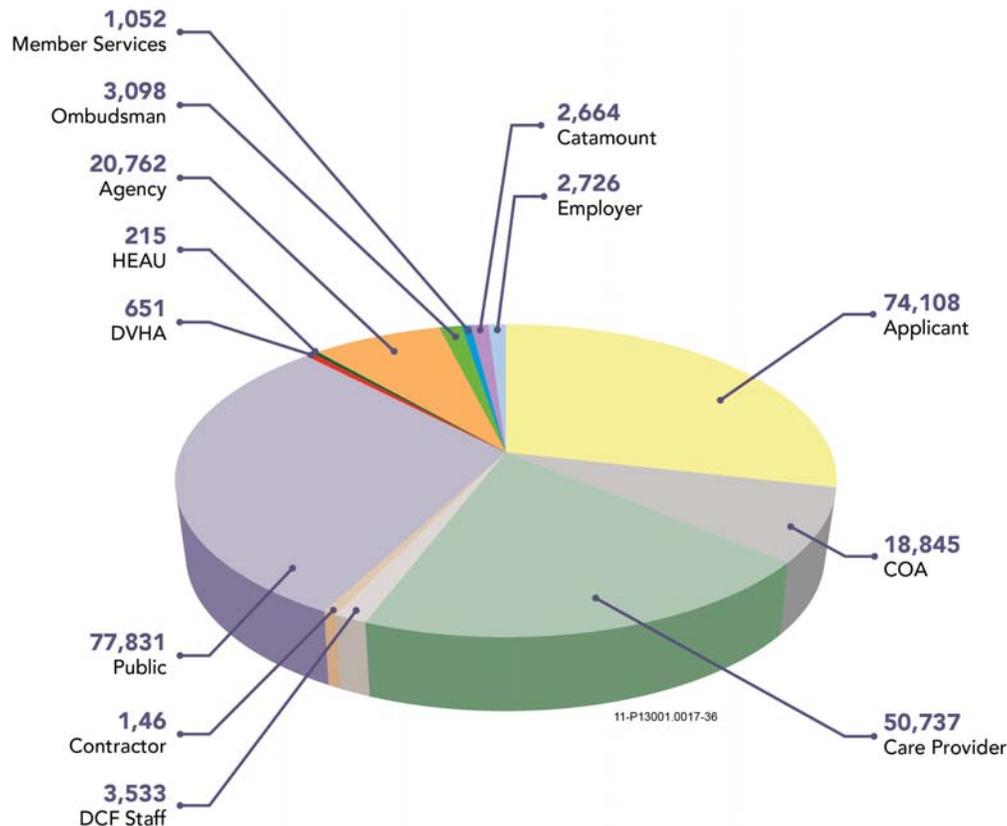
Stakeholder	Connection
<b>Area Agency on Aging (AOA):</b>	While MAXIMUS has always been a resource for AOA case managers, especially during the annual pharmacy program review period, interactions skyrocketed with the implementation of the Medicare Modernization Act in 2006, and the resulting issues with coordination of benefits. AOA case managers continue to frequently contact the HelpLine regarding specific cases or to clarify policy changes. MAXIMUS also refers callers to the AOA if it appears that the beneficiary needs the case management services provided by the AOA.
<b>Open Door and other free or low-cost clinics state-wide</b>	Clinic staff regularly contacts the HelpLine for assistance in the application process.
<b>Community Health Center (CHC)</b>	Located in Burlington, Vermont, CHC actively serves low-income and disadvantaged area residents. MAXIMUS acts as a general resource.
<b>Child Welfare and Youth Justice workers (CWYJ)</b>	CWYJ workers frequently contact the HelpLine for case specific information and problem resolution regarding children in state custody.
<b>Medicare Organizations</b>	MAXIMUS participated in quarterly Medicare Beneficiary Work Group meetings and was an active participant in a series of 'road shows' produced by this group in the spring of 2000.
<b>Department for Children and Families (DCF)/ESD Call Center</b>	MAXIMUS regularly communicates with DCF regarding individual cases and more general policy information. In addition, MAXIMUS regularly participates in meetings with DCF staff, working together to best address current program issues and challenges.
<b>Vermont Refugee Resettlement Program</b>	MAXIMUS strives to keep informed regarding the changing refugee population in Vermont. MAXIMUS has worked with the Refugee Resettlement Program staff to resolve individual beneficiary problems, and has also attended informational seminars regarding new refugee populations such as the Sudanese.
<b>MMIS and Pharmacy Benefits Management Contractors</b>	MAXIMUS regularly communicates with MMIS and Pharmacy Benefits Management contractors to resolve individual beneficiary issues, as well as to remain informed of changes to the provider end of operations that may impact clients.
<b>Hospital Social Services Department</b>	MAXIMUS works with hospital social workers to facilitate beneficiary enrollment into Green Mountain Care programs or resolve billing problems when appropriate.
<b>The Office of the Health Care Ombudsman</b>	The Office of the Health Care Ombudsman frequently contacts the HelpLine for assistance in resolving issues. MAXIMUS and the Ombudsman also meet as needed to review current issues and work together to identify solutions.
<b>Department of Aging and Independent Living (DAIL)</b>	MAXIMUS communicates with DAIL regarding individual cases and frequently refers callers with questions about personal care attendant services.
<b>BiState Primary Care Association – Application Assistors</b>	MAXIMUS maintains regular communications with BiState in an effort to coordinate assistance for individuals requiring application assistance that cannot be achieved via phone interaction.

**Exhibit 6.4-1: Vermont Green Mountain Care Stakeholders.** *Partnerships with other stakeholders result in more effective and efficient program operations.*

### 6.4.2 HelpLine Encounters

As indicated above, many different stakeholders routinely contact the HelpLine on the behalf of individual beneficiaries or to clarify program information. Since 2005, MAXIMUS has fielded

more than 18,000 calls from community or advocacy organizations (COA). In addition, we received over 20,000 calls from departments within the Agency of Human Services. Another 1,500 calls were from other contractors doing business with DVHA such as the MMIS contractor or the Pharmacy Benefits Management contractor. Eighty-five percent of HelpLine callers are program beneficiaries. *Exhibit 6.4-2: Caller Types (Excluding Beneficiaires)*, shows a break-out of caller types other than beneficiaries from 2005 through 2010.



**Exhibit 6.4-2: Caller Types (Excluding Beneficiaires).** *The HelpLine provides quick and easy access to program information for state agencies, contractors, and other stakeholders calling on behalf of beneficiaries.*

### 6.4.3 Marketing and Outreach Functions

We understand that DVHA does not intend to reinstitute field marketing and outreach functions at this time. However, having initiated and performed marketing and outreach functions in the community from 1996 to 2006, we have the experience, expertise, and stakeholder relationships in Vermont to swiftly resume these functions should DVHA decide to do so at a future date. We remain prepared to assist DVHA with guidance and/or direct performance of these functions as DVHA contemplates how it will address new Affordable Care Act requirements relative to the navigator program, including establishing creative communication means such as the web, blogs, and social media as described in *Section 6.2: Education*. We have already begun to participate in workgroup meetings and discussions with DVHA, and its contractors and stakeholders, relative to these requirements and remain prepared to continue to support your efforts as you move forward with the implementation of federal Health Care Reform.

## 6.5 MEMBER SERVICES

Vermont has long been at the vanguard of public health care reform and is poised to embark on its most ambitious endeavors yet. The Department of Vermont Health Access (DVHA) is charged with designing and implementing a new technological infrastructure, establishing the Vermont Health Benefits Exchange, migrating health care eligibility operations from the Department of Children and Families (DCF) to the DVHA, and implementing the first state hybridized single payer health care framework in the nation. As your long time partner, we welcome the challenges that these future endeavors present, and as we have been for more than 15 years, we are prepared to stand at your side to aid the smooth implementation of these significant changes.

In the sections that follow, we present our approach to member services operations and the reasons MAXIMUS remains the best choice to make certain that Green Mountain Care Member Services continues to meet the needs of Vermont's health insurance beneficiaries today and in the future. We have the appropriate systems, solutions, and staff in place to continue to provide excellent member services for Vermont beneficiaries.

MAXIMUS understands that customer service is not all about rules and regulations. It is also not about how many calls we receive or how quickly we take them. It is about addressing the issues of each and every person who calls the HelpLine. During our tenure in Vermont, MAXIMUS has responded to the needs of more than 3.6 million callers. These callers are beneficiaries, as well as providers, colleagues, stakeholders, and the general public. Through good times and more challenging times, we have maintained high levels of service and customer satisfaction, as evidenced by regular positive customer and stakeholder feedback. We have continuously challenged ourselves to improve and innovate to support the best, most efficient, and cost-effective service for Vermonters. We are prepared to continue to provide the full scope of services described in the RFP into the next contract term and offer DVHA a high-quality and risk-free solution for doing so.



**Reputation.** We have been the face of Vermont health care programs for longer than 15 years, and program beneficiaries and stakeholders know and trust us.

**Flexibility.** We have responded to DVHA's changing needs rapidly and efficiently in the past and are fully prepared to do so in the future.

**Consistency.** Choosing MAXIMUS makes certain that beneficiaries continue to receive the highest levels of service, without interruption, amid Vermont's changing health care environment.

**Operational Expertise.** We are the only vendor that has first-hand knowledge of Vermont's health care programs, beneficiaries, and delivery processes.

*"Each time I call I receive friendly, prompt service. It has been my experience that 'dealing with state agencies causes headaches' but when I call there, I feel confident that my children's health care is being taken care of."*

*- Beneficiary,  
March 2008*

## 6.5.1 Approach to Member Services

### **Question 16:** Describe the bidder's overall approach to providing member services activities.

RFP Sections 10.9.16, page 35 and 5.7-5.7.1, page 20

As indicated above, our overall approach to delivering superior service to our callers begins long before a call is routed to a Member Services Representative (MSR). To make certain we are prepared to deliver the best possible service, we provide staff with:

- Extensive initial and ongoing training
- Up-to-date references and resources in an easy-to-access format
- Proper supervision and guidance
- Ongoing monitoring and evaluation

We do all this to make certain that performance standards are met and that our customer service is delivered in a quality way that you've come to expect from us. Exceptional customer service is the culmination of these efforts.

#### 6.5.1.1 Commitment to Customer Service

Customer service is a critical component of all MAXIMUS projects. We understand that we are not providing customer service to a population—we are providing service to the individual caller on the phone at that moment. MAXIMUS recruits and hires individuals who are professional, courteous, empathetic, and non-judgmental. Some of the principles of MAXIMUS customer philosophy are as follows:

- **Program and Process Expertise:** Today's sophisticated health care delivery systems and their frequent changes make for a complex and difficult landscape for the average person to navigate. Accuracy of the information provided is imperative. In addition, it is critical not only to thoroughly know the programs and functions that we are responsible for, but also to have an understanding of how our role intersects with those of DVHA, DCF, other agencies, and other contractors. MAXIMUS staff has been guiding Vermont beneficiaries through the Vermont health care environment for more than 15 years, resulting in a level of expertise that no other vendor can offer.
- **Professionalism, Respect, and Empathy:** MAXIMUS fields HelpLine calls from diverse people with different needs, temperaments, cognitive abilities, and levels of distress. Staff is trained in listening skills, cultural sensitivity, and methods to de-escalate an angry encounter. While we recognize the importance of identifying process problems, staff attempts to focus the encounter on reaching a solution to a problem rather than placing blame. Our efforts have been rewarded by numerous accounts of positive feedback from members that are documented in the weekly report to DVHA.
- **Efficiency:** MAXIMUS understands that superior customer service goes beyond a smile in your voice and program knowledge. This service must be delivered in a highly efficient

**"The State needs to know just how great everyone there is! Each staff person patiently explained the process using layman's terms and really helped me through it."**

*-Father of Dr. Dynasaur  
Beneficiaries,  
August 2008*

manner, especially in today's fiscal climate. MAXIMUS continuously balances between offering each caller the assistance required with the need to move on to the next call and provide service to that caller. To that end, MAXIMUS has developed a plethora of policies, processes, references, and tools to optimize customer encounter efficiency. These are described in detail in previous and subsequent sections of this proposal.

### 6.5.1.2 Member Services Functions

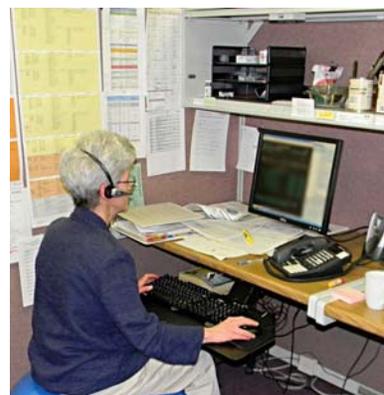
The following sections outline specific functions and tasks performed each day by Green Mountain Care Member Services.

- **Eligibility Screening:** Mailed applications have decreased from an average of 3,000 per month in 2007 to an average of 2,000 per month in 2010. This decrease does not reflect a declining interest in programs, but rather a reflection of the impact of additional options to obtain an application by email or apply online via the state-hosted Green Mountain Care website. Calls regarding eligibility have declined moderately since 2007, making up about 20 percent of total call volumes. This decline coincides with the self-service program screening and application request option in the Interactive Voice Response (IVR) system deployed by MAXIMUS in 2007, as well as the web-based screening tool supported by DVHA. Callers interested in applying for a program who do not chose the self-service screening option are routed to a telephone queue staffed by MSR Enrollment Specialists. These staff members use a high-level screening tool with a series of questions that are designed to cull out those who are not qualified for any Green Mountain Care program rather than to speculate about specific program eligibility. If it seems likely that callers may qualify for a Green Mountain Care program, they are advised that their application will be screened to find the program with the best benefits and the lowest cost that they qualify for. Should the caller have additional questions about a specific program, the MSR provides the information with a disclaimer that program eligibility is determined only after a completed application is reviewed.
- **Verifying Beneficiary Status:** With an expansion of programs and a more complicated and multi-layered eligibility process, it is not surprising that the largest percentage of calls received at Green Mountain Care Member Services is regarding beneficiary status. These calls are prompted by eligibility notices, difficulty in accessing services, publicity regarding program changes, and many other sources. MAXIMUS responds to these inquiries by verifying the beneficiary's eligibility using ACCESS (and the MMIS vendor and pharmacy benefit manager as needed), explaining changes in eligibility or programs, and resolving problems that may have an adverse effect on the beneficiary's eligibility. These calls increased significantly with the implementation of the lengthy Catamount Health Assistance and Employer-Sponsored Insurance Assistance program eligibility process, as well as periods of high levels of program churn due to various reasons.

"I just wanted to let you and others know how well the MAXIMUS team did during this Medicare Open Enrollment Period. It's like our Olympic event, and we (CVAA SHIP) depend on them a great deal to help us and they were awesome!"

- Patricia, Community Worker  
sent by email to DVHA

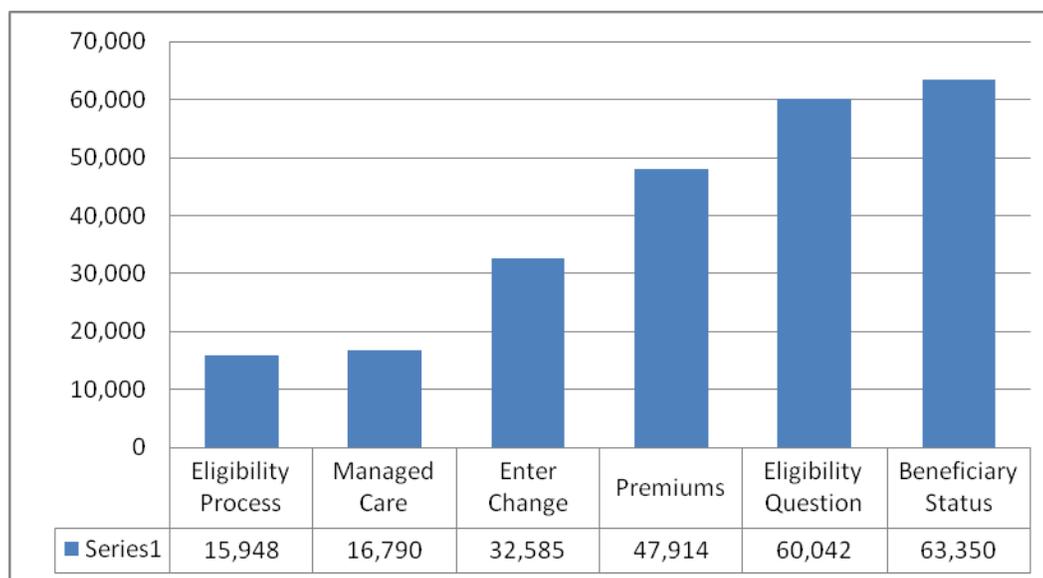
- **Referral to Other Services:** As previously stated, an important duty of member services is understanding how our work, and health care services as a whole, relate to other programs or resources in the community. We strive to provide some level of assistance to every caller, even those with needs outside of the realm of DVHA programs. Toward this end, we have developed a comprehensive Community Resources reference guide that includes detailed information regarding free and low-cost health care services, various self-help and crisis organizations, child care resources, parenting groups, and contact numbers for state-funded programs such as fuel assistance and Healthy Babies. This document is readily available to staff via our web-based Knowledge Base (KB) system and updated regularly. In addition, we regularly refer callers to the State's 411 website, another source of available social programs.
- **Entering Changes:** MAXIMUS staff processes changes reported by beneficiaries by entering the information directly into ACCESS, or by notifying the DCF Benefit Program Specialist (BPS) via an internal notification system referred to as CATN. Once notified, the BPS reviews the information provided and determines the impact on program eligibility. The following describes some of the changes recorded by MAXIMUS staff:
  - **Address or Phone Numbers:** MAXIMUS staff enters address and telephone number updates into the ACCESS system as reported by members or as documented on returned mail.
  - **Social Security Numbers:** MAXIMUS assigns temporary numbers to newborns as placeholders in the state eligibility system, and enters permanent social security numbers as they become available.
  - **Household Members:** MAXIMUS records additions or departures to households as reported. Reports of this kind prompt MAXIMUS staff to gather additional household information such as income, marital status, and commercial insurance information, as well as newborn information.
  - **Name Changes:** MAXIMUS reports name changes and creates ALIA panels in ACCESS as needed.
  - **Changes in Income:** MAXIMUS staff currently records earned and unearned income changes as reported via the HelpLine. JINC (job income) panels in ACCESS are some of the most complex, and our staff has developed a multi-page reference document to walk MSRs through the process. Reports of changes in income or employment information prompt MAXIMUS staff to query the beneficiary regarding other aspects of the case, such as child care expenses and commercial insurance possibilities through the work place.
- **Updating Third Party Liability (TPL) Information:** Today's fiscal climate makes it critical for DVHA to identify member's TPL information that includes commercial or other insurance. Recording TPL provides a cost avoidance opportunity for DVHA, placing the financial responsibility on the appropriate party. With the implementation of higher premium amounts, updating TPL is equally important to members, as those with TPL pay a reduced premium. Since 1998, MAXIMUS has completed more than 96,000 TPL related transactions. While the number of TPL transactions has remained fairly consistent over the



last few years, the time required to verify and enter the information has increased by more than 50 percent, primarily due to more rigorous HIPAA protocols practiced by all insurance companies. In addition, the level of detail and coding has increased the complexity of the process. To accurately and effectively accommodate the increased level of effort prompted by these changes, MAXIMUS has designated a fulltime TPL Clerk and has refined the process so that it is entirely electronic. This innovation prevents potential transcription errors and minimizes the potential exposure of protected health information (PHI).

- **Issuing Replacement Cards:** MAXIMUS staff enters beneficiary requests for permanent replacement program cards into the ACCESS system after verifying that a card has not been sent recently and is not on its way. MAXIMUS also advises the caller as to how to access services while waiting for the arrival of the card. For those that require a card immediately, MAXIMUS also prints and mails temporary replacement cards. As an innovation, MAXIMUS has integrated the card replacement process into our MAXDash portal, streamlining this process for staff.
- **Facilitating Compliance with Proof of Citizenship and Identity (C&I) Requirements:** Beginning in 2006 and ending with the suspension of the C&I requirement in 2009, MAXIMUS provided additional assistance to beneficiaries needing to meet this requirement. In this role, we worked with beneficiaries to define adequate proofs and advised them as to how to obtain such proofs. In addition, our staff provided beneficiaries with birth certificate request forms specific to each state, conducted extensive outreach to pending cases, and processed requests for financial assistance to obtain documents. MAXIMUS staff also provided training regarding this requirement to several stakeholder groups.
- **Providing Information:** MAXIMUS is widely recognized as the premier local source for program and process information as it relates to the Green Mountain Care programs. Our extensive training, highly developed electronic references, and quality control process make certain that we provide beneficiaries with accurate and up-to-date information. Only our staff has the experience, training, and expertise to support beneficiaries through exemplary service without interruption. *Exhibit 6.5-1: Top Call Topics* shows the approximate number of annual calls to the HelpLine broken out by the most frequent call topics.





**Exhibit 6.5-1: Top Call Topics.** *Our supervisory staff regularly works with other stakeholders to achieve expedient resolutions to beneficiary problems.*

However, the entire scope of information that we provide includes:

- Covered Services:** MAXIMUS uses comprehensive and detailed covered services matrices for all of the Green Mountain Care programs. Additional information, such as beneficiary claims and specific eligibility information, is accessed through research in the HP Enterprise system, the ACCESS system, and other detailed reference materials.
- Prior Authorizations:** In providing information regarding covered benefits, we instruct beneficiaries that some services require a prior authorization (PA). Although a provider must initiate a PA request, MAXIMUS provides information regarding which entity processes the PA for which services and advises beneficiaries to direct their providers to the appropriate source. MAXIMUS uses the MMIS vendor and the pharmacy benefit manager systems to confirm receipt and/or outcome of a PA request, and we advise the caller regarding decision timelines and protocols.
- Medicaid/Medicare Dually Eligible Programs:** The number of calls regarding dual eligible programs has increased by 156 percent since 2005, primarily as a result of the implementation of the Medicare Modernization Act (MMA) in 2006 and the introduction of Medicare Part D. We extended operating hours and participated in a vigorous triage and problem resolution effort with DVHA immediately following the implementation of MMA. These calls are typically lengthy, as they involve explaining about complex cost-sharing formulas between Medicare and Medicaid pharmacy benefits, misapplication or confusion about premium payments, or difficulty in accessing pharmacy benefits. We offer plan information regarding the cost of Medicare Part D plans as they relate to the low-income subsidy or Vermont benchmark level of payment, as well as the plan phone numbers. In cases where the beneficiary requires assistance in areas beyond the scope of our role, MAXIMUS refers them to the appropriate Area Agency on Aging (AAA) office to ensure their needs are met.
- Spend-Downs:** MAXIMUS provides beneficiaries with information about how a spend-down works, what items may be applied to a spend-down, and how to record these items

in the spend-down log. Upon request, we mail spend-down logs to beneficiaries within one business day. We also research case notes and notices to determine the amount of a beneficiary's spend-down and refer beneficiaries to their worker should they require further information.

- **Helping Members Understand Notices:** Program expansions have resulted in a lengthened and more complex eligibility process, and subsequently an increase in the types of notices sent to beneficiaries. MAXIMUS staff relies upon the ACCESS system, the Vermont Notices System, and the relatively new imaging system, OnBase, to confirm status, explain the meaning of the notice, and advise of any additional information or actions required. In cases where the caller can provide information requested in a notice, MAXIMUS enters the information directly into the appropriate ACCESS screen or via a CATN message to the worker.

- **Premium Collection Inquiries:** In 2004, MAXIMUS worked with DVHA, DCF, and other staff to design the premium collection process and rules for the programs. This also included additional premium-related screens in ACCESS and modified program notices. Additional modifications were implemented in 2006 to accommodate Medicare Part D plan (PDP) payments, and again in 2007 with the launch of the Catamount Health and Premium Assistance (CHAP) and Employer-Sponsored Insurance Assistance (ESIA) programs. These modifications included additional screens to

process incoming premium payments, as well as to document premiums paid out by the State to the various plans and some program beneficiaries. These changes, and subsequent programming glitches, prompted significant increases in calls regarding premiums. MAXIMUS quickly developed interim work-around and triaging processes, as well as new training and reference materials. Typical premium topics are explanations regarding the amount of the premium, confirmation of receipt or the mailing of a premium, reordering the allocation of payments received, explaining and facilitating the automatic payment (ACH) option, requesting refunds, and assisting the beneficiary in re-establishing coverage following a closure due to a late premium payment.

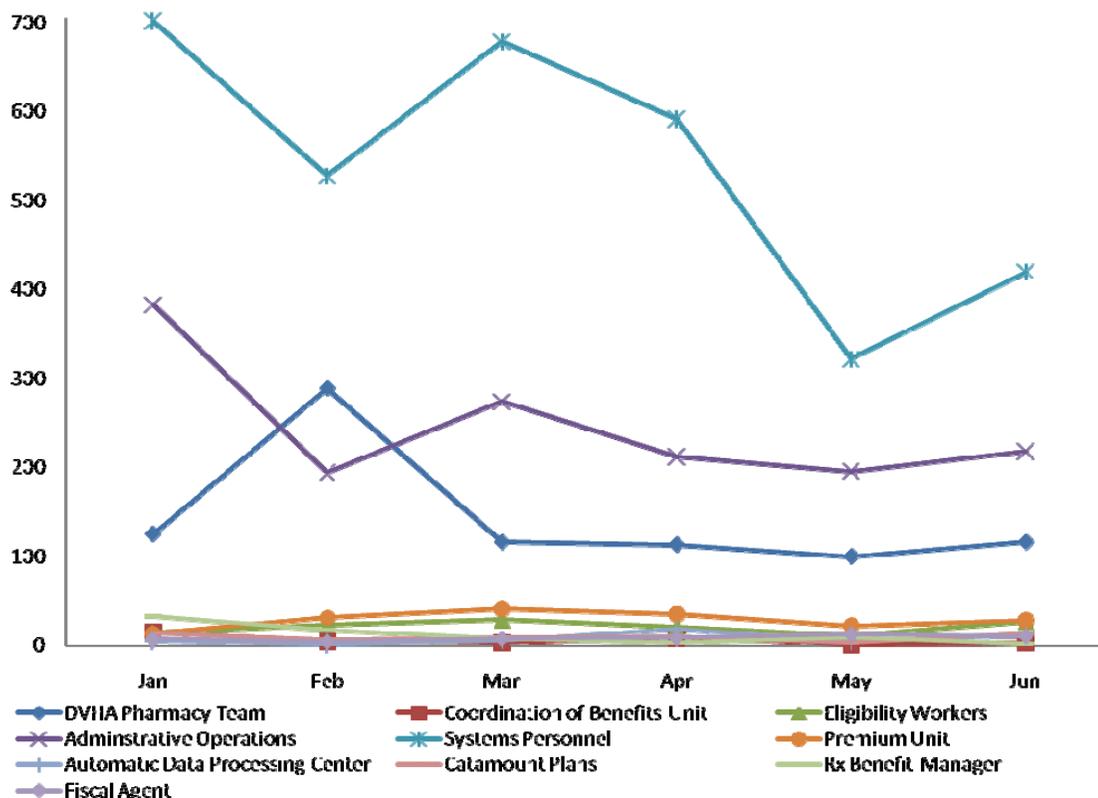
- **Resolving Billing Issues:** MAXIMUS addresses beneficiary billing issues presented via the HelpLine, by mail, or from Medicaid complaint forms forwarded by HAEU and DCF offices. Billing resolutions are often the most time consuming and labor intensive of our tasks, and billing calls are routed to our most experienced staff. MAXIMUS staff relies heavily on claims history information in the MMIS vendor and the pharmacy benefit manager systems, and eligibility and TPL information in ACCESS, to resolve these issues.

### Kristen's Story

Kristen, of Sheffield, called because one of her children was in need of medications, but the pharmacy was reporting no active coverage. The MSR reviewed the case and found that during the annual review the adults had been granted continued coverage; however, the children had been accidentally left behind and closed out. AOPS reviewed the case, reinstated the children with no lapse in coverage, and alerted the supervisor. Due to the urgent medication need, the child's case was 'goosed' to reflect same day updates and the medications were obtained.

Most billing problems presented via the HelpLine are resolved on a first-call basis. However, problems received via mail are routed to a staff member with in-depth knowledge in navigating the MMIS vendor and pharmacy benefit manager systems, as well as an understanding of how TPL status and DVHA policies affect billing issues. The staff member researches the issue, documents the time spent on a resolution, and communicates the result to the beneficiary. In all circumstances, MAXIMUS staff encourages the beneficiary to call again should he or she require further assistance. The average number of billing resolutions performed by the staff averages about 10 per month and requires approximately four dedicated hours.

- **Systems Discrepancies:** A beneficiary's ability to access services within DVHA's health care programs require that several systems reflect the same client information. MAXIMUS is often alerted to discrepancies among these systems after having received a call from a distressed beneficiary who is having difficulty accessing services. While the number of these problems is relatively few compared to our total call volume, beneficiaries in these situations often require urgent resolutions to their problems. MAXIMUS frequently intervenes with providers on the behalf of beneficiaries to make certain that the individual's immediate need is met while a formal resolution to the problem is pursued. We verify the beneficiary's status via the ACCESS system and identify any breakdowns in communication (human or otherwise) that created the discrepancy. Discrepancies are resolved via direct communication with the involved parties, followed by a formal email.
- **Advanced Problem Resolution:** More complex programs and processes have generated a steady increase in complicated problems, peaking in 2009 as beneficiaries adjusted to changes in processes prompted by DCF modernization efforts. In 2010, MAXIMUS staff worked with DVHA and DCF staff to create an advanced problem resolution process to effectively and expediently address these issues. MSRs forward issues that require resources outside of our office to our highly trained supervisory staff. Supervisors confer with DVHA, DCF, and other stakeholders via email to coordinate a resolution. Supervisors then report the outcome to the beneficiary. *Exhibit 6.5-2: Advanced Problem Resolution* shows the number of monthly emails between supervisors and other DVHA contractors, as well as units within DVHA and DCF, during the first six months of 2011.



**Exhibit 6.5-2: Advanced Problem Resolution.** *Our supervisory staff regularly works with other stakeholders to achieve expedient resolutions to beneficiary problems.*

- Access to Care Issues:** MAXIMUS routinely receives calls from beneficiaries who are distressed by their inability to access care. We address these issues by first verifying the beneficiary's eligibility status in all relevant systems to rule out a systems discrepancy. If appropriate, we mail the beneficiary an application or take other steps to resolve the issue. We also review TPL status in all systems to verify that the information is accurate. There are times when access to care issues may be provider driven. An example of this situation is dental care. Vermont is underserved when it comes to the number and availability of dentists throughout the State, especially in the rural or most populated areas. Many dentists in Vermont restrict the number of Medicaid patients they will see at any given time or have reached their capacity and may only serve the most emergent of cases. To address this problem, MAXIMUS surveys dentists on a regular basis and maintains a list of dentists indicating who is open to new patients and if there are other restrictions such as age, type of service, or residency. MAXIMUS has also developed and maintained similar lists for eyeglasses and durable medical equipment.
- Application Assistance:** Vermont's health care programs can be confusing and complex to beneficiaries. Some callers may have difficulty understanding them and completing applications due to literacy and comprehension problems. Other beneficiaries have disabilities such as visual or hearing impairments that affect their ability to complete applications. MAXIMUS assists beneficiaries in the following manner:

  - Reading the application over the phone

- Completing the application and mailing it to the caller for a signature
  - Referring the caller to an Application Assistor within the community or through BiState Primary Care Association
  - Adjusting the delivery of information to better suit the caller's needs
- **Primary Care Plus (PC Plus) Specific Functions:** While MAXIMUS addresses issues that span across all Green Mountain Care programs, there are some functions performed specifically in relation to *PC Plus*. This section briefly outlines these functions. We present more information in *Section 6.3: Enrollment*.
- **Enrollment:** MAXIMUS outreaches eligible program beneficiaries for enrollment into *PC Plus* via mail and telephone, and then enrolls them with their choice of Primary Care Provider (PCP).
  - **Identify Available Providers:** MAXIMUS uses the search function in the MAXSTAR provider database to obtain lists of providers that meet an enrollee's specifications. We can search by name and with any combination of gender, geographic location, or status (accepting new patients).
  - **PCP Change:** DVHA allows *PC Plus* enrollees to change PCPs as often as once per month without providing a reason. In addition to requests via the HelpLine, provider offices mail or fax requests for changes on a daily basis. To improve this process, MAXIMUS developed a PCP Change Request Form that requires the signature of the enrollee, the PCP choice, and enrollee identifying information. The form also notes that PCP changes are effective on the first of each month. Once received, MAXIMUS enters the transfer in ACCESS and notes the transaction in MANA notes. If we are unable to make the change, we fax the original request and a letter of explanation back to the provider office or call them to resolve the issue.
  - **PCP Transfer Activities:** MAXIMUS worked with DVHA, DCF, and the MMIS vendor to develop a process to transfer members from one PCP to another if their current PCP should become unavailable. An individual requiring a transfer usually originates with the provider due to a member's behavior or failure to comply with protocols. MAXIMUS outreaches the member and attempts to obtain a new PCP choice. These can be challenging as it is difficult to identify other providers willing to accept the member as a patient. If outreach attempts do not yield a PCP choice, MAXIMUS staff manually assigns the member to a PCP available to new patients in the enrollee's area. When the provider's entire patient roster requires a new PCP, the MMIS vendor attempts to find a PCP willing to absorb those patients into their own practice whenever possible, and a systems generated 'blanket transfer' is completed by DVHA. However, in some cases, these groups may require individual outreach by MAXIMUS staff. If the member fails to respond in a timely manner, MAXIMUS manually assigns the member to an available PCP.
  - **PC Plus Welcome:** Beneficiaries enrolling in *PC Plus* via mail or the auto-assignment process do not offer an opportunity for managed care education. MAXIMUS mails *PC Plus* Member Handbooks to all newly enrolled members, but also outreaches to members who have not been educated regarding managed care. Using a file provided by DVHA, designated MSRs contact the member by mail and telephone to welcome them to the program.

- restrictions to the level of services are updated in the MAXIMUS reference and also entered by MAXIMUS staff directly into the Provider Directory hosted by the MMIS vendor on the web. Finally, MAXIMUS mails a notice advising the beneficiary of the dentist in their area that the child has been enrolled with and encouraging them to begin or continue preventative care. To date, over 46,000 children have voluntarily enrolled with a dentist, and 11,000 have been manually assigned to a dentist.
- **Application Tracking:** Also in 2008, MAXIMUS worked with DVHA to design an application tracking database intended to yield data regarding the response rate and outcome of individuals requesting applications to determine the reasons an individual fails to follow through by submitting an application. MAXIMUS modified call logging tools and processes to capture new applicants identifying information, and we electronically transferred that data to the application tracking database hosted by DVHA. Using this database and a manual look-up process, MAXIMUS staff tracked the progress of an application using ACCESS and outreached applicants at various stages of the process to offer assistance. Individuals who failed to return an application were queried as to the reason. Response to these queries was extremely low and unrevealing. However, beneficiary feedback indicated that outreach to explain the next step of the application and eligibility process was very helpful. Application tracking functions ceased in 2010. During its tenure, MAXIMUS tracked and researched the status of 8,731 applicants; mailed 5,009 inquiry or reminder letters; made 2,029 outreach calls; and sent 1,261 emails.
- **CHAP Support and Enrollment:** MAXIMUS began working with DVHA, DCF, and other parties to design the CHAP program in 2006, and implemented the program in October 2007. Initially, DVHA chose to limit our role in the enrollment process, opting to perform all outreach and mail functions and to require beneficiaries to contact participating plans, MVP and BCBS, to enroll in their systems. Our primary function was to explain the multi-layered application and enrollment process to the beneficiary and advise them of the next action required. However, serious system issues, failures in the process, underestimation of workloads by the Catamount plans, and overestimation of beneficiary follow-through rates resulted in extensive problems during the enrollment process. Ultimately, it became necessary for MAXIMUS and DCF to create a triage process and coordinate manual interventions by several different parties to promote the success of the enrollment process. As a result, the initial stakeholders, MAXIMUS, DVHA, and DCF, returned to the drawing table and redesigned the process so that MAXIMUS staff enrolls beneficiaries in the Catamount plans of their choice. This paperless enrollment process was implemented in 2009 and resolved the vast majority of enrollment problems. Currently, we receive on average of 800 CHAP enrollment calls per month.
- **Support of Employer-Sponsored Insurance Assistance (ESIA) Programs:** DVHA also launched the ESIA and VHAP ESIA programs in 2007. This implementation significantly impacted the eligibility process, requiring the identification and verification of availability of employer-sponsored insurance for most applicants. This process also requires considerable cooperation from employers in the verification process. While the Coordination of Benefits (COB) unit at DVHA does the majority of the legwork in processing the required information, MAXIMUS plays an important role in explaining the complicated process to callers, routing calls to the COB unit when appropriate, and facilitating problem resolutions as required.

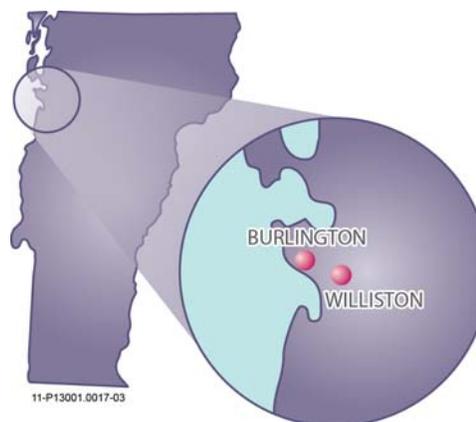
As the sections above describe, MAXIMUS has worked with DVHA and other stakeholders for more than 15 years to efficiently respond to new challenges while maintaining high levels of performance and customer satisfaction. MAXIMUS is the only vendor that has witnessed and assisted in DVHA's evolution, giving us a realistic understanding of what it will take to fully realize DVHA's vision for the future. We are excited at the prospect of continuing to be part of this vision.

### 6.5.1.3 Facility Requirements

RFP Section 5.9, page 22

#### 6.5.1.3.1 Location

MAXIMUS has a local facility in place, fully equipped and convenient to DVHA and Vermont beneficiaries. For more than 15 years, we have maintained an office of operations at 101 Cherry Street, Suite 320, Burlington, Vermont. Our Burlington location is a mere 7.8 miles from DVHA's office in Williston, accessible by Rte. 2 and I-89. One advantage of our current location is that it is directly accessed by the CCTA bus routes, affording beneficiaries the option of seeking face-to-face assistance with applications, managed care enrollment, or general questions about eligibility or covered services by walking in. This is an option that many beneficiaries have used over the years, as evidenced by the 100 to 125 walk-ins we serve annually. Our current facility is in place, and operational, on day one of the new contract term.



#### 6.5.1.3.2 Facility Lease Fees

We understand the budget constraints that DVHA is facing and continuously seek ways to reduce costs whenever possible. Our corporate real estate team in Reston, Virginia regularly works with possible. As required in the RFP, a breakdown of our facility lease fees per square foot of rented space, as well as the square foot charges for any common space shared by other tenants, is included in *Section 8: Cost Proposal*. Other non-utility fees associated with our leased space are also included in *Section 8: Cost Proposal*.

#### 6.5.1.3.3 Equipment and Furniture

Having an established member services office of operations reduces the risks associated with a tight implementation schedule and is the lowest risk solution for DVHA. MAXIMUS currently has all the equipment and furniture necessary to perform the activities outlined in the RFP and is fully functional now, as it will be on the contract begin date of December 1, 2011. MAXIMUS also fully understands we are responsible for the technological systems to support enrollment and member services and stand ready to act in that capacity now and in the future.



As described in *Section 6.5.1.4: Telephone Access and Hours of Operation*, we currently provide, and will continue to provide, the necessary telephone systems and telephone equipment

to support the operation. MAXIMUS also provides the computer workstations, printers, servers, hubs, data cabling and technical support for the continued operation of the member services operations.

**"You are the best kept secret in Burlington. I love that I can come in and speak with a knowledgeable person who will happily answer my questions."**

*- Beneficiary*

#### **6.5.1.3.4 Access to DCF District Offices**

We currently perform most enrollment, education and general member services functions via our HelpLine and by mail, and occasionally in-person at our Burlington office. We understand that should the need arise, we have the option of utilizing space at the DCF District Offices, including conference rooms, for purposes of enrollment, education and occasional outreach activities. We understand that while space is limited in the DCF District Offices, each facility is prepared to accommodate Green Mountain Care Member Services staff as needed.

#### **6.5.1.4 Telephone Access and Hours of Operation**

RFP Section 5.3 page 15

MAXIMUS understands that our HelpLine is the primary gateway to Green Mountain Care program information and services for beneficiaries and applicants. We recognize the essential service we provide to Vermont citizens and pride ourselves on enabling individuals to make the best health care choices available to them. We are dedicated to providing education and assistance to beneficiaries in a manner consistent with the high quality of service we have delivered as your member services provider for the past 15 years.



We provide live telephone coverage from 7:45 a.m. to 4:30 p.m., Monday through Friday, excluding the recognized holidays as specified in the RFP. Our staff members educate program enrollees and the public about their health care program options, explain program eligibility and benefits, assist individuals in completing their applications, process enrollments forms, and serve as a clearinghouse for written materials such as applications and brochures. All of our personnel receive comprehensive training on Vermont health care programs, so that they are well educated and informed on all aspects of program eligibility, covered services, third party liability, fair hearings, prior approval for services, managed care education and enrollment, and how to deliver exceptional customer service.

break and lunch schedules, and use of paid time off. We have an excellent record of accomplishment in meeting performance expectations in Vermont and plan to continue to provide the live telephone coverage needed in order to meet beneficiary needs.

We provide a detailed description of our approach to staffing, including how we provide appropriate telephone coverage, in *Section 6.6: Staffing*. We further describe our approach to meeting call center performance standards in *Section 6.8: Timeframes/Performance Standards*.

We have two toll free numbers directed to our HelpLine—one for regular calls and one dedicated to receiving TTY calls. To support the average call volume of 1,500 calls per day, we currently have two PRI voice circuits in place and are adding a third to allow for additional capacity to support the IVR customer satisfaction survey and potential volume increases in the future. This offers additional flexibility in managing periodic call surges associated with program changes or outreach activities. We acknowledge our responsibility to incur all costs associated with maintaining both toll free numbers and phone lines and to return the toll free numbers to DVHA at the end of the contract term if needed.

Our HelpLine has evolved during the past 15 years as a result of program changes and health care reform, and with this evolution, we have continuously adapted and improved the call center technology that supports our day-to-day operations. *Exhibit 6.5-3: Call Center Technology* summarizes the call center systems that enable us to deliver efficient, yet customer-focused service to Green Mountain Care beneficiaries and a well-managed, performance driven solution to DVHA. We provide additional details on the various elements throughout this section.

### Letter of Appreciation

"I just wanted to express how grateful I am for Jasmine's assistance. Because of a snafu at the processing center, my Medicaid was terminated. I had been calling and calling trying to straighten this out. The staff at Green Mountain Care was quite helpful. However, the staff I talked with at the processing center on Friday, February 4, 2011, was quite rude, not to mention the royal run-around they gave me. At my wits end, I called Green Mountain Care again and talked with Jasmine. She read my file and determined that I could not have caused the snafu. She took this matter to you, her supervisor, and my Medicaid was reinstated retroactively. You have no idea how profoundly grateful I am to the both of you. I have appointments with my oncologist and CT scans which I thought I would have to cancel. Out-of-pocket expenses for these services would have been prohibitive for me. You have an exemplary employee in Jasmine to whom I am indebted."

– Ruth, Medicaid Beneficiary

several potential circumstances that may occur, pre-programmed into the IVR. If we have a fire alarm on office closing due to weather conditions, or on emergency, we can quickly activate the appropriate message.

We have a system in place to make sure that individuals who are hearing or speech impaired have the same access to our services as any other caller. When an individual calls the TTY toll free line, he or she is given the opportunity to leave a message on our TTY answering system. The TTY software displays the number of TTY messages that have been left on the desktop of one of our MSR Supervisors, who is responsible for monitoring and responding to these messages each day. We use Vermont Relay Service to facilitate return calls to anyone who has left us a TTY message.

We use Language Line interpretation services to assist callers whose primary language is not spoken by our staff. This service is available during all HelpLine operating hours and callers are provided this service free of charge. The process for using Language Line services is simple; the MSR stays on the line with the caller so the caller never has to hang up and call another number for translation assistance.

During our current contract, we upgraded our phone system to a Mitel 5000 communications platform. Our phone system includes Automated Call Distribution (ACD), which queues incoming telephone calls to our three previously described MSR teams. The ACD maximizes utilization of resources by presenting calls to an available MSR with the most appropriate set of skills to respond to a caller's needs. We play informative messages to callers awaiting connection to an MSR, which we customize based on current happenings. For example, during the State's recent mass premium refund initiative, we played a message related to this as an additional source of information to beneficiaries.

Our ACD system also provides tools with which we conduct routine monitoring and analysis of call center metrics. Supervisors continuously monitor real-time conditions using a graphical interface on their desktops, as shown in *Exhibit 6.5-4: Real-Time Call Monitoring*, so that we can quickly re-allocate resources in the event of an unexpected call surge.



## 6.5.2 Approach to Resolving Consumer-Related Problems

### **Question 17: Describe the bidder's approach to resolving consumer related problems.**

RFP Section 10.9.17, page 35

#### 6.5.2.1 Resolving Consumer Problems

MAXIMUS understands the importance of responding to customer concerns and complaints. Our staff has extensive experience responding to and resolving beneficiary complaints and has been doing so effectively in Vermont since January 1996. We have the protocols in place, and can continue to effectively perform these functions for Green Mountain Care Member Services into the future. In the section below, we describe our proposed process for resolving member-related problems.

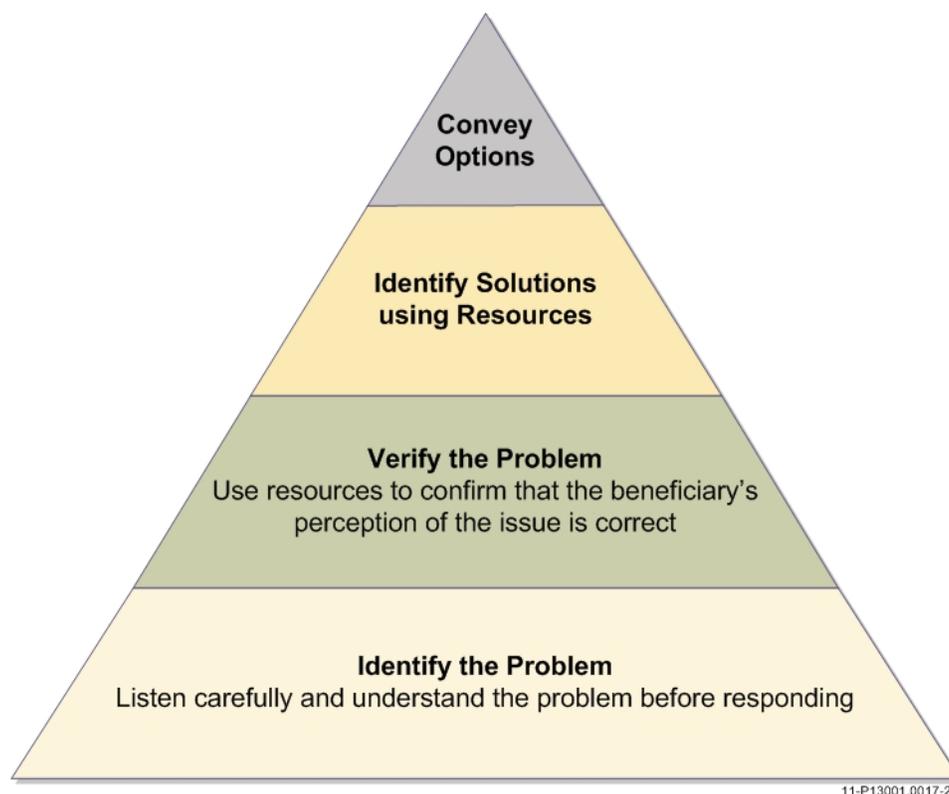
When responding to a complaint, the first step is to identify the nature of the complaint and determine if it can be resolved informally. As problems are being resolved, our staff makes certain that beneficiaries and project management remain informed of progress and final decisions. If the complaint is not resolved informally, we inform the beneficiary as to the appropriate grievance, appeal, and complaint process. These options were subject to a major revision in 2007 and continue to be modified to present day.

#### 6.5.2.2 Problem Escalation

MAXIMUS strives to resolve beneficiary issues at the first contact as a means of achieving both efficiency and high customer satisfaction. MAXIMUS trains all staff in basic problem solving skills and provides them with the tools necessary to address most beneficiary issues. In cases where further research is required, we escalate the problem to a supervisor or another staff member who has been identified as a subject matter expert in the areas pertaining to the specific beneficiary issue. Project management monitors the status of the problem and verifies that staff provides resolution and/or follow up with the beneficiary within one business day. The number of problems requiring triage, a high level of research, and manual intervention by multiple parties has increased exponentially in the past five years due to the expansion of programs, the increased complexity of these programs, extensive systems alterations, ESD modernization efforts, and a rise in program participants. MAXIMUS began tracking the 'behind the scenes' resources required to achieve resolution, and we are pleased to describe how we approach problems and assist beneficiaries in resolving these problems.

#### 6.5.2.3 Basic Problem-Solving Skills

MAXIMUS trains staff to utilize all available resources in addressing beneficiary issues. The most critical of these resources is the staff member's ability to understand and assess the issue accurately. To that end, MAXIMUS trains our staff to use active listening skills, restate the problem so that the beneficiary may confirm that we have properly understood the issue, and use resources effectively to identify the appropriate course of action. *Exhibit 6.5-9: Problem Resolution Pyramid* illustrates these principles.



**Exhibit 6.5-9: Problem Resolution Pyramid.** MAXIMUS trains our staff to use active listening and research skills when responding to beneficiary problems.

#### 6.5.2.4 Types of Complaints

Frequently, beneficiaries base complaints on misinformation, and we can easily resolve these issues by providing the beneficiary with correct or additional information. Beneficiaries may direct their complaints toward MAXIMUS, DVHA, HAEU, DCF, a provider, other contractors, or any entity working in conjunction with DVHA. Frequent complaints include issues involving difficulty in contacting various agencies, dissatisfaction with a provider, and dissatisfaction with changes in DVHA programs or processes. DVHA implemented significant changes in 2006, 2007, 2008, and 2009. Some of these, such as adjustments to premium amounts, benefit packages, and eligibility requirements, generated a noteworthy amount of complaints. Even changes that were ultimately positive for beneficiaries, such as program expansions, generated complaints regarding typical start up problems. MAXIMUS staff currently records all complaints using the HelpLine screens in MAXSTAR. We report the resulting statistics and the details of each complaint in the weekly and monthly reports to DVHA. Some of the more frequent complaints received by the HelpLine include:

- **Provider Complaints:** Beneficiaries routinely contact the HelpLine to complain about the conduct of providers. Staff address the problem by assisting the beneficiary in identifying another provider, offering to mail a provider complaint form, and offering to document the complaint in the weekly report to DVHA.
- **Personnel Complaints:** Some beneficiaries are dissatisfied with the level of service provided by staff employed by the State of Vermont or a contractor. Our staff use the following guidelines when recording personnel complaints:

- Attempt to address the problem that initiated the conflict rather than the perceived issue that caused the problem
- Urge the beneficiary to address the matter directly with the parties involved
- Remain neutral
- Offer to document the complaint in the weekly report to DVHA
- Offer to refer the complaint to DCF management

MAXIMUS does not attempt to validate a complaint against personnel unless it is a MAXIMUS staff member. In these cases, project management reviews all available information such as call recordings and call logs, follows up as appropriate with the staff member involved, and reports the findings to DVHA.

- **Policy Complaints:** Economic, political, and legislative forces drive frequent change to Vermont health care programs. Beneficiaries often contact the HelpLine to express their frustration with changes in policy and benefits. Our staff members proceed as follows:
  - Do not debate the change
  - Acknowledge the beneficiary's frustration
  - Verify what has changed and what remains the same
  - Refer the beneficiary to his or her local legislator or the Governor's Action Hotline to lodge a complaint
  - Offer to file a complaint in the weekly report to DVHA

#### 6.5.2.5 Incident Reports in MAXSTAR

MAXIMUS is careful to document all complaints, including the facts as presented by the beneficiary, additional information researched by project management, and the outcome of the incident. MAXIMUS saves information about all complaints fielded in the notes field of the MAXSTAR call log.

Our staff logs each complaint as an "incident report" and prints each one for review by project management. Maintaining this information electronically allows us to link the details of the complaint with the HelpLine call record containing the date and time of the call and the staff person involved. MAXIMUS staff uses the search function in MAXSTAR to access a beneficiary's entire call history. This approach often presents a clear history of the beneficiary's actions, as well as the responses of MAXIMUS staff.

#### 6.5.2.6 Informal Resolutions

MAXIMUS staff makes every attempt to resolve problems or complaints informally. Informal ways in which our project staff addresses various issues include:

- **Post Call Problem Triage:** MAXIMUS staff has always pursued all available and appropriate avenues to resolve a caller's problem. Particularly complex problems are referred to a supervisor and often include significant research in different systems and several emails and telephone calls to other agencies or contractors on the beneficiary's behalf. MAXIMUS began tracking this 'behind the scenes' use of resources in 2010 as a result of an increase in the frequency of these problems. Supervisors work on an average of more than 600 of these cases per month.

- **Weekly Report to DVHA:**

MAXIMUS communicates complaints to DVHA via a weekly report using the information provided in the incident reports. Our staff is careful to explain to beneficiaries that this report is a vehicle to make their issues known, but does not result in any direct action or follow up from DVHA. Beneficiaries wishing for a formal response from DVHA or other parties are encouraged to put their issue in writing or file a formal complaint.

- **Provider Complaint Forms:**

Documentation of provider complaints in the weekly report to DVHA are often accompanied by the beneficiary filing a provider complaint form with the Office of Professional Regulation in Montpelier, Vermont. While the MMIS vendor can address instances where providers fail to fulfill the terms of their agreement as Medicaid providers, many complaints regarding providers involve allegations of mistreatment and misconduct. Personnel document the complaint and mail the beneficiary a provider complaint form. The beneficiary is advised to return the form to the address provided on the form. MAXIMUS is not involved beyond that point.

- **Governor's Action Hotline:** Some complaints are related to issues that are beyond the ability of member services to resolve. These issues are often general statements about State policy or other global requirements. In these cases, our staff advises beneficiaries to contact their State Legislator and the Governor's Action Hotline to express their dissatisfaction regarding program parameters and policies, as Vermont's political body ultimately controls program policies and expenditures. In some cases, we refer beneficiaries to their local town office or the website <http://www.leg.state.vt.us/legdir/findmember3.cfm> to identify their local representatives.

- **Referrals to the Office of the Health Care Ombudsman:** The State of Vermont contracts with the Office of the Health Care Ombudsman to provide professional mediation services to residents in regards to their health care services. MAXIMUS typically refers callers to the Ombudsman when we have exhausted all other possibilities for resolution. The Ombudsman frequently contacts MAXIMUS for information regarding specific cases. MAXIMUS staff researches the case history using ACCESS, MAXSTAR, the pharmacy benefit management system, and the MMIS. For the past five years, HelpLine staff has assisted Ombudsman staff in researching an average of 43 cases per month.

### Joe's Story

Joe called the HelpLine completely distraught when he was unable to pick up a prescription for his daughter, a Dr. Dynasaur beneficiary. The prescription helps his daughter to maintain normal blood counts during her cancer treatment. He had been calling around for several days and felt it was now a life or death situation. MAXIMUS supervisors worked with AOPS, the MMIS vendor, and the pharmacy benefit manager staff to resolve the problem. Joe obtained the prescription prior to the end of the business day.

#### 6.5.2.7 Formal Complaints

Beneficiaries wishing to file a formal complaint provide details to our staff, who then record the information in a Grievance, Appeals, and Complaint (GAC) form developed by MAXIMUS and DVHA in 2007. The form is forwarded to a supervisor who confirms no further information is needed and then forwards it to the designated complaint officer within DVHA.

### 6.5.2.8 Grievances

Grievances are defined by DVHA as an expression of dissatisfaction about an action, such as aspects of interpersonal relationships: rudeness, failure to respect a beneficiary's rights, or the quality of care or services provided by DVHA, DCF, or a party acting on their behalf. A grievance is not the appropriate avenue to address a complaint about a denied authorization request, an eligibility decision, or a non-covered service. As above, MAXIMUS completes a GAC intake form and forwards the information to DVHA.

### 6.5.2.9 Appeals

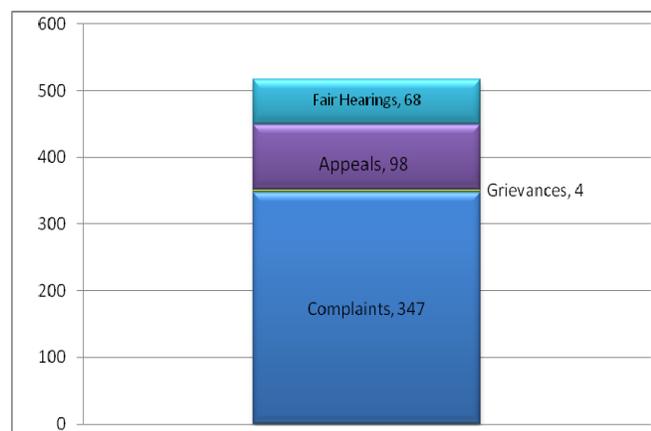
An appeal is a formal review of a decision regarding a denial, limitation, or reduction of a covered service by a health care professional that did not make the original decision. Requests for appeals are documented and submitted in the same way grievances and complaints are, using the GAC intake form.

### 6.5.2.10 Fair Hearings

Fair hearings are a legal process to contest any decision. Fair hearings may be filed simultaneous with other types of requests. MAXIMUS fully recognizes that applicants or beneficiaries have a right to request a fair hearing on any decision rendered by DVHA, DCF, or a party acting on their behalf. MAXIMUS also recognizes that a fair hearing is not always the most effective avenue to appeal a decision. Staff carefully presents all viable options to the individual in an unbiased manner so that he or she can make an informed decision.

MAXIMUS addresses complaints regarding program eligibility requirements or the scope of covered services by explaining that the State designs specifications for each program to support high quality health care while maintaining economic feasibility. MAXIMUS attempts to explain decisions, but ultimately refers beneficiaries to their workers to appeal eligibility and premium decisions. However, we do submit fair hearing requests on the behalf of beneficiaries wishing to appeal prior authorization decisions and managed care decisions, as well as any other requests that fall outside of the realm of eligibility or premium fair hearings.

When assisting beneficiaries requesting a fair hearing, our staff collects the data relevant to the request and forwards the information to a staff member designated as the Fair Hearing Coordinator. The Fair Hearing Coordinator compiles the information into a memo to the Assistant Attorney General's office, the DVHA representative, and the Human Services Board. Based upon experience, our staff developed an email process to transfer this information. Using secure email is expedient and allows for better tracking and accountability. *Exhibit 6.5-10: Problem Resolution Options* shows activity in this area of operations for 2010.



**Exhibit 6.5-10: Problem Resolution Options.** MAXIMUS follows rigid protocols to comply with the grievance, appeals and complaint policies.

### 6.5.2.11 Exception (formerly M108) Requests

Medicaid/Dr. Dynasaur beneficiaries request coverage for a service or item not on the Medicaid covered services list by submitting an exception form developed by DVHA. The beneficiary's provider fills out the form, providing reasons and documentation supporting the need for the requested service or item. Clinical staff at DVHA reviews these requests. MAXIMUS explains exception request process as an option in appropriate circumstances and mails the forms to the beneficiary upon request.

### 6.5.3 Plan to Coordinate Member Service Activities

**Question 18:** *Describe the bidder's plan to coordinate member services activities with DVHA, HP and Office of Health Care Ombudsman.*

RFP Section 10.9.18, page 35

#### 6.5.3.1 Coordination of Member Services Activities

MAXIMUS has a long history of working as partners with DVHA, HP, the Office of the Health Care Ombudsman, and other stakeholders towards the common goal of serving the Green Mountain Care population. We rely on several key personnel within these groups to communicate policy and program changes, as well as to confirm and clarify issues as they arise. MAXIMUS has been at DVHA's side for more than 15 years, sharing in the glory of program expansions and key health care reform, but also working with DVHA and other stakeholders to address and resolve the myriad of problems that come with progressive changes to processes and programs.

#### 6.5.3.2 Working with DVHA and DCF

MAXIMUS has been part of a true collaboration in Vermont, regularly attending or participating in work groups sponsored by DVHA and DCF. We believe these gatherings have fostered more streamlined, efficient, and customer-driven solutions to problems for both beneficiaries and the stakeholders in these programs. This type of collaboration is not typical between state agencies and contractors, and MAXIMUS has appreciated being part of an environment that embraces ideas and input from so many different parties with a stake in the outcome. Our involvement in the front end of these efforts has enabled MAXIMUS to serve DVHA and beneficiaries better. When MAXIMUS sits at the table, beneficiaries have a voice. To date, as depicted in *Exhibit 6.5-11: MAXIMUS Collaboration with DVHA and DCF*, MAXIMUS has joined DVHA in the following work groups.

**"We have worked with you every day for years now. MAXIMUS does an incredible job. I notice a number of things daily, including accuracy, quantity, quality, professional demeanor, learning ability, and the list could go on and on. I can count on my emails and contacts from MAXIMUS for on time results."**

*- Eric, DCF/ESD/IT  
Staff Member*

Date	State Objective	MAXIMUS Collaboration
1998	Establish centralized member services and enrollment member services unit	Obtained documentation of program resources and conferred extensively with State staff to create protocols, training materials, and references
	Create the Primary Care Plus PCCM program	Met regularly with DVHA staff to develop systems, processes, policy, and materials to support the <b>PC Plus</b> managed care program
2002	Expand Vermont pharmacy programs, implement a Preferred Drug List, and redesign pharmacy program cost sharing policies	Worked with State staff and contractors to develop training and references
	Establish the pharmacy benefit manager	Established visual access to the pharmacy benefit management system, and developed training and reference materials
2003	Install new notices database and redesign existing notices	Met regularly with State staff to revise notice language and establish visual access to the notices within the system
	Implement and enforce HIPAA policies	Worked with DVHA to confirm compliance with DVHA and HIPAA policy
2004	Premium collection process redesign	Met frequently with State staff to design policy, processes, and systems to support changing premium collection from a retrospective to prospective model
	Transition to a new pharmacy benefit manager	Met with the State and the new contractor to establish visual access to the new system and develop training and reference materials
2006	Integrate Medicare Part D pharmacy benefits with existing Vermont pharmacy programs, and ensure that beneficiaries are held harmless during the transition period	Met with State staff to develop protocols, conducted additional outreach to impacted populations, extended operation hours to address increased call volumes, and provided support staff to DVHA VPharm Central call center
	Develop protocols to ensure compliance with the federal proof of citizenship and identity (C&I) requirement	Met extensively with State staff to develop protocols and determine workload expectations
2007	Implement Catamount Health with Premium Assistance (CHAP) and Employer-Sponsored Insurance Assistance (ESIA)	Met extensively with State staff to design policy, processes, notices, and systems to support the new programs, and worked with State staff to develop workarounds to address problems during implementation
2008	Create handbooks for all Green Mountain Care programs and develop new grievance, appeals, and complaint (GAC) policies to comply with MCO regulations	Participated in the design of the handbooks and assumed responsibility for more complex GAC processes
	Implement the Dental Home Initiative	Participated in the system and process design, modified materials, and performed function
	Implement Application Tracking	Participated in the system and process design, modified materials, and performed function
2009	Implement Catamount paperless enrollment	Offered to assume responsibility for Catamount enrollments and worked with State staff to redesign the system, notices, and protocols
	Support the Economic Services Department (ESD) Call Center as part of the AHS modernization effort	Began entering changes for district-based cases and established an enhanced problem resolution process

**Exhibit 6.5-11: MAXIMUS Collaborations with DVHA and DCF.** *MAXIMUS has a long history of supporting State initiatives and stands ready to do so during future endeavors.*

Date	State Objective	MAXIMUS Collaboration
2010	Support the ESD Application Document Processing Center as part of the modernization effort	Modified training, processes, and materials to use the new document database
	Expanded problem resolution efforts	Established a triage process with several stakeholders to resolve beneficiary issues
2011	Implementation of Dr. Dynasaur program premium grace period	Assisted in the creation of notices and responded to beneficiary inquiries

**Exhibit 6.5-11: MAXIMUS Collaborations with DVHA and DCF (continued).** *MAXIMUS has a long history of supporting State initiatives and stands ready to do so during future endeavors.*

### 6.5.3.3 Working with HP Enterprise Services (MMIS Vendor)

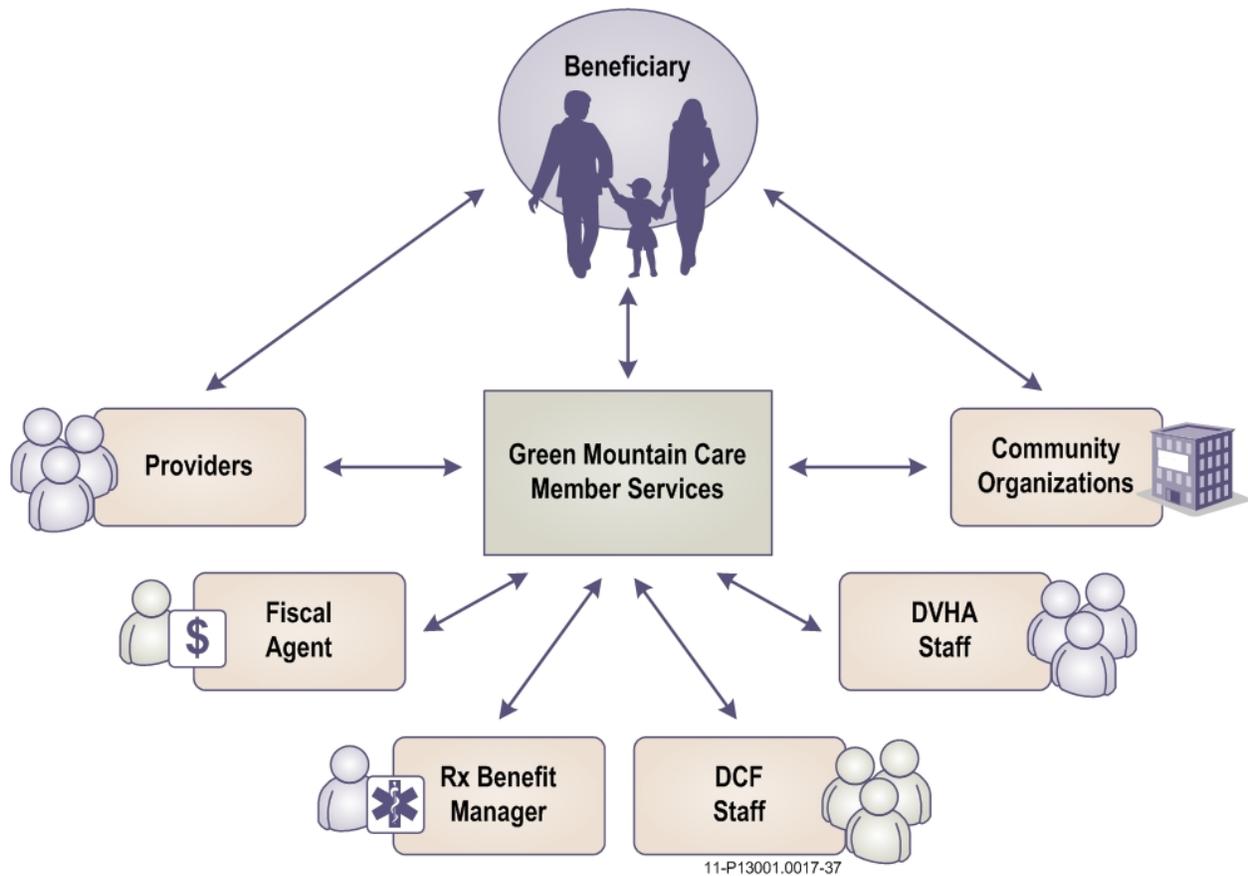
As contractors for DVHA, MAXIMUS and HP Enterprise Services regularly collaborate to facilitate the success of Green Mountain Care programs. MAXIMUS staff has visual access to the HP Enterprise system to access data regarding claims, beneficiary status, prior authorizations, provider status, provider lock-ins, premium information, specialist geographical data, provider participation in *PC Plus*, and dental benefit limits. Additionally, MAXIMUS updates dental provider status directly into the HP Enterprise system. MAXIMUS staff communicates with HP Enterprise Services staff on a daily basis to resolve beneficiary problems, assist in PCP transfers, and convey information regarding provider status culled from an average of 700 calls to the HelpLine from providers each month. As needed, MAXIMUS, DVHA, and HP Enterprise staff meets to resolve issues and develop effective protocols that serve the needs of all parties involved, but most especially, those of our mutual clients.

### 6.5.3.4 Working with the Office of Health Care Ombudsman

MAXIMUS fully understands our role as Green Mountain Care Member Services. As described in previous sections, our staff is highly trained and well supplied with up-to-date and easy-to-use references. Our goal is to provide the highest level of assistance and customer service to our callers, while still appropriately representing DVHA and Green Mountain Care programs. However, there are some instances where the Office of Health Care Ombudsman is better able to advocate for the beneficiary. We refer cases to the Office of Health Care Ombudsman in circumstances when we have exhausted all resources.

In addition, the Office of Health Care Ombudsman contacts Green Mountain Care Member Services on behalf of beneficiaries on an average of 40 times per month. During these calls, we research the issue and provide information available within ACCESS, MMIS, the pharmacy benefit management system, and the OnBase system.

For longer than 15 years, MAXIMUS has fostered professional relationships with those parties that share an interest in serving beneficiaries of Vermont health care programs. *Exhibit 6.5-12: MAXIMUS Coordination with Stakeholders* demonstrates the interactions between beneficiaries, MAXIMUS, and other stakeholders.



**Exhibit 6.5-12: MAXIMUS Coordination with Stakeholders.** *MAXIMUS has a long history of supporting State initiatives and stands ready to do so during future endeavors.*

## 6.6 STAFFING

In the course of our more than 15 years of service to Vermont and more than 35 years providing services to government agencies and programs, we have learned many valuable lessons about how to staff and organize projects in ways that maximize effectiveness and efficiency, provide adequate and appropriate coverage, and control costs. With these lessons in mind, we offer a team that combines extensive health care customer service, application and enrollment assistance, and call center operations experience; demonstrated focus on interagency and stakeholder coordination; data system and telephony expertise; and direct and unique experience serving Vermont health service program participants.

Our staff members have local knowledge and experience working with program-eligible populations in the State of Vermont. Respecting the health-related beliefs, communication styles, cultural values, behaviors, and attitudes of the Vermont beneficiary population, we specifically recruit staff members who have roots in the local community and reflect the citizenry of Vermont. With MAXIMUS, the Department of Vermont Health Access (DVHA) will continue to benefit from a close working relationship with the staff that you know and trust.

As described in *Section 4.4: Proposed Staff*, MAXIMUS offers Vermont an experienced, knowledgeable, and well-trained project staff and management team for the operation of Green Mountain Care Member Services. In the following sections, we discuss our staffing solution which includes our methodology for ensuring proper staffing levels and appropriate telephone coverage, and our approach to orient and train personnel, provide ongoing training, and train staff on understanding and serving the special needs populations in Vermont. We also describe our strategies for making certain that staff provide accurate information and achieve performance standards, including our internal quality control methods and quality assurance (QA) program, as well as our approach for monitoring and evaluating beneficiary satisfaction.



**Subject Matter Expertise.** Our Vermont-based frontline management and advisory staff bring 147 years of hands-on experience in delivering services to Vermont's health care program enrollees and beneficiaries, coordinating with DVHA and program stakeholders to do what is right for beneficiaries.

**Continuity.** More than 60 percent of our Green Mountain Care Member Services team has worked with the project for two years or more, with several serving Vermont for more than 15 years.

**Innovations.** To respond to the many program expansions and growing volume of content our staff needs to master, we enhance our established processes for conducting training and maintaining policy and procedures by incorporating innovative tools such as our MAXFit interview process, web-based Knowledge Base (KB) system, and our integrated dashboard known as MAXDash.

**Capacity.** MAXIMUS has more than 6,500 employees who have dedicated their careers to serving government programs, and we maintain more than 28 health and human services customer service call centers throughout the US and Canada; our corporate resources and financial strength give us the infrastructure to continue to grow with your program.

### 6.6.1 Staffing Level Methodology

**Question 19:** *Describe the bidder's methodology to ascertain the appropriate level of staffing (direct, supervisory, and administrative) in order to meet the requirements of this contract.*

RFP Sections 10.9.19, page 35 and 5.8, page 21

Our approach to staffing for the upcoming contract period reflects our understanding of DVHA's focus on increased access, improved quality, cost-efficiency, and purposeful coordination of health care services as described in the Request for Proposal (RFP). In keeping with these priorities, we have carefully evaluated all aspects of our project organization and have identified and defined what it takes to perform all activities required.

To calculate direct, supervisory, and administrative staffing needs, we will continue to utilize several tools, including Erlang C modeling and workforce management software, to analyze actual call center patterns against a certain level of performance. To determine optimal staffing levels for Vermont, we have built a profile of estimated calls received, per half hour, based on actual historical call center data from the existing Vermont project. We then apply this profile to the expected total incoming call volume and run the resulting data through a call center simulator based on the Erlang C statistical model, loaded with the telephone response standards from the RFP. The Erlang C model assumes that calls arrive at the call center randomly, rather than in a steady stream. We incorporate normal lunch and break schedules to build a required call center staffing model that can meet peak demands without excessive overstaffing.

Our model examines member service data including calls handled, wait times, talk times, and abandon factors to calculate staffing needs. Also, our past performance and understanding of the numbers of calls handled over the years provides us an understanding no other bidder can match. Further, our Automated Call Distribution (ACD) Call Center Suite application allows our management team to watch for staffing needs throughout the day and trend out needs over time. We can calculate average length of calls, look at average calls handled throughout the day, and estimate staffing needs to address average incoming call volumes. This is how we staff for phone coverage, as well as special duties such as third party liability (TPL) processing, billing resolution, fair hearing coordination duties, and more. We essentially calculate how much time it takes to process one of these transactions and calculate a level of effort compared to one FTE. Based on the information provided in the RFP related to workload and contractual performance, as well as our experience serving as your member services contractor for more than 15 years, we have developed a realistic, reliable staffing model for the Vermont project. We remain open to discussing our proposed staffing with DVHA at your request.



## 6.6.2 Appropriate Telephone Coverage

### **Question 20:** *Describe the bidder's approach to ensure appropriate telephone coverage.*

RFP Section 10.9.20, page 35

During our tenure as your member services contractor, we have established the capability to adeptly identify needs and adapt telephone coverage to call patterns, as well as proactively anticipate fluctuating volumes. For example, calls are heaviest on Mondays and during lunch times each day, with a characteristic reduction in volume later in the week. Other predictable patterns include call volume spikes the day after a holiday or a long weekend, as well as at the end of the month after the standard mailing and distribution of premium bills and closure notices.



We also rely upon the State to inform us of special notices, mass mailings, or programmatic changes that may cause increased volume for a period of time or on an ongoing basis. Further, we maintain a continuous learning mode, assisted by technology solutions that support our strategic decision making—including staffing coverage decisions—and validated by seasoned managers who operate from a combination of experience, intuition, and quantitative analysis.

We have the experience-based capacity to forecast fluctuations in call volume and implement strategies to respond to identified demands. For example, from November 2010 to January 2011, due to start-up problems related to DCF modernization efforts, we received high call volumes, unhappy callers, and many cases requiring problem resolution. In an effort to manage and better serve callers, MAXIMUS implemented a call triage and message-taking protocol. We hired additional Member Services Representatives (MSRs) to take messages during peak volume times, and project staff worked overtime throughout the holiday season to address the many caller issues. The majority of callers were pleased to have someone to speak with regarding their concerns and happy someone called them back so quickly.

MAXIMUS also draws on the expertise of our 28 customer service call centers across the country. This means several practical benefits for DVHA:

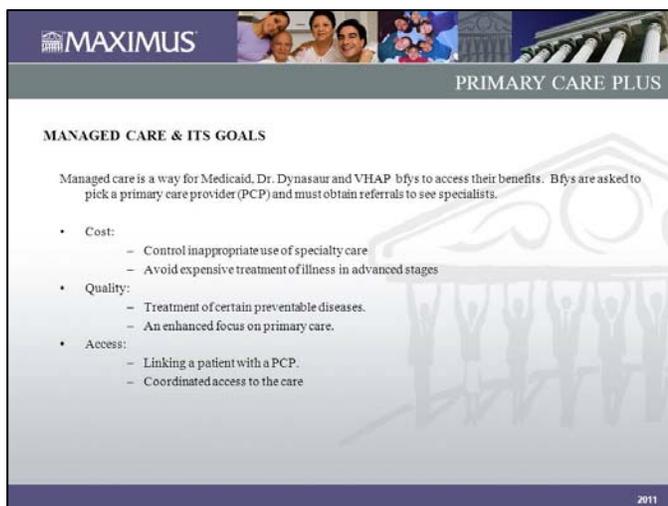
- Disaster recovery and personnel back-up capacity to deal with unanticipated or emergency surges in volume and to help provide business continuity in the event of a major disruption
- Access to the most efficient and cost-effective technology
- Shared innovations that appropriately and sensitively balance highly assisted and personalized service with the availability of automated options

**MAXIMUS has been operating the Vermont HelpLine for more than a decade and has gained a great deal of expertise managing call volumes to make certain we achieve performance standards without compromising our high standards of customer service.**

The premise of the staff tag in *Exhibit 6.6-1* is that MSRs do not have a fixed lunch; instead, they "tag" each other upon returning to prevent an overlap of MSRs logged out and potential shortage spikes of MSRs on the phones every 30 minutes. MSR staff cannot deviate from the established schedule without prior authorization from a supervisor. During times of employee absences, supervisors review and adjust the schedule to provide sufficient coverage throughout the day.

- **Managing Planned Absences:** MAXIMUS routinely manages the number of planned staff absences allowed on any given day. This approval process takes into consideration mailing and billing cycles and other events that may drive fluctuations in call volume. We use our compilation of years of historical data to understand future patterns, seasonal shifts, percentage response rates to mailings, program changes, and other events. All requests are submitted to a supervisor for review and forwarded to the Operations Manager for final approval. If approved, the information is recorded on a master calendar that is posted on the office's electronic staffing calendar for all staff to review prior to submitting a request.
- **Supervisory and Additional Staff Back-Up Coverage:** During times of peak call volume or increased service demand, MAXIMUS mobilizes additional staff to provide proper coverage, handle incoming member calls, or offer education services as required. Our established relationships with staffing agencies enable these organizations to understand the particular skills individuals need to be successful MSRs and quickly identify interim, new, or replacement staff for us as needed.

MAXIMUS has been operating the Vermont HelpLine for more than 15 years, and we have gained a great deal of expertise managing call volumes to make certain we provide Vermonters with the level of service they have come to expect. Throughout our time in Vermont, we have demonstrated our ability to respond to call fluctuations and extreme peaks while meeting contractual performance standards with rare exceptions. Even when call volumes exceed contractual expectations as sometimes occurs during times of program expansion and enhancement, we devise strategies to handle the additional volume and deliver the best possible service for beneficiaries. For example, we implemented message-taking via temporary staff when the call volume far exceeded contractual expectations. During winter 2010, we took hundreds of messages and had staff work overtime to successfully return these calls.



We ask participants to share their results as a group, discussing their answers and identifying what reference materials they used to construct their answers. New hires have quizzes after each training module and assessments after each major section. They must pass these to move ahead to take live calls. More intensive testing of new hires continues for a few months after new-hire training has commenced, making certain that staff members are meeting our performance expectations. Veteran staff members are not exempt from the testing process, as performance and skill evaluation is continuous throughout an individual's "MSR life." We follow up regularly with refresher training courses that include quizzes and group discussion review as needed, and we administer assessments of the entire staff on a periodic basis.

We test each MSR on a variety of topics including programmatic knowledge retention, customer service skills, system application proficiency, and project protocols. Usually these are multiple choice and short answer tests graded immediately. Feedback is given individually, and staff is always

encouraged to ask questions. We distribute weekly evaluations detailing strengths and areas needing improvement to the trainees, as well as assessments at the end of each phase.

After completion of each phase, we administer assessments at one week and again one month after trainees have transitioned to their positions in the call center. The evaluations and assessments are invaluable tools used by project management to judge if a trainee is suited to the position early in the training process. If any test question prompts incorrect answers at an unacceptable rate, this signals us to review any materials that may be in need of revision or identify new training opportunities.

If an individual regularly scores poorly, the trainee is asked to consult with a MAXIMUS trainer to resolve the concern in a supportive and professional manner.

Training participants also complete course evaluations during each phase of training. Training staff may modify a training module based on this feedback, as training is a fluid process that we continually evaluate for effectiveness. The time and resources required for phased training are slightly less than previous models employed by the project, as trainees grasp information more quickly having applied it to real life scenarios while taking calls.

### Mark's Story

Mark, authorized representative of his elderly mother, called Green Mountain Care Member Services to check on his mother's status. The MSR advised him that his mother had closed out, but also noted that she had been responding to all requests for information on time and that, perhaps, her review should have been extended. The supervisor asked the State's Administrative Operations (AOPS) if the case could be "bumped" (extension request for a review) since the beneficiary had responded timely. The issue was resolved the same morning, the gap in coverage was filled, and Mark and his mom were "extremely happy and grateful."

**"During my phase training, I was able to learn new programs and protocols and then immediately take calls on that exact subject. This allowed me to master all subjects and excel in the MSR position!"**

*- MSR Response,  
Training Survey Results*



As Vermont moves through these significant changes in health care delivery, we know how this will impact our current contract operations. We have built in training protocols to make certain our staff are properly trained to assist beneficiaries in understanding new health needs. Our Green Mountain Care Member Services training approach is superior to and likely looks much different than that of our competitors. Most of our staff have been with the project for years and have already received

extensive training on all program and job-specific components. This affords us the opportunity to focus resources on promoting continuous improvement, supporting new initiatives, program changes and expansions, continuing education, refresher training, and more.

Our training approach embodies DVHA objectives. We understand that a quality training program must identify needs, continuously evolve and measure its own effectiveness, integrate collaborative input, and ultimately support your vision. MAXIMUS ensures our training is current, taking complex legislation and regulation, and breaks it down in a way our call center and other staff can understand and use.

Our training program is flexible so it can be updated frequently if policies change and it is comprehensive to cover all aspects of the program. As soon as we are made aware of any program or policy modification, we respond and train to each and every change. Minor changes are updated on all relevant references in the KB system, and the staff is notified via email of the change as well as where the information can be located in the KB. An example of this type of change would be an update in Catamount premium amounts. If the change relates to a reference that MSR's keep printed and at their desk, they receive an email of the change. The information is then updated in the KB, and a new copy of the reference is placed in their mailbox, such as notification that a new eligibility worker has been hired. If the change is more significant, all references are updated and new resources are created and loaded into the KB as needed. The Training Unit Supervisor also meets with all the MSR's, typically during team meetings throughout the week, to maintain phone line coverage and train them on any changes. A recent example of this was the implementation of the Dr. Dynasaur grace period.

**MAXIMUS has been operating the Vermont HelpLine for more than a decade and has gained a great deal of expertise managing call volumes to make certain we achieve performance standards.**

Staff are continually notified of program or policy changes via email, and all references are kept up to date on the KB. In addition, if a staff member requests or a supervisor recommends further MSR training, this is delivered as appropriate. At times, this may involve sending training materials and modules for review. It could consist of an existing MSR sitting in during the training of new staff during a certain topic, or it could include one-on-one training either in the training unit or at the MSR's desk.

The MAXIMUS training approach first looks to support the mission and business needs of the DHVA. Through a collaborative approach, together we address these fundamental needs, as well as the diverse needs of the beneficiaries we serve. MAXIMUS has designed, developed, delivered, and continuously improved our multi-faceted training program focused on meeting your needs and objectives. Our extensive interaction and systematic feedback from and with the State, as well as MAXIMUS global knowledge of training practices, makes certain that all of the components of our training program are continuously improved. Our training team's current hands-on work experience performing these tasks uniquely qualifies us to train our member services education and enrollment workforce.

Our comprehensive, innovative training strategy is performance-based: we demonstrate a strategy that focuses not only on knowledge acquisition, but also on the application of that knowledge in a specific business context which we understand from our years of experience on this project. It is designed, delivered, and continually improved to support our workforce as they perform the services needed by beneficiaries and potential enrollees and required by our contract. Our model of training links the learning of policy with its associated business practices and systems in a dynamic and interactive way to enhance learning and retention while increasing the abilities of our employees to execute these practices in the workplace sooner and more effectively.

We have a proven record of rapid response to new requirements and changes. During our time as your contractor, we have produced accurate, up-to-date training needed to support our workforce's understanding of any new requirements or changes. MAXIMUS has honed and enhanced our extensive curriculum library through an evolved and effective system of review by project and management staff. These comprehensive evaluations focus on the complete training program from initial skill sets and learning process to post-class retention and the execution of these skills in the call center. We also leverage existing training materials, our corporate Center for Employee Development (CED), program staff leadership, and subject matter experts (SMEs) to complement our training program. In addition, MAXIMUS offers a comprehensive, blended approach to training delivery, tailored to meet the unique needs of Vermont's programs and populations.

**"Training as an MSR for MAXIMUS has not only left me ready to assist the public with accessing and understanding their health care, but has helped me gain a stronger personal understanding of how these programs impact my future and the lives of those around me."**

*- MSR Response,  
Training Survey Results*

From 2004 through 2005 the State redesigned the premium programs and processing. This required members to pay up front before coverage could begin. MAXIMUS was at the table with State staff, planning and creating a training program for all DCF and DVHA staff members. The references and PowerPoint training slides we helped develop were used for this purpose.

MAXIMUS has the infrastructure to respond to change with minimal disruption. We continue to build a solid foundation for managing change by conducting the following activities:

- Continuously developing and updating easy-to-use reference materials that reflect changes in programs and policies
- Making certain updated materials are immediately available to staff
- Getting regular feedback from MSRs about beneficiary concerns and implementing responsive process improvements
- Scheduling training when required so staff are aware of new policies, procedures, and programs
- Continuously assessing staff knowledge of policies, procedures, and programs
- Collaborating with relevant stakeholders to obtain new information and notice of pending changes

MAXIMUS staff has access to a comprehensive electronic resource and reference library that both supports job functions and enhances contact with Vermont beneficiaries. Our reference materials are reviewed and updated daily by our Training Unit Supervisor. As changes occur, it is often necessary to reevaluate the effectiveness of each resource and determine if it continues to meet call center objectives. Periodically, some resources are archived and new ones take their place. Updates also occur on an annual, monthly and often daily basis. For example, we know that income limits change every year for Vermont's health care programs. This requires us to update all related reference materials. Once alerted to the electronic DCF Policy and Procedure Bulletin from the State, we adjust all impacted materials. MAXIMUS staff are then alerted via email of the new information and referred to the electronic document on the KB system. This offers potential relevance in responding to future business needs as a possible Navigator with the Health Insurance Exchange. It is important to the State that whoever handles this role completely aligns services with the HelpLine and others who will be assisting people in understanding the Exchange.



As policies and program needs change, project staff are continually updated and provided with the training necessary to accommodate these changes. While regularly scheduled training allows us to update staff in a proactive manner, there are times when immediate changes to program policies or benefits require a rapid response. MAXIMUS is prepared to handle "real-time" changes of programs, policies, and benefits. We are able to identify and implement changes on the same day. Before we take action, we first consider the business needs of DVHA. DVHA drives the business objectives

upon which we base our training approach. Once identified, we review the severity and significance of the change and collaboratively take action. The MAXIMUS Project Director confers with the Operations Manager, MSR Supervisors, and the Training Unit Supervisor to identify the very best approach for staff training.

In addition, through our QA process, we are able to assess the accuracy and appropriateness of information provided to beneficiaries. For example, our use of live call monitoring allows our supervisors to monitor whether appropriate information is provided to callers. More information about QA with regard to member services is provided in our response to *Question 26 (Section 6.6.8)*.

**MAXIMUS training at our projects is supported and augmented by the MAXIMUS Center for Employee Development located in Reston, Virginia.**

MAXIMUS values our longtime partnership with the State of Vermont. Over the past 15 years, our team has benefited from the collaborative sharing of information that occurs between project staff and personnel within the State. We have worked with you in identifying needs, developing solutions, and implementing change. Our efforts have helped us establish valuable relationships with agencies and community organizations throughout the State. MAXIMUS is flexible, adaptable to change, and open to new opportunities for learning. Our partnerships have allowed Vermont project staff to develop the knowledge, tools, and infrastructure to master program evolution and change.

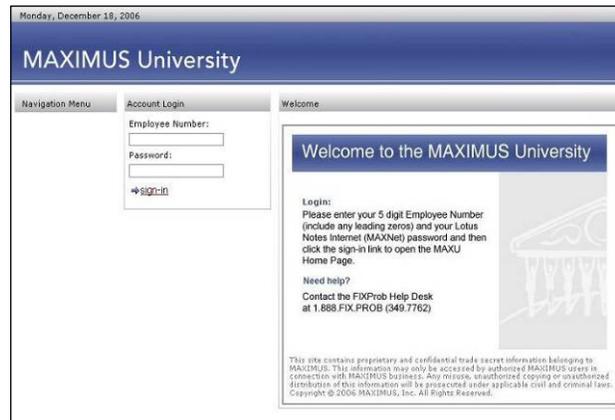
### **Professional Development Opportunities**

MAXIMUS also provides a number of additional professional development opportunities for ongoing training for our staff including:

- **Corporate Center for Employee Development (CED):** MAXIMUS is committed to offering professional development and growth opportunities through training and development courses offered at both the project and the corporate level. Training efforts at our projects are also supported by the additional resources and expertise of the CED. The purpose of CED is to provide professional development courses, tools, and resources to all of our employees and projects. With a staff of instructional designers and training professionals, CED oversees the design, development and delivery of a core business curriculum designed to instill in our employees the knowledge and skills necessary to better serve our consumers. CED supports locally delivered training programs, provides project trainers with electronic toolkits, coordinates off-site meetings for management, and shares best practices across the organization.

The individual training activities of the project are supplemented by the professional training opportunities offered by the CED. The project has, on numerous occasions, taken advantage of CED training offerings, all in the project's ongoing effort to develop staff and provide opportunities for professional growth. The CED provides audio/web conference training opportunities as well as classroom style training. The topic being presented, the format of the training, and the number of staff that may benefit from the training, are factored into whether project staff are sent to the CED for specialized training, or we request to have CED staff deliver/present the training on site at the project.

- **Corporate Learning Management System (LMS):** Beyond curriculum development, CED also serves as a unifying agent in promoting integration, collaboration, and knowledge sharing among our geographically dispersed workforce. Through the CED we have implemented the use of an LMS at the corporate level. This online computer-based training system allows existing staff the ability to view and complete designated training courses, including ongoing training, refresher training, or quick and easy training about programmatic changes/updates, online at their workstations. The ability for staff to remain at their workstations and complete a self-study training course/session eliminates the need to have MSRs removed from the floor to attend an instructor-led training session. Therefore, training occurs when and where it is most convenient to the staff member, without disrupting HelpLine operations. The LMS has the ability to schedule course requirements, track course completion, tabulate and record quiz/test results, and complete course evaluations. This does not eliminate or replace the traditional instructor-led training set up for staff.



- **MAXIMUS Tuition Reimbursement Plan:** Encouraging the continuing education of all MAXIMUS staff members is a fundamental tenet of our commitment to employee development. Through supporting employees in their efforts to enhance their qualifications, we raise the standards of service delivery and professionalism in the work environment. MAXIMUS assists employees with continuing education tuition fees on a sliding scale in relation to the grade the employee receives in the course taken. We find that investing in our employees in this way promotes employee loyalty, increases staff retention, and improves their overall skills.

By continuing to invest in our seasoned staff by further developing them, we produce an efficient, effective project team made up of a mix of valuable experience and broad perspectives. Green Mountain Care Member Services is prepared to address the need for effective and efficient delivery of ongoing staff training and professional development, fully supported by DVHA and MAXIMUS corporate resources.

### 6.6.6 Assisting Individuals with Special Needs

**Question 24:** *Describe the bidder's approach to train personnel in understanding the needs of, and assisting individuals with special needs (i.e., disabled, elderly.).*

RFP Sections 10.9.24, page 36 and 5.8.1, page 22

MAXIMUS has a long history of assisting special needs populations in Vermont. In February 2001, we contracted with the then Office of Vermont Health Access (OVHA) to administer case management functions for the Consumer-Directed Personal Care Attendant Services Program (PCA). PCA services provided a Medicaid benefit offering non-clinical, one-on-one services to special needs children and young adults. The project model included the utilization of Registered Nurses, Physical Therapists, and Social Work professionals to provide education and assistance to consumers seeking to self-direct PCA services for children with special health care needs. Project responsibilities included conducting initial and ongoing home visits, completing six-month eligibility reassessments, creating care plans for services, and conducting regular QA checks. Before this program ended in June 2004, our staff averaged 72 in-home visits per month. Client numbers increased from 191 in 2001 to 757 in 2004. The project saved considerable funds for the State of Vermont over the previous model and greatly improved access to PCA services for children. As a result of this experience, MAXIMUS knows how to tailor our training to meet the more complex care, specialized service, and care coordination needs of these individuals.

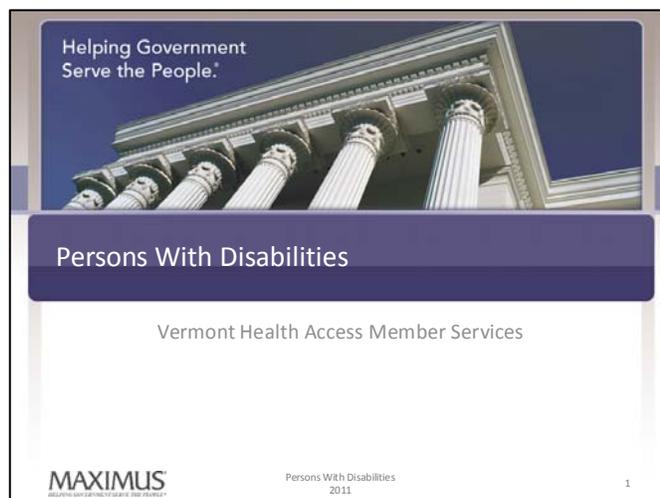


MAXIMUS is keenly aware of Vermont's current health care climate. We understand the needs of Vermont's aged, blind, and disabled special populations and have specific training modules, staff reference materials, and in-house communication tools allowing us to assist individuals and their personal advocates with these needs. We train our staff on how to effectively communicate with diverse audiences in a sensitive and competent manner. We help individuals with special needs enroll into managed care, providing them with comprehensive, personalized education regarding their managed care benefits. In addition, we have developed an extensive listing of Vermont's most frequently asked for community resources, which makes our MSRs pivotal in meeting the special needs of individuals throughout the State.

MAXIMUS understands and strongly supports your commitment to ensuring that all beneficiaries with disabilities receive quality care and have ready access to appropriate services and providers. We have deep understanding and insight obtained through years of successful interactions with people with disabilities and the Vermont program officials who dedicate their lives to serving and supporting them.

### 6.6.6.1 Understanding Special Needs

We provide our core module on the aged, blind, and disabled populations to both newly hired and veteran staff members. We also offer refresher trainings in the form of guest lecturers, group training sessions, and web conference training sessions on diversity delivered through the MAXIMUS CED. Our training identifies the barriers that elderly, blind, or disabled individuals face when trying to access health care. Often these individuals have cognitive difficulties, mobility impairments, lack of social support services, and in some cases, difficulty in understanding their own health care needs and program options. Our goal is to promote understanding and identify the tools with which project staff may best assist individuals with special needs.

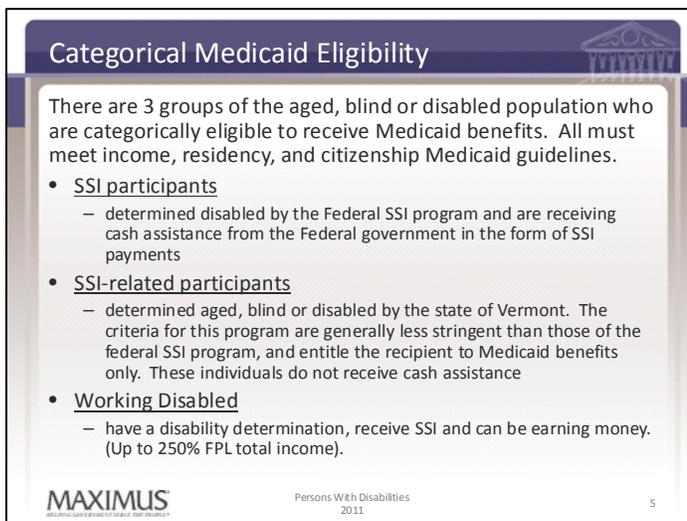


The training objective of our module entitled Persons with Disabilities is "To gain a thorough understanding of the health care needs of persons with disabilities and how to provide all the information needed to make informed health care choices, and to help the beneficiaries understand what their rights are and that they have access to their health care benefits."

This training module also speaks to the SSI population and their unique relationship with Vermont Medicaid. Included in this module are the following components.

- **Aged, Blind, and Disabled (ABD) Defined:** Discusses the categorical definitions of each in relation to Vermont's Medicaid programs
- **SSI, SSI-related, and Working Disabled Defined:** Discusses the Social Security Administration and the State of Vermont Disability Determination Services Unit in relationship to categorical eligibility for Vermont's Medicaid programs
- **Types of Disabilities and Accommodations:** Describes the various types of disabilities and the accommodations that persons with a type of disability can benefit from; for example, sensory or communicative disorders, developmental, physical, cognitive, emotional or psychiatric, chronic health conditions and hidden disabilities
- **"People First" Philosophy:** Reviews how to refer to the person first and the disability second, remembering that the person is much greater than the disability
- **Sensitivity and Common Sense:** Discusses how to use appropriate language, avoid inappropriate or insensitive terms and identify correct terminology used to identify various conditions; for example, wheelchair user instead of wheelchair bound, mental health condition instead of insane
- **Enrollment into Managed Care:** Presents how to enroll individuals with the primary care doctor of their choice and provide appropriate education as many beneficiaries in the ABD population receive multiple and ongoing services with specialists; covers use of the *PC Plus* Enrollment Script

- **Understanding Special Needs and Tips to Assist:** Acknowledges the special needs of Vermont beneficiaries; provide trainees with listening techniques and other customer service tips
- **Relationship with Community Agencies:** Describes the relationship MAXIMUS has with other organizations and appropriate referral scenarios, including Area Agencies on Aging (AOA), Vermont Center for Independent Living (VCIL), Vocational Rehabilitation, Vermont Association for the Blind and Visually Impaired, Department of Aging and Independent Living (DAIL), local Department of Health and DCF District Offices, community mental health centers, and others
- **Internal Project Resources:** Reviews available electronic resources including:
  - Medicaid provider directories and lists for durable medical equipment, vision and dental services, hearing aids, as well as out-of-state providers
  - Disability resources such as the Working Disabled Brochure, Community Resources Matrix, and Covered Services Matrix
  - List of patient assistance programs from pharmaceutical manufacturers
- **Americans with Disabilities Act (ADA):** Reviews critical guidelines governing the rights of disabled individuals, including handicap accessibility ratings for business establishments, State offices, and health care providers



### 6.6.6.2 Training Approach

We provide all project staff with a basic understanding of the issues facing special populations. Through the use of various training techniques we personalize each trainee's experience. Staff participates in group presentations and discussion, role plays, group case studies, and computer examples utilizing "real call" scenarios, as well as listening exercises. Each staff member is given necessary phone lists and develops expertise in utilizing both internal electronic resources and our alternative communication tools.

### 6.6.6.3 Supportive Learning Materials

MAXIMUS understands that it is often necessary to employ special techniques and procedures to properly serve individuals with special needs. That is why we have developed reference materials for staff that support them in their role as MSRs. As the member services contractor, we have developed comprehensive information tools and detailed scripts for MSRs to use as a guide to educate enrollees. We introduce beneficiaries to the rules of managed care and highlight covered services that are relevant to the special needs of the aged, blind, and disabled.

MAXIMUS answers questions from applicants, beneficiaries and other parties regarding Vermont's health care programs and assists individuals based upon established internal protocols.

There are, however, times when someone did not qualify for a program, had a case closed, or sought an item or service not normally covered under their current program that could not be requested using the exception (formerly M108) form. In order to provide high quality customer service to every caller, MSRs refer to the Community Resources Matrices. We house special resource guides for the elderly and the disabled in our KB system.

In addition to the elderly and disabled community resource listings, we also provide other electronic information to facilitate the ability of our MSRs to deliver customer service to special needs populations. These resources available in our KB system include:

- List of patient assistance programs from pharmaceutical manufacturers
- Medicaid participating provider lists for durable medical equipment, dental, vision, hearing aids and out-of-state providers
- Medicare Rx Card information and contact phone numbers

#### 6.6.6.4 Alternative Tools to Assist

MAXIMUS makes every effort to overcome barriers to a beneficiary's active participation in the member services experience. Some of these barriers include language differences, disabilities, and varying literacy levels. The list that follows briefly describes the tools we use to address these barriers for callers with special health care needs.



- **ASL Interpreters:** Requests for American Sign Language interpreters can be made through MAXIMUS; however we generally use the Vermont Video Relay service.
- **TTY/TDD:** MAXIMUS maintains a toll free number for a TDD/TTY machine and utilizes the Vermont Video Relay Service to assist our hearing-impaired clients.
- **Materials in Alternative Formats:** To accommodate individuals for whom English is not their primary language, all managed care enrollment packages include a prominently displayed translation of the statement, "If you need help translating this information, please call 1-800-250-8427."
  - Braille translations are provided via the Vermont Association for the Blind and Visually Impaired upon request
  - Materials may be requested in alternative formats such as large print for the elderly
  - Materials are clear, direct, and written at a sixth grade literacy level

#### 6.6.6.5 Responding to the Unique Needs of the Individual

The MAXIMUS training approach appreciates that individuals learn in different ways. This approach is not only applicable to the training needs of project staff but also to the aged, blind, and disabled populations in Vermont. MAXIMUS understands that individuals with special needs may experience hesitancy and confusion when presented with new information about their health care programs and may need alternative ways in which they can have their needs met. In our years of experience as the Vermont contractor, we have encountered many callers that are simply not comfortable or able to have their needs addressed over the phone. MAXIMUS makes accommodations to meet the needs of these individuals.

MAXIMUS understands that member services HelpLine operations must be efficient and address the needs of our callers. We also understand and have the capability to address the unique needs of those requiring special assistance. Our project office in Burlington, Vermont is conveniently located on the bus line and within walking distance of many State and community organizations. This makes us accessible to those individuals who may require special assistance or even desire a face-to-face meeting. Every staff member is trained in how to handle walk-in beneficiaries, understanding the need to sign in every visitor, take safety precautions by not closing the door to their meeting, and ask for assistance when needed. The scope of assistance is similar to that of the calls on the HelpLine activities except the meeting occurs within our offices. Regardless of the visitor's nature or ability, project staff provides respectful and knowledgeable service.

### 6.6.7 Providing Accurate Information to Beneficiaries

#### **Question 25:** *How will the bidder ensure that personnel are providing sufficient and accurate information to individuals?*

RFP Section 10.9.25, page 36

We provide all staff, but particularly MSRs, with continual performance assessment and feedback. As described in our response to *Question 19* through *Question 23* (Sections 6.6.1 through 6.6.5), MAXIMUS utilizes a variety of methods and strategies for identifying, developing, and maintaining staff to deliver complete and accurate information to every individual, including:

- **Established staff recruitment and hiring practices via temporary to permanent staffing arrangements:** Offering the opportunity to vet, train, and evaluate personnel as a cost-effective means to retain the most qualified and appropriate staff
- **Effective staffing and scheduling methodology:** Enabling strategic personnel decision-making that is validated by an experienced leadership team applying a strong combination of quantitative analysis and insight from years of direct HelpLine member services in Vermont
- **Comprehensive new hire and ongoing staff training program:** Providing continuous professional development opportunities as well as tracking and assessment of progress to confirm staff ability to perform as required with re-evaluation and refresher training as appropriate
- **Innovative information systems and tools, defined policies and procedures, and other means such as checklists and desk guides:** Offering ready access to information via our KB system and resources like our MAXDash system that enhance the ability of staff to quickly and easily retrieve information and materials to assist callers and enable staff to respond to the myriad of questions and issues presented by Vermont program callers
- **Consistent consultation with DVHA and other key stakeholders:** Through regular contact, meetings, and close working relationships, we remain abreast of the most current program information as well as updates and changes to requirements, covered services, or policies and procedures to support the timely notification and immediate implementation of change by project staff



■ **Ongoing communication and feedback concerning staff member knowledge, skills, and performance through:**

- Weekly team meetings between supervisors and their staff to discuss important topics and to relay critical changes to programs, policies, and procedures that impact MSR work and information provided to callers
- Weekly management team meetings to discuss project operations, identify needs, and create informed action plans
- Monthly project meetings as a forum to discuss overall project status and issues such as performance, training, quality assurance (QA), new initiatives and program/policy changes and to recognize high achievers by presenting co-worker and service awards

As we have done throughout the years administering Green Mountain Care Member Services, we continue to systematically monitor, assess, and evaluate the quality of staff knowledge, communication, and benefits counseling skills to support accurate and responsive customer service through formal quality control and QA activities as described in the following sections.

### Quality Monitoring and Evaluation of MSR Staff Performance



Our quality monitoring and control activities systematically and regularly assess each MSR's accuracy, thoroughness, professionalism, courtesy, and unbiased approach to member services. Our effective monitoring techniques and quality controls are in place to assess the customer service skills of our MSRs, including timeliness and efficiency of calls, as well as the accuracy, completeness, delivery, and confidentiality of information. MSRs are kept apprised of their progress in meeting their productivity and quality

goals on a daily, weekly, and monthly basis. MSRs receive routine feedback in both written and verbal formats. Project management uses results from these activities to address deficiencies on an individual and systematic level.

Using a standard tool, we measure performance and quality by monitoring recorded calls and scoring the calls on content accuracy, listening skills, professional demeanor, and follow-through, among other things. We track productivity through various ACD and systems reports. We use the compiled data and information to provide constructive feedback to staff. The level of monitoring decreases as staff members demonstrate continued high performance levels. Any decrease in performance levels prompts an increase in monitoring and other remedial actions. We post project-wide call performance results on a weekly basis.

Our established QA monitoring methods help to ensure that individuals receive complete and accurate information from our staff. MAXIMUS monitors both live and recorded telephone calls and provides timely feedback to staff. Our call monitoring techniques include:

- **Live Call Monitoring:** With real-time reports, MAXIMUS supervisors see instantaneous service statistics and participate in silent, live monitoring of staff for QA and training purposes. Our phone system plays an informative message for all callers to promote awareness of potential call monitoring for QA purposes. Supervisor monitoring of live calls allows immediate intervention as needed, providing staff with real-time direction and guidance.

- **Recorded Call Monitoring – OAISYS Application:** Green Mountain Care Member Services employs this sophisticated application to record all phone calls, including both video (screen capture of the end user's desktop) and audio portions of the call. OAISYS call recording software allows for 100 percent call monitoring and recording. Call center supervisors review the audio and video of calls from their personal workstations using OAISYS Management Studio, making it easy and convenient to use. Having both video and audio recordings is invaluable as both learning tools for new hires and in evaluating workflow of existing staff during our routine quality control checks. Review of recorded phone conversations enables supervisors to provide direction and guidance to staff on an ongoing basis. It also allows supervisory staff to note trends and make recommendations for additional training in targeted areas. Each staff member is reviewed by their immediate and other supervisors to help ensure MSRs are evaluated fairly and consistently.
- **Call Monitoring Review and Feedback:** As part of our QA initiative, call monitoring allows staff to have a sample of their calls reviewed, scored, and compared to internal QA goals. Supervisors and the Training Unit Supervisor review a predetermined number of calls each month to assess MSR performance against quality assurance standards. The levels of review, like the recording level described above, are based on the MSR's previous performance. We show an example of the checklist used to monitor and document the calls in *Exhibit 6.6-3: Call Monitoring Checklist*.

includes implementing ongoing operational approaches that promote and cultivate quality, supported by a corporate culture that instills quality as an overriding mission.

An effective quality management plan must be consistent, objective, and manageable. By clearly defining the standards by which service delivery for Green Mountain Care Member Services is observed and evaluated, all staff members have a consistent understanding of expectations and how to reach peak performance to support DVHA goals.

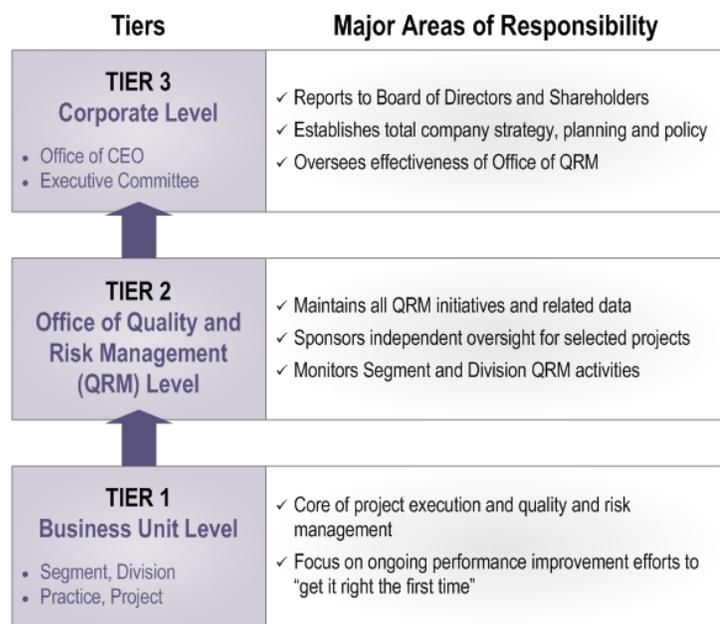
In this section, we first describe our corporate level support to all of our projects. We then explain our overall approach to quality assurance and demonstrate our specific quality controls and reports for member services activities for Vermont.

### 6.6.8.1 Corporate Level Support

Our strong commitment to quality is demonstrated by the involvement of our corporate Office of Quality and Risk Management (QRM). The QRM was created and empowered to make sure that a commitment to quality is central to our operations, continued growth, and improvement as a company. This office oversees projects to make sure contract and internal standards of quality are met, and provides support in developing appropriate quality plans and providing tools to achieve success.

QRM supports our "quality first" philosophy by making sure that industry standard practices are in place throughout the company. Instilling these practices in all of our projects allows for greater accountability, more efficient processes, a disciplined use of proven methodologies, and continuous performance improvement. Our quality framework begins with management reporting to monitor performance on core business objectives. Key quality and performance metrics are captured, reviewed, and evaluated to identify opportunities for improvement. Existing processes are analyzed for consistency, reliability, and efficiency. The identification and integration of best practices are encouraged across the company.

Our approach to quality and risk management is requirements-based, customer-focused, and performance-driven. To ensure that our commitment to quality is implemented throughout the company, a formal internal structure is maintained, as illustrated in *Exhibit 6.6-4: Quality Structure Overview*.



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**Exhibit 6.6-4: Quality Structure Overview.** Three tiers of responsibility help ensure that our quality and risk management approach is carried out internally and in each MAXIMUS project.

Three tiers of responsibility promote accountability across business units to help monitor and foster exceptional project quality and execution. The framework incorporates a variety of perspectives, a comprehensive range of methods, and several key company-wide initiatives.

### 6.6.8.2 Quality Management Framework

Throughout our history of managing large public sector projects we have developed strategies that enable us to proactively identify risks and intervene when projects experience challenges. The collaboration and interaction within the management framework provides projects with a range of expert guidance and multiple avenues for knowledge sharing and risk identification. This structure enables MAXIMUS to monitor processes and address challenges throughout the project life cycle. The strategies we use are adapted over time, based on experience, and adapted to the unique needs of each project.

During ongoing operations, there is a constant check and balance between our project management and our corporate oversight. A project never feels like an island. Rather, there is an ongoing support system for Green Mountain Care Member Services, including frequent communication and guidance, as well as submission of monthly reports that show contract standards and deliverables and project performance in meeting these requirements. These reports act as an early warning system if the project is having particular difficulty in any area, and they will help with consistent monitoring and project course corrections. However, over the course of our 15 years as your contractor, we have never experienced such an issue.

On a quarterly basis projects also submit a self-assessment—modeled after a "balanced scorecard" approach—which provides an opportunity to identify risks and potential need for corporate support. At the end of each fiscal year, the QRM conducts an annual client satisfaction survey. When results from the survey indicate a problem, QRM initiates follow-up activities to make sure deficiencies in service are addressed.

### 6.6.8.3 Project Level Quality Assurance

Through our many years of providing sensitive, confidential, and appropriate member services to an increasingly diverse population in Vermont, we have become more and more proficient at measuring, evaluating, and improving our performance at the project and individual levels. Our quality assurance approach consists of phases or tasks that constantly interact and blend into one another, including:

- Knowing what we want to accomplish
- Understanding how to measure our performance
- Taking action to correct any deficiencies
- Determining how to improve performance (in addition to correcting problems)
- Monitoring the results of our corrective and quality improvement actions
- Re-assessing to make certain desired outcomes have occurred



Through quality assurance, we develop remediation solutions to prevent recurrence of risks or issues with project and individual employee performance. We incorporate the lessons learned

from remediation to improve upon processes, procedures, training, and employee mentoring and support. By identifying best practices and areas that represent a challenge, we have information to further improve.

Over the term of our partnership with DVHA, we have worked hand-in-hand to determine, implement, and refine the most fruitful, verifiable, and actionable ways of monitoring project performance. Our Green Mountain Care Member Services QA/QC activities monitor all areas of project operations to verify compliance with contractual requirements. Quality monitoring is multi-faceted and includes the evaluation of all project functions through assorted avenues, such as:



- Reviewing staff interactions with beneficiaries
- Confirming the adequacy of training and employee program understanding through periodic staff testing and customer surveys
- Performing call monitoring and data reviews to verify the objective and unbiased nature of each employee's benefits counseling activities
- Measuring accuracy and timeliness of system data entry
- Monitoring mailroom activities and fulfillment of notices, forms, and written materials
- Document achievement of contractual performance standards and timeframes

Our staff members responsible for quality assurance develop and maintain regular project activity reports. These reports cover topics widely related to project operations, such as call activity, types, topics and resolutions; enrollment transactions and results; delivery of program specific services; mailhouse activity; and other activities such as TPL transactions and grievances, appeals, complaints, and fair hearings processed by the project.

The staff gathers project performance data to meet and support broad project objectives and contractual requirements. This data enables the project to identify opportunities for increased efficiencies and operational improvements. MAXIMUS provides DVHA with weekly reports containing Call Statistics and Topics, Complaints and Compliments, and Month to Date Totals/Averages. We present an example of weekly call report results from June 2011 in *Exhibit 6.6-5: Weekly Call Statistics*.

MAXIMUS staff handled a total of 5,528 calls during this weekly reporting period. The project answered a total of 4,867 incoming HelpLine calls and placed 661 outgoing calls. This means that on average MAXIMUS staff handled 1,382 calls per day. This week, the project far exceeded all standards including the abandonment rate, two minute and four minute standards.				
<b>Abandon Percentage</b>		<b>Percent Answered &lt; 2 min</b>		<b>Percent Answered &lt; 4 min</b>
0.5%		100%		100%
<b>IVR Calls In (24 hrs.)</b>		<b>MSU Calls In</b>		<b>MSU Calls Answered</b>
6,164		4,895		4,867
<b>MSU Calls Out</b>				
661				
<b>Total Calls Handled</b>	<b>Average Calls Daily</b>	<b>Average TTA Seconds</b>	<b>Average Call Length</b>	<b>Longest Wait</b>
5,528	1,382	10	04:01	02:56

**Exhibit 6.6-5: Weekly Call Statistics.** MAXIMUS presents consistent, quantitative proof of performance standard achievement and smooth Green Mountain Care Member Services operations.

MAXIMUS submits monthly reports to DVHA for ongoing monitoring and evaluation. The monthly report narrative and accompanying exhibits detail our member services, enrollment, mail, and other activities performed through the HelpLine each month. While we often experience moments of high call volumes and call durations, we are continually successful in meeting and exceeding our contractual obligations and goals. Comprehensive monthly reports summarize results as shown in *Exhibit 6.6-6: MAXIMUS Monthly Reporting Parameters*.

Green Mountain Care Member Services Monthly Reporting Parameters	
Call Statistics	Summary of information on daily calls gathered from the IVR
Caller Type	Report on identified category for each HelpLine caller
Program Type	Display of calls received by percentage from each Vermont program
Call Topics	Report on business process the customer conducts during each call
Call Resolution	Report on business process the MSR conducts to resolve each call
Referral Source	Representation of the source generating calls to the HelpLine
<b>PC Plus</b> Enrollment	Confirmed enrollments via the HelpLine, email, in-person, or mailed enrollment form and remained program eligible through the effective date of the enrollment
<b>Other PC Plus</b> Activities	Display of disenrollment activity by reason; summary of outreach activities; and report on dental enrollment activity
Catamount	Summary of functions performed in support of Catamount health plans and Catamount Health Access Program (CHAP)
Mailings	Report on mailing of enrollment packages, notices, program handbooks, applications, forms, and other documents
Other Activities	Report on activities related to TPL; Grievances, Appeals, Complaints, and Fair Hearings; Post-Call Problem Resolution; and the Green Mountain Care website

**Exhibit 6.6-6: MAXIMUS Monthly Reporting Parameters.** Green Mountain Care Member Services is continually successful in meeting and exceeding our contractual obligations and goals.

As seen in *Exhibit 6.6-7: Contractual Performance Standards Results for May 2011*, while the project continues to experience periods of high call volumes and call durations, we remain successful in meeting and exceeding our contractual obligations and standards.

	Did not meet standard	Met standard	Exceeded standard	Far exceeded standard
Operate a "live" toll-free line				✓
Maintain a toll-free TDD/TTY line				✓
Provide translation via the Language Line				✓
Answer calls w.in 25 sec				✓
Abandonment rate < 10 %				✓
Answer 95% of calls within 2 minutes			✓	
Answer 100% of calls within 4 minutes		✓		
Mail monthly enrollment forms within 5 business days			✓	
Mail daily enrollment forms within 1 business day			✓	
Enter enrollment forms within 2 business days			✓	
Return incomplete forms within 2 business days			✓	
Mail confirmation letters within 2 business days			✓	
Maintain an auto-assignment rate of < 25%				✓

**Exhibit 6.6-7: Contractual Performance Standards Results for May 2011.** *Monitoring enables us to create a complete linkage between quality assurance, performance assessment, and training—translating to exceptional staff performance.*

We provide DVHA with written reports to document our pertinent business process results. The reports also include a record of project efforts to implement internal controls and to improve operational procedures. The supporting report documentation includes results of monitoring of applicable business processes during each week and month. This enables DVHA to see how we are performing to contract expectations, and if needed, drill down into the details to find out even more.

### 6.6.9 Measuring Beneficiary Satisfaction

**Question 27:** *Provide a description of how the bidder will evaluate beneficiary satisfaction with enrollment process and member services, and how bidder will use evaluation findings to strengthen its operations.*

RFP Section 10.9.27, page 36

Maintaining and increasing customer satisfaction is one of the key objectives of the Vermont project. To ensure that Green Mountain Care Member Services continues to provide timely, accurate, and courteous service to the beneficiaries we serve, MAXIMUS tracks customer feedback on an ongoing basis in our MAXSTAR call tracking system. Currently, we record complaints on an internal Incident Report and submit this for inclusion in our weekly reports to DVHA. We summarize key points concerning Incident Reports as follows:



- Staff has visual access to all systems to better research complaints
- MAXIMUS focuses resources on researching a solution to the complaint rather than an explanation of the complaint

### 6.6.9.1 Informal Customer Feedback

Our customers are always willing to provide feedback in an informal way. To motivate and encourage staff, we post letters from customers on our "Wall of WOWS." Here are just a few quotes from some of the people we serve:

**"I am surprised, pleased and amazed by the state programs, and your professionalism. Folks like you all make it easy and a pleasure to talk to, and if there are ever any tricky parts to the process, your knowledge and caring really help."**

*-Judith,  
Beneficiary*

**"I want to thank you all for the 'on the ball' great service I receive from you each time I call! I love how easily I can get through your phone system, and how quickly my call is always answered by your knowledgeable staff. I've dealt with multiple federal and state agencies and yours is by far the best service I've ever received!"**

*-HelpLine Caller*

While we are delighted to receive this sort of positive feedback, MAXIMUS also swiftly address negative feedback received by beneficiaries or other parties. We immediately attempt to address the individual's issue to his or her satisfaction. Following that, allegations of inadequacy or wrong-doing on the part of MAXIMUS staff are immediately and thoroughly investigated using all of the tools available. The most useful information is typically found in the call recordings housed in the OASYS system, but project management also reviews call records in MAXSTAR and any relevant notes in the ACCESS system. Project management uses the information to address the level of an individual's performance, to modify current protocols or practices, or to revise and enhance current references. Usually we are able to take proper internal corrective and disciplinary action to remedy any issues. In severe cases where staff behaves unprofessionally or supplies incorrect information affecting an individual's coverage or status, we communicate actions and outcomes of our related investigations to DVHA as necessary.

### 6.6.9.2 Management Observation

In addition, supervisors use data gleaned from call monitoring and other quality assurance activities to measure client satisfaction during HelpLine interactions. Based on these observations, we accordingly adjust business practices as well as provide coaching and feedback to staff to improve performance.

### 6.6.9.3 Solicitation of Staff Feedback

MAXIMUS recognizes that our greatest asset is our employees. At Green Mountain Care Member Services, there is no one better to gauge beneficiary satisfaction or evaluate front-end

processes than MSRs and other front-line staff. While most new processes or protocols originate with project management, none are implemented without first soliciting feedback from the end users. More complex procedures are often rolled out on a pilot basis, allowing project staff to test and tweak aspects of the procedure prior to implementing project wide.

We maintain a suggestion box. Suggestions, anonymous or otherwise, are evaluated by a staff committee for potential benefits. This process often involves research and further solicitation of feedback from staff. Once the committee has evaluated the suggestion, they present their findings to project management.

#### **6.6.9.4 Use of Subcontractors**

**Question 28:** *Describe the bidder's plan to use subcontractors. Bidder will include the name, address, and scope of work to be performed by each subcontractor and the estimated percentage of the total work effort included in each subcontract without reference to price.*

RFP Section 10.9.28, page 36

MAXIMUS has not utilized subcontractors in our administration of this project during our tenure in Vermont. We have no plans to do so in the coming contract term, as we maintain the capability to successfully provide Green Mountain Care Member Services in a cost-effective manner independent of subcontractors.



## 6.7 DATA REPORTING EXCHANGE

The ability to successfully exchange data and produce and submit detailed reports regarding all aspects of our operations is integral to effective management of Green Mountain Care Member Services. The best barometer for evaluating whether a contractor is able to effectively execute these functions is a successful history of having already done so. For well over a decade, MAXIMUS has successfully exchanged data with the Department of Vermont Health Access (DVHA) and relevant State contractors, without issue, to effectively support member services operations in Vermont.

To support both internal and external management and oversight, we have developed a flexible reporting process to produce reports that provide needed information clearly and succinctly. As we have demonstrated consistently throughout our tenure in Vermont, our reporting platform is flexible and easily adapted to meet DVHA's emerging needs and requirements.

### 6.7.1 Plan to Exchange Data

**Question 29:** *Describe the bidder's plan to exchange data with DVHA and HP.*

RFP Section 10.9.29, page 36, and 5.10 - 5.10.1, page 22

MAXIMUS will continue to provide secure and efficient methods for communication and data exchange with DVHA, HP Enterprise Solutions, and any subsequent Vermont fiscal agent. MAXIMUS offers DVHA a low-risk, low-cost plan by providing stable, tested data exchange from day one of the new contract. During development of the Vermont Medicaid Management Information System (MMIS) and eligibility systems, MAXIMUS will work closely with DVHA and HP to adapt data exchange methodology to the new systems.

MAXIMUS is in the unique position of having intimate knowledge of and experience with Green Mountain Care programs and the data needed to provide excellent member services for these programs. This knowledge and experience forms the solid base needed to support a smooth transition to exchanging data with the new MMIS and eligibility systems. Having partnered with DVHA through many changes, we welcome the opportunity to continue supporting you through whatever changes may come.



**Capacity to adapt to future needs**

**MAXIMUS... Vermont's proven partner to achieve its goals; yesterday, today, and tomorrow**

**Low-Risk Experience-Tested Data Exchange Solution.** We have data connectivity, security protocols, and working relationships with other contractors already in place and operational on day one.

**DVHA-Approved Reporting Solution.** We produce clear, usable reports that provide the information DVHA needs for results-oriented project management and for reporting to stakeholders about programs.

**Experienced Vermont Staff.** Our Vermont-based systems and reporting staff are established and trained on the intricacies of the required data exchanges and the use, format, and timing of reports.

**The Right Technology.** Our MAXSTAR system, telephony solution, reporting mechanisms, and MAXDash integration software are cost effective, low risk and already tailored to meet the specific needs of Vermont now. This technology is adaptable to address any future needs that may emerge.

**Extensive Experience in Developing and Implementing Data Exchanges with Diverse State Systems.** MAXIMUS has successfully collaborated with states as they move to MITA-compliant, SOA-based systems. We have a solid understanding of these systems, having deployed many to support our numerous enrollment and member services projects.

### 6.7.1.1 Accessing MMIS

Our staff is currently fully trained in accessing MMIS data. We have developed training specifically tailored to educating staff on the intricacies of the MMIS. No additional training would be required under the new contract, eliminating the learning curve that would be associated with new staff. DVHA can, therefore, focus on overseeing the development of the new MMIS and eligibility systems.

### 6.7.1.2 New MITA-Compliant Systems

In response to advances in technology and current and significant projected changes to the Vermont health care landscape, DVHA is undertaking replacement of the current MMIS along with other major systems migrations. By selecting MAXIMUS, DVHA has the dual benefit of having a partner that offers a comprehensive understanding of the existing programs and databases, along with a high-value and no-risk solution that has all of the components in place to meet the requirements identified for Green Mountain Care Member Services. In addition, MAXIMUS as an organization is well-acquainted with the current requirements for Medicaid Information Technology Architecture (MITA) established by the Center for Medicaid & State Operations (CMSO) and remains abreast of changes and updates to these protocols as they are released. In the sections that follow, we offer strong evidence of our capability to understand, create, develop, and interface with MITA systems.

MAXIMUS has developed processes and procedures for interfacing with MITA-certified or MITA-compliant systems from our systems. Our development staff refers to state and federal legislation, mandates, and guidelines when making changes to systems already in place in our projects, customizing systems for new contracts, or developing new systems or versions of systems. All adaptations, customization, and development also are conducted to leverage existing state systems.

MAXIMUS has experience with and understanding of MITA compliance requirements, including:

- **Development of health information applications that can interface with a MITA-certified system:** MAXIMUS provides health IT consulting services from planning to contract award to assist states in meeting their Medicaid objectives within the MITA Framework. An example of MAXIMUS consulting pertaining to MITA is when the Louisiana Department of Health and Hospitals (DHH) contracted with MAXIMUS to conduct and document a MITA State Self-Assessment (SS-A) review. DHH subsequently asked MAXIMUS to develop the *Louisiana State Medicaid Health Information Technology Plan*.
- **Experience operating in a MITA environment or familiarity with the components of MITA:** MAXIMUS staff have experience and familiarity with MITA compliance as we continue to work internally on our own systems and externally as we interface with other client systems. In addition, we add to our knowledge and involvement in the MITA initiative by our association and participation with entities such as the NASCIO Health Care Working Group examining state-driven health IT efforts to meet evolving needs arising from the Patient Protection and Affordable Care Act and the Health Care Education and Reconciliation Act of 2010; the HL7 Financial Management MITA Project; and the MITA Technical Architecture Committee, a collaboration between the private and public sectors.

MAXDash, to streamline service delivery. MAXIMUS systems are in place and readily adaptable to meet emerging requirements under the new contract. We have established secure connectivity to State and contractor systems and to the Internet. In *Section 9.2:*

*Equipment/Hardware* and *Section 9.3: Software and Database Management System*, we discuss the equipment, hardware, software, and systems used to perform Green Mountain Care Member Services for the new contract period. We understand and accept that we continue to be responsible for the costs associated with this infrastructure and our connection to the Internet.

## 6.7.2 Reporting Requirements

**Question 30:** *Describe the bidder's approach to meet all reporting requirements described in RFP.*

RFP Sections 10.9.30, page 36, and 5.10.2, page 24

Reports are an integral part of project management. MAXIMUS supervisors, managers and quality assurance staff depend on reports to help them monitor performance, staffing, and other factors of operation. We provide reports to DVHA to support their monitoring of Green Mountain Care Member Services and to facilitate an understanding of our operations. As your partner since 1996, we have fulfilled your requirements for weekly, monthly, and quarterly reports. In addition to the requirements for reports at defined intervals, we have provided ad hoc reports when requested.

### Weekly and Monthly Reporting Requirements

To meet all reporting requirements, we integrate information from both internal sources, such as MAXSTAR call logs and Contact Center Suite, and external sources, such as the current eligibility system, ACCESS. We have collaborated with DVHA to create reports that are truly meaningful. We will continue to provide the same level of service moving forward into the new contract period. We are able to do this without having to invest additional resources into reports development and staff training. Building on our experience adapting to new state systems in other states, we will work closely with DVHA to make needed adjustments to reports that use data from the new MMIS and eligibility systems. In *Exhibit 6.7-2: Green Mountain Care Member Services Reports*, we provide information about some of the reports we produce on a weekly, monthly and quarterly basis. *Appendix E: Sample Reports* provides samples of some of these reports.

Frequency	Reports	Source of Data
Weekly	Incident Report including information about complaints received and corresponding actions to respond to each complaint	■ MAXSTAR
Weekly and monthly	Call center data reports summarizing telephone activity, including information that shows the number of incoming and outgoing calls, average time to answer, and duration of calls during the period	■ Contact Center Suite
Monthly	Number of referrals, enrollments, automatic re-enrollments, and transfers processed in the period	■ DVHA eligibility file
Monthly	Incidence of voluntary selection of plan and auto assignment	■ ACCESS
Monthly	Incidence of primary care provider selection by beneficiaries	■ DVHA eligibility file
Monthly	Summaries of telephone activity, including the number of calls by type of caller, program or programs, and topic of and disposition of call	■ MAXSTAR

**Exhibit 6.7-2: Green Mountain Care Member Services Reports.** *Having DVHA-approved reports and reporting procedures, MAXIMUS is able to produce clear, useful, and accurate reports from the first day of operations in the new contract period.*

## 6.8 TIMEFRAMES/PERFORMANCE STANDARDS

**Question 31:** *Describe how the bidder will monitor compliance with each of the requirements listed, and the minimum timeframes for the identified functions and performance standards. Describe how deficiencies will be addressed.*

RFP Sections 10.9.31, page 36 and 6-6.4, page 25

As a company, MAXIMUS places a high priority on quality and invests time and resources to perfectly position our projects to consistently deliver high quality services to the beneficiaries we are contracted to serve. We have all of the functional components in place to deliver efficient, timely, and accurate Green Mountain Care Member Services and meet all required performance standards identified in the RFP on the first day of operations under the new contract. We have been doing so consistently since Vermont operations commenced in 1996, and we can attest that we will continue to do so into the future. We know from direct experience how vitally important it is to the Vermonters we serve that we comply with all contractual performance standards, particularly those around timeliness and service levels. At a corporate level, we place the utmost priority around maintaining contract compliance and overall quality. We have procedures and protocols in place to report and monitor each of our projects on a regular basis to make certain all performance standards are achieved and to intervene and promptly address issues if needed.

Our approach to compliance monitoring entails a cycle of planned and systematic evaluation activities for collecting and analyzing call volume statistics and other operational trend data. This analytical process helps us assess the overall performance and effectiveness of project functions, identify and address a deficiency before it becomes a problem, and develop operational improvements. The following four activities represent the core of the MAXIMUS approach to evaluating operational performance and decreasing the likelihood of deficiencies.

- **Performance Monitoring:** Our structured and strategic approach to properly executing the scope of work for Green Mountain Care Member Services is built around a thorough understanding of the statement of work and other contractual requirements. We make certain that all required tasks and deliverables are understood, accounted for, and closely monitored throughout the contract period to guarantee the timely execution and delivery of each one.



**Capacity to adapt to future needs**

**MAXIMUS... Vermont's proven partner to achieve its goals; yesterday, today and tomorrow**

**Trusted Project Management Team.** Our managers will continue working closely with DVHA to monitor our ongoing operations for compliance with all required performance standards.

**Consistent Performance Outcomes.** We have continually met or exceeded performance standards throughout our tenure in Vermont.

**Technology Support.** MAXSTAR integrates with State systems to perform required data exchanges and allows for accurate reporting of performance standards.

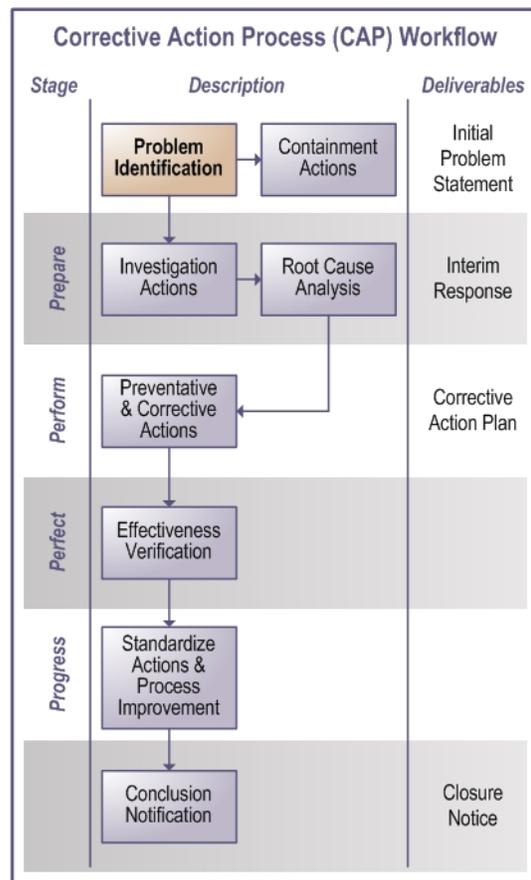
**Proven Compliance Monitoring Approach.** Our performance monitoring activities help us assess operational performance, identify deficiencies, take corrective action, and continuously improve quality.

**Three-Tiered Training Program.** Our MSRs undergo rigorous training that includes all aspects of program eligibility, covered services, third party liability, fair hearings, prior approval for services, special programs, managed care education and enrollment, and how to deliver exceptional customer service.

### 6.8.5 Proactive Approach to Problem Solving and Addressing Deficiencies

We recognize that any functional component of any member services operation can experience a problem or deficiency. To address this, MAXIMUS takes a proactive approach to preventing problems before they occur. We strive to limit issues, but when they happen, we aggressively contain them, rapidly correct them, and implement a corrective action process to help eliminate future occurrences. As shown in *Exhibit 6.8-10: Corrective Action Process Workflow*, we identify and address problems or undesirable deviations from quality and performance standards through the following stages:

- **Problem Identification and Investigation:** During the first two stages, we identify a potential problem before it reaches an unacceptable level and develop preliminary containment actions. We then conduct a root cause analysis to determine whether the potential problem is related to coordination and integration issues, inadequate staffing or productivity levels, ambiguous program policies and procedures, systems or telecommunications technology problems, lack of training for the staff, or a combination of factors.
- **Preventive and Corrective Actions:** Once we identify the cause of a problem, we develop alternative solutions for corrective action and implement those that are most feasible. These proposed solutions could occur in regular meetings or in a special ad hoc corrective action planning meeting with management.
- **Verification of Results:** The next stage involves determining the impact or outcome of the newly implemented solution. Our Operations Manager verifies the effectiveness and timeliness of the corrective/preventive actions implemented to make certain the cause of the problem has been resolved or eliminated. Regular, intensive monitoring is conducted to evaluate the results and determine the effectiveness of the solution. If improvement is deemed insufficient, the process starts all over again. Results are fully documented to help build our management best practices.
- **Continual Process Improvements:** Our process workflows are subject to an ongoing cycle of review that results in further improvements in our business processes, performance, targets, and efficiency. The process of preventive and corrective actions is one means of identifying potential noncompliance issues and making continuous quality improvements. The identification of suboptimal performance occurs through daily monitoring and tracking



**Exhibit 6.8-10: Corrective Action Process Workflow.** Our workflow process includes identification of the root cause of the problem as well as development of actions to prevent reoccurrence.

of progress toward performance goals through our review and analysis of management and statistical reports.

### **6.8.6 MAXIMUS Experience with Performance-Based Contracts**

RFP Section 6, page 25

MAXIMUS has considerable experience managing performance-based contracts nationwide where all or part of our payment is tied to such things as meeting established performance criteria and/or the type and quantity of services rendered, amounts collected, or a dollar amount per transaction processed. We are adept at tracking and reporting our performance against established criteria and producing invoices that reflect the impact of performance on payment. We remain open to negotiating with DVHA to determine how performance indicators will link to payment in the next contract term.

## 6.9 TRANSITION PERIOD/START UP

As the current Green Mountain Care Member Services contractor, MAXIMUS has everything in place and functioning well, including a facility, work stations, telephony, data systems, training, policies and procedures, staff, and innovative tools developed over the course of 15 years of experience providing these services. We require no transition or start up to continue providing member services under the new contract.

By selecting MAXIMUS, the Department of Vermont Health Access (DVHA) eliminates transition risk and takes a crucial step toward reducing ongoing operational risks. This is especially important during a time when DVHA is facing multiple procurements and systems transitions along with the need to implement federal health care reform and Act 48 requirements. Not only does the potential transition of member services at this time present risk for DVHA and its beneficiaries, but DVHA would be denied the benefit of a knowledgeable partner, with extensive local and national experience in each of these areas, at a time when our input and assistance is important to meet these challenges.

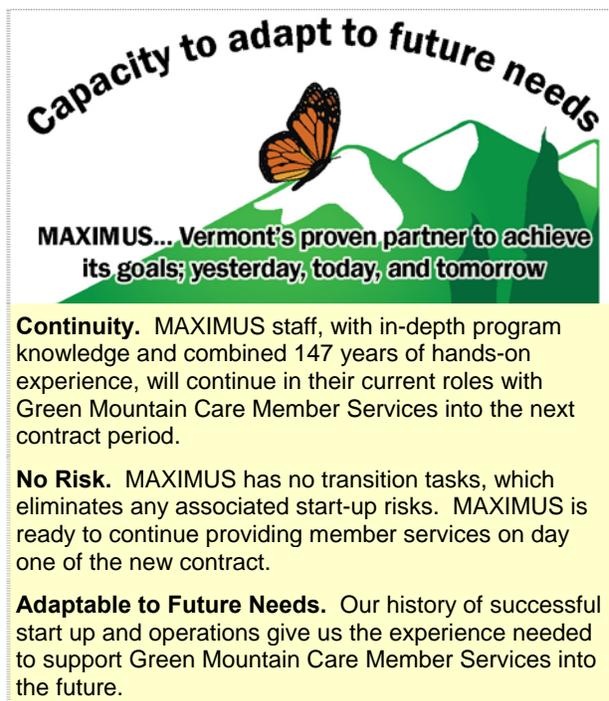
While MAXIMUS is ready to operate on day one of the upcoming contract term, we have identified some activities that are required to maintain our operation and help ensure its continued smooth functioning. None of these activities are mission critical; however, they reflect our commitment to innovation, as we have demonstrated over the last 15 years, to help ensure we remain positioned to provide secure, reliable, and effective member services for Vermont's Green Mountain Care programs. Additional detail regarding these proposed activities is provided in the section that follows.

### 6.9.1 Plan to be Fully Operational

**Question 32:** *Describe the bidder's plan during the transition period to be fully operational on December 1, 2011. The description should include hiring and training of staff, development of training/policy manuals, coordinating activities with DVHA and the existing enrollment and member services contractor.*

RFP Section 10.9.32, page 36

By choosing MAXIMUS as your Green Mountain Care Member Services contractor, DVHA can eliminate risks associated with program transition because we require no transition. Our competitors have to start from square one with several key implementation tasks: identify and build out a facility; recruit, hire, and train staff; establish working relationships with DVHA, other contractors and state agencies, and stakeholder counterparts; and develop a workable



**Capacity to adapt to future needs**

**MAXIMUS... Vermont's proven partner to achieve its goals; yesterday, today, and tomorrow**

**Continuity.** MAXIMUS staff, with in-depth program knowledge and combined 147 years of hands-on experience, will continue in their current roles with Green Mountain Care Member Services into the next contract period.

**No Risk.** MAXIMUS has no transition tasks, which eliminates any associated start-up risks. MAXIMUS is ready to continue providing member services on day one of the new contract.

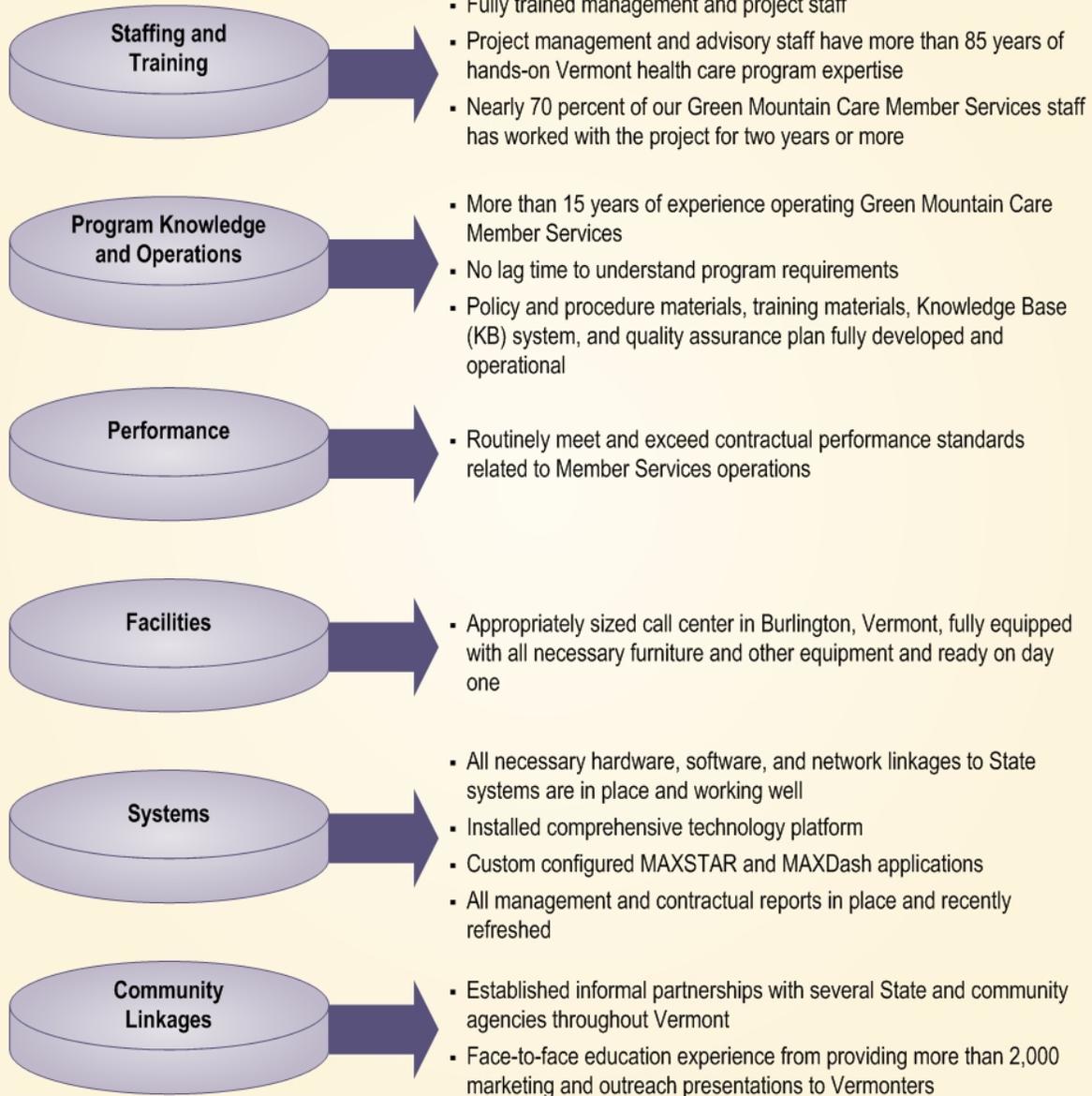
**Adaptable to Future Needs.** Our history of successful start up and operations give us the experience needed to support Green Mountain Care Member Services into the future.

training, quality assurance, and governance infrastructure. MAXIMUS has all of these elements in place and they are proven, offering no risk for DVHA or program beneficiaries. While securing a facility and infrastructure are important, even more significant is the complexity of Green Mountain Care programs. It can take as long as six months to fully train staff regarding all aspects of these programs. The wealth of knowledge we have gained over the last 15 years is not easily transferrable and would prove challenging for an entity to assume, as demonstrated by the recent DCF call center effort. Any bidder that suggests information can be easily mastered in a short period of time is underestimating the sheer volume and complexity of information and processes that are supported by Green Mountain Care Member Services.

We currently provide all of the services outlined in the Request for Proposals (RFP) and are prepared to continue administering these services as we transition into the new contract term on December 1, 2011. Elements of our infrastructure already in place include:

- **Hiring and Training Staff:** Key management staff members will be continuing in their current roles, and they are ready to provide required services on day one of the new contract. We are fully staffed so we have no hiring and training tasks, unlike a new contractor that will need to recruit, hire, and train new staff on the intricacies of Green Mountain Care programs and member services operations. During our initial implementation of both managed care operations in 1996 and member services in 1998 and in the years since, MAXIMUS spent much time refining our business processes to achieve efficiencies, as well as to understand the inner workings of DVHA. We have devoted many years to achieving these close working relationships and gaining in-depth program knowledge, which enables us to provide the very highest quality customer service. The time saved by avoiding the need to re-create professional relationships and in-depth program awareness can instead be allocated to improve our business processes and focus on the implementation of innovations and proposed optional enhancements, which we will implement upon approval by DVHA. Should the need for additional staff be identified over time, we have a recruitment, hiring, and staff training plan in place. We discuss hiring and training staff in more detail in *Section 6.6: Staffing*.
- **Development of Training/Policy Manuals:** MAXIMUS has been working closely with DVHA since our initial contract in 1996 to create and revise training materials and policy manuals that prepare our staff to effectively communicate with beneficiaries, providing the highest quality customer service and delivering accurate and objective information. As a result of having established training materials and policy manuals, MAXIMUS eliminates related transition tasks and can focus on program changes, new health care reform initiatives, new policies and procedures, and refresher training. We have processes in place to help ensure all materials are kept current as programs change and evolve and provide additional details on the development of our training and policy manuals in *Section 6.6: Staffing*.
- **Coordinating Activities with DVHA and Existing Contractor:** Transitioning a project from one contractor to another creates not only risk but additional burden for DVHA officials managing the transition process. Selecting MAXIMUS eliminates this risk and burden for DVHA and enables you to dedicate precious staff resources to supporting your many upcoming initiatives. *Exhibit 6.9-1: MAXIMUS – The No-Risk Solution* describes our approach and capabilities that already are in place and functioning well for Green Mountain Care Member Services.

## MAXIMUS - Vermont's Proven Partner with the Capability to Adapt to Meet your Future Needs



11-P13001.0017-34

**Exhibit 6.9-1: MAXIMUS – The No-Risk Solution.** *MAXIMUS is the only contractor with a proven infrastructure and knowledgeable staff in place and no transition tasks.*

A decision to select MAXIMUS for the new contract period benefits DVHA, as well as all individuals served by Green Mountain Care Member Services, in several major ways:

- Seamless continuation of member services specified in the RFP scope of work is guaranteed when operations under the new contract begin on December 1, 2011
- The numerous risks associated with a new contractor's learning curve during the implementation period and for a long period thereafter are avoided
- DVHA can be reassured that its performance standards and expectations are met from the start of the new contract period
- DVHA will not need to expend the financial or staff resources necessary to support the implementation of a new contractor's solution
- DVHA is assured of a partner, with the experience and understanding, both locally and on a national level, to aid you as you embrace significant upcoming challenges

## 6. RESPONSES TO QUESTIONS

MAXIMUS is grateful for the opportunity to have served millions of Vermont Medicaid and Medicare beneficiaries. As the scope and reach of managed care and member services in Vermont has grown, we have been a steady and reliable partner, meeting or exceeding our performance standards and showing flexibility, adaptability, and an unwavering commitment to the Vermonters who depend on the Green Mountain Care programs. Our proposal leverages and sustains what is working currently, while proposing new innovations for the coming contract term and offering new ideas and recognition of the Department of Vermont Health Access's ambitious plans for change. Building on a track record of success, ensuring a seamless and no risk continuation of operations, and offering new value-added and innovative features, we are your best choice now and for the future.

RFP Sections 7, page 28 and 10.9, page 33

The bidder must describe its ability and approach to provide the requested services by responding to each of the questions listed below. Responses to questions must be preceded by repetition of the question and must be in the same sequence as used in this RFP. Any attachment(s) submitted in response to a question must be marked clearly with the question number to which it refers. Bidders are cautioned to submit only those materials that directly relate to the questions posed. Responses to questions should be efficiently constructed and no longer than necessary to demonstrate applicant's ability to provide the requested services, demonstrate its understanding of responsibilities, or describe its approach to performing its duties.

MAXIMUS has had the pleasure of partnering with the Department of Vermont Health Access (DVHA) to serve Vermonters since 1996. During the initial years of our partnership, our role was important, but more limited in scope than that of today. In the early years, we performed managed care outreach, education, and enrollment for the newly created VHAP program along with Dr. Dynasaur and traditional Medicaid. We provided general income guidelines and application assistance for the health care programs at the time, including Medicaid, Dr. Dynasaur, VHAP, VHAP Pharmacy, and the then newly created VScript program. As DVHA (known at the time as the Office of Vermont Health



**The Best Partner for Vermont: Yesterday, Today, and Tomorrow.** It has been our pleasure serving as your partner for the past 15 years and adapting our business model to respond to a plethora of changes and growth to the Vermont health care programs. We are inspired and excited to be by your side to support you as new initiatives are implemented, such as single payer health care and the Affordable Care Act, should you choose us to remain as your partner into the future.

**Subject Matter Expertise.** As the only company that has served as the Vermont Green Mountain Care Member Services contractor, MAXIMUS brings comprehensive and unmatched knowledge of DVHA's goals and mission, program requirements, and future plans.

**A Seasoned and Knowledgeable Management Team.** Our team of talented professionals, all well known to DVHA, collectively possessing more than 85 years of Vermont program experience, remains intact and fully engaged for the coming contract term.

**Innovations Based on Best Practices.** While we have been a stable and high-performing contractor, we are pleased to bring a set of new operational innovations that reflect our experience and position as the nation's dominant company providing enrollment broker services.

**Technology.** Our technology platform is in place and fully functional – offering no risk for DVHA, and includes our innovative dashboard, know as MAXDash, MAXSTAR call tracking and reporting system, and rich Knowledge Base (KB) system. Our systems have been specifically customized to meet current needs and are adaptable to address future needs. Our automated IVR system offers consumers 24x7 self-service options.

**A Foundation for the Future.** In combination with our role as your contractor for Green Mountain Care, our proposal offers experienced staff, economies of scale, and productivity enhancements to save money now while providing a robust infrastructure to support your evolution through Health Care Reform and all the changes and challenges that may encompass.

Access) deftly responded to new mandates by the Vermont Legislature, MAXIMUS worked in tandem with you to ensure that deadlines were achieved, goals were met, costs were contained, and Vermonters received the high quality service they have come to expect. We are grateful to literally have had "a seat at the table" as Vermont embarked upon its journey to conceptualize, implement, and operationalize one of the most impressive, innovative, and forward-thinking health care programs in the nation. We have implemented new programs and taken on new initiatives repeatedly in the middle of our contract term and we look forward to further opportunities to negotiate in good faith on future contract amendments which may be necessary to help Vermont implement upcoming changes to its programs.



As with our other Medicaid administrative services contracts, the truest and most objective validation of our performance is the longevity of our partnership with DVHA. Following our original selection in 1996, our contract has been renewed twice, in 2000 and 2005, and its scope has increased on other occasions. For example, we expanded operations to support *PC Plus* (adding *PC Plus* member services to our

role), to help Vermont comply with the new citizenship and identity requirements mandated by the Medicare Modernization Act (MMA), and to support Green Mountain Care. We recently executed the tenth contract amendment for our existing member services contract. We look forward to continuing our long record of success for many reasons, including the strong desire of every member of our team to continue serving Vermont's children, adults, families, persons with disabilities, and the elderly through the Green Mountain Care programs.

Our key strengths reflect the experience, knowledge, relationships, and infrastructure we have developed and strengthened during the years we have been privileged to serve Vermont's families:

- Long-serving and stable staff, including numerous individuals who have been with the project since its beginning, who understand DVHA's goals, challenges, and constraints at a level that would be impossible without our longevity and successful history with DVHA and the Green Mountain Care programs
- Member Services Representatives (MSRs), Supervisors, and Managers who understand the program's policies, systems, beneficiaries, and providers at a level that will take many years for another company to acquire
- Productive, positive, and trusting relationships with State agencies, providers, community based organizations, and other stakeholders



- A technology team and proven database management system that is currently functional in Vermont, tested, tailored to DVHA's programs, and ready for the next contract term – a claim no other vendor can make
- A streamlined operational strategy that leverages technology and best practices to produce an optimally productive and efficient operation that doesn't sacrifice customer service
- Avoidance of the costs and demand on the time and energy of DVHA's staff that would be necessary to facilitate the transition to a new vendor

MAXIMUS values and supports DVHA's vision for the future and the challenges that you face in the coming years and we are committed to helping you get there. We have the capacity and skill to adapt to meet any of your future needs. Just as important is our appreciation for the possible barriers and obstacles to success that may appear as change is implemented, and the ways in which they can be overcome or minimized with sufficient planning and insights. We bring this knowledge and understanding from our position and history as the nation's leading Medicaid enrollment broker by a wide margin, with services currently offered to almost 18 million individuals in 13 states. This represents almost two-thirds of the nation's Medicaid managed care participants, encompassing a remarkable diversity of geographic, linguistic, and cultural populations.

While we are justifiably proud of our work in the nation's largest and most diverse Medicaid programs (California, New York, and Texas), we are equally proud of our approach to smaller, yet highly ambitious programs like Vermont's Green Mountain Care. In fact, our willingness to make the necessary investments in projects where our economies of scale are necessarily smaller because the volumes are relatively low, speaks to our ultimate corporate value of commitment to our clients that facilitates the delivery of exceptional customer service, no matter the size or location of our projects.

Our Vermont staff are in place and currently providing services to Green Mountain Care beneficiaries. They are loyal, dedicated, and share your vision for the future. Many of them have been with the project since its inception. Our management team has a cumulative total of 85 years of experience working directly with DVHA and your programs.



Over the years, we have formulated best practices which we share both formally and informally among our projects across the country. One of the primary reasons for our success is our ability to tailor our approach to meet the particular needs of beneficiaries and government partners, as well as our ability to inject creativity and best practices into both new and ongoing operations. Our ultimate goal is to provide individuals with the proper information and support needed to help them make the best and most informed decisions concerning their available program alternatives.

In many of our enrollment broker projects, MAXIMUS has been shoulder-to-shoulder with our state clients as the transition to managed care from PCCM or fee-for-service has occurred, either incrementally or more aggressively and quickly. With this enormous reservoir of experience, we bring several critical advantages that no other company can reasonably or plausibly claim to match:

- Communication, technology, operational, and training best practices that carefully and effectively negotiate the fine line between cost-conscious efficiency and exemplary benefit counseling and member service that is strategically targeted at educating and enrolling beneficiaries
- Member materials and websites that are suitable for low-literate audiences while matching or exceeding the highest standards of private sector communication, social marketing, and social media
- Outreach to and coordination with the provider and advocate community in a way that respects and responds to their concerns while remaining faithful to the State's overall vision

**Your partner with the proven capacity to adapt to future needs—yesterday, today, and tomorrow**

The Green Mountain Care Member Services procurement arrives at a particularly challenging time for Vermont and DVHA. We understand that now, perhaps more than ever, DVHA requires a partner that not only has a deep understanding of the health care landscape in Vermont, but can serve as your partner and offer sage guidance, drawing from knowledge and experience at a national level, to assist you as you tackle these significant hurdles. Among these challenges is the shift to ensure that the Vermont



**Based on our long and highly successful partnership, MAXIMUS has a deep understanding of the Vermont health care programs and the upcoming challenges DVHA faces—and we are committed to helping you get there.**

health care programs adapt to comply with all new federal requirements mandated by the Affordable Care Act. In addition, Vermont has taken the bold step to be the first in the nation to pass legislation mandating the migration to a single payer health care system. These two initiatives alone would be daunting for many states and state agencies. However, DVHA has several other challenges it needs to rise up to meet simultaneously. Included among these are several major systems migrations including that of the current Medicaid Management Information System (MMIS) and the beneficiary eligibility system currently known as ACCESS. Added to this is the future migration of health care eligibility operations from the Department of Children and Families (DCF) to DVHA. Accomplishing even one of these tasks would be taxing for any organization. Handling them all at once is a daunting task. Based on our experience working with DVHA for many years, we are confident that all will be accomplished in a way that exceeds expectations. We are also confident that we have, and have demonstrated, the knowledge, experience, and ability to once again be

the partner that is by your side to aid you as you meet these challenges and exceed all expectations.

We approach this procurement with an unusually high level of excitement and anticipation. Providing medical assistance to nearly 26 percent of Vermonters, DVHA has faced many challenges and MAXIMUS has been by your side, meeting these challenges since 1996. We know Vermont, and we know your programs. Moving forward together, we are excited about where the State is going, and in the following subsections, we show you how we can help you get there. Throughout our proposal, we have presented new ideas, technology, and processes, and have demonstrated our commitment to partnering with you as you move to the next level with health care reform, and become the first state to implement a single payer, or universal access, health care bill.

Our proposal embodies pride in what we have accomplished as your partner, gratitude for the trust you initially placed in us that has been confirmed over several contract re-procurements and amendments, and excitement over the new features we are offering to help position DVHA as we move forward together. *Section 6: Response to Questions* describes our ability and approach to provide the requested services. We have responded to each question by stating the question and providing our answer in the same sequence as used in the RFP. We provide real-life vignettes that demonstrate our approach to providing services, the resources we have developed, and the bonds that we have created with the Vermonters we know and serve. Subsections include:

- *Section 6.1: Outreach*
- *Section 6.2: Education*
- *Section 6.3: Enrollment*
- *Section 6.4: Coordination*
- *Section 6.5: Member Services*
- *Section 6.6: Staffing*
- *Section 6.7: Data Reporting Exchange*
- *Section 6.8: Timeframes/Performance Standards*
- *Section 6.9: Transition Period/Start Up*

## 7. WORK PLAN

The Department of Vermont Health Access expects on-time implementation of required services and systems as they are critical to supporting the Green Mountain Care programs. MAXIMUS is your proven, no-risk choice for providing these services since we have a full complement of experienced and trained staff in Vermont, proven management leadership, and effective systems and infrastructure.

RFP Sections 10.10, page 36 and 5.1, page 14

The bidder shall provide an implementation timeline with a description and listing of tasks and subtasks to be performed in order to meet the requirements of the RFP. The implementation timeline should be presented in the form of a timeline or Gantt chart, identifying the timeframe for commencement and completion of each task.

The Department of Vermont Health Access (DVHA) needs a contractor that is able to meet all functional requirements and provide beneficiaries with effective Green Mountain Care Member Services on day one of the new contract. DVHA's selection of MAXIMUS avoids any risks associated with transitioning services to a new contractor, as we require no actual transition activities and have proven our ability to meet all needs and requirements. We understand the complexities of Green Mountain Care programs and have the capacity to accommodate program growth and changes yet to come. Our knowledge and infrastructure, developed and enhanced over 15 years of continuous improvements and innovations, represents a no-risk, cost-efficient, and non-disruptive transition solution.



**Capacity to adapt to future needs**

**MAXIMUS... Vermont's proven partner to achieve its goals; yesterday, today, and tomorrow**

**No Risk.** The tasks in our work plan are limited to upgrading our telephony and data systems prior to the December 1, 2011 start date for the new contract, thereby eliminating any associated transition and start up risks.

**Enhancements and Innovations.** Since we have no implementation tasks, MAXIMUS can concentrate on enhancing our existing scripts, protocols, procedure manuals, and training materials.

*Exhibit 7-1: MAXIMUS Readiness to Deliver the Full Scope of Services for Green Mountain Care Member Services* provides a summary of the various work plan tasks included in a typical transition and identifies the components that are already in place. As this exhibit demonstrates, MAXIMUS has already completed all of the tasks required for Green Mountain Care Member Services operations. The summary depicts the transitional tasks that MAXIMUS assumes will be completed by the successful bidder to implement Green Mountain Care Member Services.

## 8. COST PROPOSAL

We recognize that the Department of Vermont Health Access is facing significant budgetary constraints in the coming years, while simultaneously needing to devise and implement significant modifications to technology, programs, and processes in response to upcoming initiatives. As we have done for the last three consecutive years, we have reduced our overall price while at the same time supporting an increasing volume of calls and level of operational and program complexity. We are ready and able to provide the full scope of services described for Green Mountain Care Member Services, in a way that poses no risks for the Department of Vermont Health Access, the Vermont programs, or program beneficiaries.

RFP Section 10.11, Page 36; Example Cost Form, Page 44

MAXIMUS is pleased to present our cost proposal to fulfill the scope of services described in the Member Services for Green Mountain Care Request for Proposals (RFP) released by the Department of Vermont Health Access (DVHA) on July 1, 2011. Based on the RFP, Amendment #1 to the RFP, and Questions and Answers provided by DVHA on August 4, 2011, we are including a price for the initial 19 months of operations, from December 1, 2011 through June 30, 2013. In accordance with your guidance, the period of performance for Year 1 is from December 1, 2011 to November 30, 2012 and the period of performance for Year 2 is from December 1, 2012 through June 30, 2013.

We have carefully analyzed the requirements in the RFP and evaluated the need for resources to assist DVHA in a responsible manner, meet all programmatic requirements, and provide Vermonters with innovative, efficient, and high quality member services. As always, we are open to discussing items for which DVHA believes more cost effective solutions exist. MAXIMUS has enjoyed serving as your partner since 1996. We would be glad to discuss any of our assumptions with you in greater detail at your request. In addition to base costs estimated to provide the core services described in the RFP statement of work (SOW), we have offered several Optional Enhancements for your consideration, included as Section 11: *Optional Enhancements*. These items have not been included in our pricing; however, we are prepared to provide cost estimates for any or all of these additional services upon request. Our detailed cost form is provided at the end of this section as *Exhibit 8-1: Cost Forms for Year 1 and Year 2*.



Costs for each period are divided into the following major categories: personnel costs, materials production and printing costs, administrative/other costs, and overall organization administrative costs. We have based these costs on the actual costs incurred for performing the scope of services in our current Vermont contract. We have tailored our costs in response to specific information presented in the RFP, Amendment #1 to the RFP, and Questions and Answers.

Management. Additionally all travel, equipment, and supply costs associated with these staff members are G&A expenses. General and administrative costs are allocated on a consistent on the basis to projects using total direct and indirect costs (excluding subcontractors) as the base.

**Fee:** As a for-profit firm, MAXIMUS allocates a small fee to all costs excluding those designated as pass through costs.

## **8.8 TOTAL DIRECT AND INDIRECT COSTS**

Total Direct and Indirect Costs are the sum of all the expenses previously described in this document.

## **8.9 TOTAL COSTS**

Total costs are defined as the sum of all direct costs, indirect costs, total cost, and all pass-through costs outlined in this document.

MAXIMUS proposes a reasonable and responsible budget to continue operating Green Mountain Care Member Services. These costs reflect our considerable experience as your partner and, in nearly all instances; they reflect actual historical project expenses. MAXIMUS looks forward to continuing our partnership with DVHA in the coming contract term. We are open to discussing and negotiating items where another method of implementation may result in lower costs. Thank you for considering our cost proposal to continue providing high quality member services for Vermont.

## 9. RESPONSE TO TECHNOLOGY REQUIREMENTS

The Department of Vermont Health Access can expect MAXIMUS to continue providing the technology to support Green Mountain Care Member Services operations. Technology is not the solution to providing services—it supports our staff as they answer telephone inquiries, disseminate important health program information, and otherwise help beneficiaries and their families access the health care services they need. Our proven technologies are currently in place assisting Vermonters, and they are easily adaptable to meet future challenges in Vermont.

RFP Section 10.15, page 38

Responses to this RFP must include a section entitled "Response to Technology Requirements" within which the State will find the information needed to have a clear understanding of the technologies that will be used to perform the Scope of Work and how they will be used, and that related issues, such as security, are fully understood and managed by the proposing bidder. If the bidder proposes the use of sub-contractors, proposals must also incorporate into the responses similar information as it relates to the sub-contractor.

Bidders must submit a proposal which includes technology support adequate to fulfill the Scope of Work. The bidder must describe the components of the approach, pertinent implementation and operational issues, support from the organization, expectations of the State and how the Scope of Work will be supported. The proposal must describe the level of system performance and reliability as it relates to performance of the Scope of Work and general performance requirements.

The proposal must provide the following information:

To ensure success in Vermont's changing environment, the Department of Vermont Health Access (DVHA) needs an experienced partner with the proven ability to implement quickly and ensure that no disruptions in service occur at this critical time, when Vermont faces both state and federal health care reforms.

MAXIMUS is that partner. In the subsections that follow, we describe the technology we propose to effectively support Green Mountain Care Member Services in the current environment, and position ourselves to deftly adapt to future changes as Act 48 and the Affordable Care Act (ACA) are implemented in Vermont. The technology solution we offer is mindful of the current platform and offers creative solutions to respond to some of the limitations inherent in the existing environment, such as the need to access multiple state legacy systems. It is easily adapted to accommodate future growth and changes. Our technology solution represents the best value for DVHA, avoiding the unnecessary cost of a large system expansion at a time when future needs continue to be defined.



**Stable, Proven Technology.** Current technology is already in place to support Green Mountain Care Member Services. It is proven and has a stable track record of successfully delivering services to beneficiaries.

**Scalability and Flexibility.** Our solution is adaptable and scalable to meet current and future needs as DVHA addresses new goals and challenges.

**Staff Already Trained.** MAXIMUS staff is already adept at using technology needed to support operations and provide appropriate assistance and support for beneficiaries. Retraining is not necessary, allowing DVHA to focus on upcoming program and other changes.

**No Risk.** Since our solutions are in place and proven to meet RFP requirements, MAXIMUS presents DVHA with a no-risk solution and enables you to focus on other impending challenges.

## 9.1 BIDDER'S TECHNOLOGY APPROACH

RFP Section 10.15.1, page 39

An overview narrative of Bidder's technology approach to fulfilling the Scope of Work and meeting the requirements detailed below. The narrative should touch on each of the topics listed below in a manner which allows a non-technical reviewer to understand the intentions of the Bidder and why the proposed approach has merit. Bidder's proposal must also include a high-level technical implementation plan which would form the basis for a detailed technical implementation plan if Bidder is selected as the Contractor, and which would be updated and fully detailed as an early contract deliverable.

Our approach to providing superior customer service in our call centers is based on hiring and training experienced, qualified staff and supporting them with technology customized to fit the needs of the people we serve. To support our staff for Green Mountain Care Member Services, MAXIMUS has a well-functioning, comprehensive technology platform already in place. We currently use a combination of hardware and software which have proven effective during our tenure in Vermont. Unlike our competitors, who would need to implement a new technology solution, MAXIMUS has the technology and tools in place to ensure a risk-free implementation and seamless service continuity for Vermont beneficiaries. The current platform is scalable and can easily be expanded in the future to respond to emerging needs. Our solution brings together innovation and a proven platform to deliver member services with virtually no risk.

Green Mountain Care Member Services currently has all of the computer hardware and software necessary to meet the requirements identified in the RFP. All Member Services Representatives (MSRs) have desktop workstations to perform the daily tasks required for their job responsibilities. The workstations have Microsoft Office Suite, MAXDash desktop integration software, and TN3270 Telnet software for connection to the ACCESS Eligibility System. Our workstations, networked printers, scanner/fax, LAN switches, servers, routers, telecom system, TDD/TTY, and associated software are already in place and operational. We have established connectivity to State systems in accordance with RFP requirements.

As DVHA has learned throughout our more than 15-year partnership, our staff truly cares about the people they serve. Consequently, they strive to provide the most valuable member services support possible, remaining sensitive to the needs of the vulnerable population that the programs cover. By providing a robust and adaptable technology solution, we empower staff to efficiently and compassionately assist beneficiaries so that they may obtain needed health care services and information. *Exhibit 9.1-1: Technology Approach Features and Benefits* highlights our technology solution to ensure that our staff is equipped with the tools they need to provide the highest level of member services to Vermont beneficiaries.

As the incumbent member services contractor for DVHA, MAXIMUS has all of the technology and equipment in place to support all requirements outlined for the ongoing operation of Green Mountain Care Member Services. All technical efforts are complete, and there are no outstanding tasks remaining. As part of our ongoing effort to continuously improve and refresh our technology platform, some tasks will be completed in the near future including migrating the hosting of our Vermont MAXSTAR call tracking and provider file application to our corporate data center in Reston, Virginia. We propose this migration in order to take advantage of the redundant backup systems offered by our Reston data center and high level of security provided by the corporate resources. This transfer is planned to occur during our existing contract term, so that the transfer will be completed and thoroughly tested prior to commencement of the new contract period.

With the exception of minor IVR changes to facilitate the customer satisfaction survey, as indicated in the work plan in *Section 7: Work Plan*, we have no further tasks to present as an implementation plan for our technology.

## 9.2 EQUIPMENT/HARDWARE

RFP Section 10.15.2, page 39

Bidder must describe:

- a. the equipment (e.g., personal computers, servers, routers, laptops, mobile devices) that will be used to perform the Scope of Work.
- b. equipment ownership. Contractors are expected to provide, through ownership, lease or sub-contract all equipment required to effectively perform the Scope of Work.
- c. where the equipment will reside.
- d. how the equipment will be used to perform the Scope of Work and by whom.
- e. the approach, including software, which will be used to protect against viruses and other malware.
- f. the equipment that will be purchased specifically to perform the Scope of Work.
- g. the need for use of any State owned equipment.

The systems that we use to support Green Mountain Care Member Services are complex with a wide variety of functions. In order to use these systems and all of the various state systems that interconnect, we must have robust hardware and equipment behind them.

### 9.2.1 Equipment Used to Perform the Scope of Work

The hardware and software we propose to support Green Mountain Care Member Services are based on proven industry standards and are stable systems that perform well and have the flexibility and scalability to support future goals. The technical equipment proposed will adapt to the changing vision for health-related programs in Vermont. As your current partner, the equipment described here is already in place, supporting Green Mountain Care Member Services. Technology refresh or equipment upgrades which may be needed in the future are driven by the lifecycle of a given piece of hardware and the fast-paced changes in hardware technology. We describe the equipment to be used in support of Green Mountain Care Member Services in *Exhibit 9.2-1: MAXIMUS Equipment*.

Our west coast data center in Rancho Cordova, California, serves as a disaster recovery facility for the Reston location. It can support systems from around the country for all corporate projects should the need arise to move operations to the west coast. The facility has the necessary power and generator capacity to support twice the total system output of the primary system in Virginia. Should it ever become necessary, MAXIMUS is able to switch systems operation to California to continue to support Green Mountain Care Member Services operations in Burlington.

#### **9.2.4 How Equipment will be Used and by Whom**

The computer and other equipment we propose is established to provide optimal support for Green Mountain Care Member Services. We explain how that equipment will be used in support of our operations, and by whom, in the following subsections.

##### **9.2.4.1 Office Equipment and Personal Computers**

To successfully provide Green Mountain Care Member Services, it is important to use supporting technology that assists us in serving Vermont beneficiaries. We use multiple applications, from the standard Microsoft Office suite to the custom-configured MAXSTAR and MAXDash. To be able to utilize these applications our staff is provided personal computer workstations which are used in the daily workflow to access these key applications. Our call center staff uses the desktop personal computer (PC) workstations to track beneficiary contacts in MAXSTAR, search for beneficiaries using MAXDash, process enrollment requests in ACCESS, and complete all other member services tasks outlined in the RFP. Supervisors and project management use either laptops or desktop PCs to monitor call flow and processes and to listen to calls for quality assurance and ongoing training purposes.

PCs are also used by the in-office mailroom staff. The computers are used by staff to access all of the mailing requests processed by MAXSTAR. These mailing lists are used in a mail merge to create electronic copies of the mail request files. The resultant files are then processed into a hard copy version on the Ricoh multifunction printer and mailed according to the requirements of the contract.

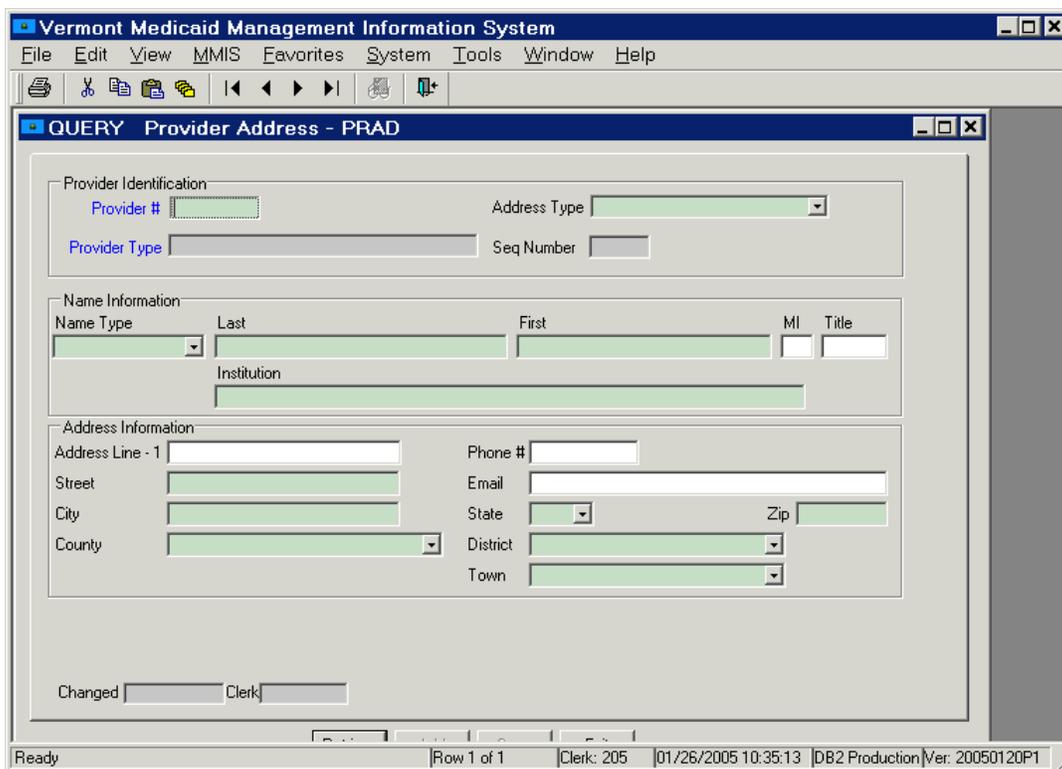
##### **9.2.4.2 Telecommunications Equipment Use**

With a focus on both quality and cost effectiveness, MAXIMUS intends to leverage the current Mitel Private Brand Exchange (PBX) phone switch and enhance its Automated Call Distribution (ACD) functionality and reporting with the Mitel Contact Center Suite. *Exhibit 9.2-2: Telephony Solution*, illustrates our integrated phone system components.

most up-to-date and accurate information regarding their health care enrollment and coverage. Our staff is already trained on and experienced in using all systems for Green Mountain Care Member Services, including the ACCESS system for eligibility inquiries, case updates, and member enrollment, the HP Enterprise System (MMIS) for billing and coverage issues, the Vermont Medicaid web portal for provider lookups, the RxClaim pharmacy benefits management system (MedMetrics) for pharmacy issues, the DCF system for member notices, and OnBase system to view beneficiary documents that have been received and scanned.

MAXIMUS enters all beneficiary information directly into screens within the ACCESS system and updates member information in real time. Our staff is trained and experienced in all aspects of the ACCESS system, providing beneficiaries with a vital link to their health care coverage information. We use TN 3270 terminal emulation software on each workstation to link to ACCESS.

Accessing both the MMIS and Pharmacy Benefits systems through MAXDash, our staff are able to look up the information they need to assist callers. *Exhibit 9.3-3: MMIS Provider Query Screen* and *Exhibit 9.3-4: Pharmacy Benefits System Patient Search Screen*, show examples of inquiry screens used within these applications.



**Exhibit 9.3-3: MMIS Provider Query Screen.** MAXIMUS staff are adept at accessing the MMIS system in order to provide callers with information about claims and covered services issues.

(MITA) standards. As State systems are upgraded in the future, we will continue to follow the approved procedures to implement real-time connectivity and batch interfaces for these systems.

As the incumbent contractor providing Green Mountain Care Member Services, we have established connectivity to access all necessary State systems. This includes the ACCESS system for eligibility inquiries, case updates, and member enrollment, the HP MMIS System for medical billing and coverage issues, the MedMetrics pharmacy benefits management system for pharmacy issues, and the DCF system for member notices. Our connectivity to State systems has been enhanced by use of MAXDash, previously discussed, that provides an integrated interface to multiple systems, thereby simplifying basic searches and data entry functions.

#### 9.4.4 Secure Transmission/Transfer of Data

As MAXIMUS continues to operate health and human services projects that serve children, adults, and families throughout the country, we continue to champion their right to privacy. MAXIMUS ensures that information collected about members is protected in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Final Rules and Standards, as well as DVHA's own security policies, MAXIMUS security requirements, and other applicable State and federal mandates. We provide more details associated with HIPAA compliance in *Section 9.5: Security Plan*.

We safeguard Protected Health Information (PHI) and Electronic PHI (E PHI) by applying stringent policies and procedures, conducting comprehensive staff training, performing regular security audits, and maintaining regular review and updates of our best practices, developed across multiple projects but customized to fit project-specific requirements.

We understand the importance of maintaining the privacy of Vermont's members and safeguarding the confidential information entrusted to us. This is evident by our comprehensive Information Security Policy, maintained by our corporate OIS Security and Audit Team.

Some of the highlights of our attention to maintaining secure transmission of information include:

- **Electronic Transactions:** Having designed and conducted HIPAA-compliant electronic data transactions in multiple states, MAXIMUS has implemented a variety of approaches to sharing and safeguarding electronic data transactions.

In Vermont, MAXIMUS uses the Secure File Transfer Protocol (SFTP) to exchange files

#### **Key Security Standards Guiding Our Ongoing Security Strategy**

- *Department of Defense Information Technology Security Certification and Accreditation Process (DITSCAP)*
- *International Standards Association's (ISO) security standard 17799 (based on British Standard 7799), Code of Practice for Information Security Management—comprehensive information security guidance*
- *OMB Circular A-130, Appendix III*
- *NIST Special Publications 800-18, 800-26, and 800-30*
- *International Systems Audit and Control Association's (ISACA) Control Objectives for Information and Related Technology (CobiT)*
- *General Accounting Office's (GAO) Federal Information System Controls Audit Manual (FISCAM)*
- *Carnegie Mellon University's Software Security Engineering Capability Maturity Model (SEI-CMM)*
- *National Security Agency's (NSA) INFOSEC Assessment Methodology (IAM)*

with the State and other key stakeholders. The State currently sends files via FTP, but they are working on upgrading their file transfers to SFTP, as well. Because we have a site-to-site virtual private network (VPN) configured, all data going over the Internet between the corporate network and the State is encrypted.

- **Electronic Correspondence:** Transmission of electronic correspondence which may contain PHI/EPHI to DVHA is done through the State's secure email option.
- **Data Transmission:** MAXIMUS focuses considerable attention on providing a secure and resilient network environment for the projects we support. The network is the framework that provides secure user access to data center services and an infrastructure for the deployment and interconnection of shared data center components, including applications, servers, appliances, and storage. Our network is designed to optimize application availability and performance, while protecting application and data integrity.

In addition, MAXIMUS uses tools and devices to protect the confidentiality, integrity, and availability of data transferred using the internet, including encryption protocols. Separate redundant firewalls are deployed at the perimeter of the network in all MAXIMUS data centers to protect the network. Each firewall performs a separate function to further isolate traffic and if necessary, provide additional redundancy.

**Data encryption is required for all sensitive, protected confidential information transmissions outside of the MAXIMUS network.**

Inbound and outbound network device traffic is logged, including successful and failed attempts to connect to the network. The logs are stored on the firewall management server accessible only to the Security and Audit department. Logs are compressed and stored on CD ROM for archival purposes and saved for a period of three years before being properly destroyed. Firewall log files are reviewed for any network traffic abnormalities both manually and programmatically using the Webtrends Firewall Suite. We contract with an outside security company to perform external penetration testing of our most critical applications and risk assessments of major project locations.

All these safeguards and components contribute to a secure environment and compliance with HIPAA and other applicable confidentiality and security regulations governing operation of Green Mountain Care Member Services.

## 9.5 SECURITY PLAN

RFP Section 10.15.5, page 40

Bidder must provide State with a security plan that:

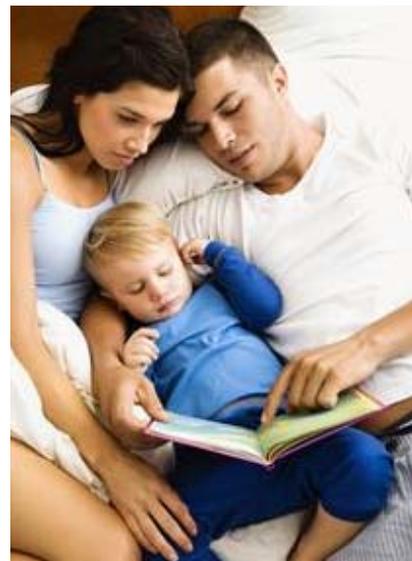
- a. Adheres to the National Institute of Standards and Technology (NIST) Special Publication 800-53 rev 2 recommended security controls, moderate impact baseline ([http://csrc.nist.gov/publications/nistpubs/800-53-Rev2 / sp800-53-rev2-annex2.pdf](http://csrc.nist.gov/publications/nistpubs/800-53-Rev2/sp800-53-rev2-annex2.pdf) with exception to CA-6 Security Accreditation) or equivalent security framework.
- b. Is fully compliant with HIPAA requirements, to include Administrative, Physical and Technical safeguards including a current Risk Assessment.

In its response to the RFP, Bidder may choose to provide an assurance that requirements are met and language sufficient to demonstrate bidder's approach and an overview of the Security Plan. The selected Bidder will be required to submit for approval to State its complete Security Plan prior to contract execution. The State reserves the right to do security checks.

The Department of Vermont Health Access (DVHA) faces many challenges as it moves forward with its Green Mountain Care initiatives in the face of health care reform, replacement of the MMIS and eligibility systems, and implementation of extensive changes to comply with the Affordable Care Act (ACA) and Act 48. As part of that scenario, it is important to be able to allay concerns about security for the member services to be provided, including administrative, physical, and technical security as stipulated by the HIPAA Security Rule standards. DVHA has enough to be concerned about with these future needs without risking security breaches associated with the operation of Green Mountain Care Member Services.

As a leading government contractor operating health and human services projects, MAXIMUS has a strong understanding of information and physical security requirements and associated privacy and confidentiality laws and regulations. We have a comprehensive approach to security for each of our contracts and a long history of understanding the implementation of security policies covering physical, software, and personnel security protocols. Through the many contracts we operate for both federal and state government agencies, we have a depth of experience complying with applicable standards, policies, laws, and regulations. Our best practices ensure that adequate security is incorporated in the information systems we provide for our clients. We look forward to continuing to safeguard Vermont beneficiaries' confidential information as we have since 1996.

Our corporate Office of Information Services (OIS) Security and Audit team provides information technology services and supportive systems to a wide variety of state health and human services, child welfare, education, financial, and administrative agencies. Across numerous states, our experienced teams of project directors, project managers, and information technology professionals have assisted clients in the planning, design, procurement, and implementation of information systems. This experience includes Medicaid



**Protecting Vermont beneficiaries' confidential health information is the focus of our established security policies.**

eligibility and enrollment systems, Statewide Child Welfare Information Systems, Student Information Systems, child care management and child support enforcement systems, enterprise resource planning systems, and public employee retirement systems.

MAXIMUS maintains secure connections to the Social Security Administration, and we have attained Department of Defense Information Technology Security Certification and Accreditation Process (DITSCAP) security clearance for several CMS network connections. These connections are in addition to the many state client connections we have implemented and maintain in conjunction with state technical staff.

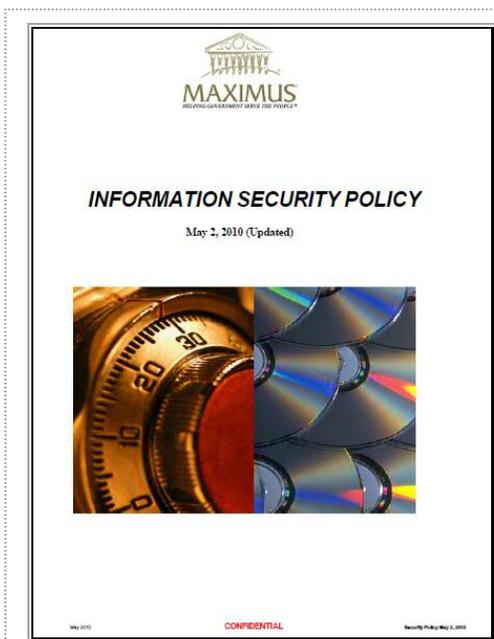
We have faced concerns similar to those identified for Green Mountain Care Member Services at our other health services projects across the nation, and we have developed solutions that reflect our understanding of and expertise in physical and data security. Our established policies successfully protect confidential information from unauthorized access. We apply our deep knowledge and experience to provide a secure operating environment for our Vermont facilities, staff, systems, and processes, affording DVHA a high level of confidence that the services being provided meet the needs and safeguard the interests of Green Mountain Care beneficiaries.

### 9.5.1 Security Plan

We present our corporate Information Security Policy, upon which our Security Plan for Green Mountain Care Member Services is based, in *Appendix F: Information Security Policy*. This corporate policy serves as the foundation for all project security requirements—physical, equipment, data, and personnel—and we review and update it regularly to reflect new requirements. Our Security Plan for Green Mountain Care Member Services includes additional facility-specific and systems-specific policies tailored to meet contract requirements and HIPAA security rules for protecting the confidential information entrusted to our care in providing member services in Vermont. We are prepared to submit our finalized plan prior to contract execution, per RFP requirements.

#### 9.5.1.1 NIST Adherence

We use the National Institute of Science and Technology (NIST) methodology for developing Security Plans, as detailed in NIST Special Publication 800-18, Guide for Developing Security Plans for Information Technology Systems. Our Information Security Policy, maintained by our OIS Security and Audit team defines the requirements pertaining to physical and information security, as well as authorized use. We have an extensive program inclusive of employee training, continuing education, specific situational alerts, and auditing to completely maintain all appropriate security protocols.



**Our Security Plan for the member services contract will be modeled after our established corporate security policy.**

Security standards that guide our ongoing security strategy include:

- Department of Defense Information Technology Security Certification and Accreditation Process (DITSCAP)
- International Standards Association's (ISO) security standard 27000 suite, Code of Practice for Information Security Management—comprehensive information security guidance
- OMB Circular A-130, Appendix III
- NIST Special Publications 800-18, 800-53-Rev2, and 800-30
- International Systems Audit and Control Association's (ISACA) Control Objectives for Information and Related Technology (COBIT)
- General Accounting Office's (GAO) Federal Information System Controls Audit Manual (FISCAM)
- Carnegie Mellon University's Software Security Engineering Capability Maturity Model (SEI-CMM)
- National Security Agency's (NSA) INFOSEC Assessment Methodology (IAM)
- FIPS 199 – Standards for Security Categorization of Federal Information and Information Systems
- FIPS 200 – Minimum Security Standards for Federal Information and Information Systems
- Federal Information Security Management Act of 2002 (FISMA)

#### 9.5.1.2 HIPAA Compliance

MAXIMUS champions the right to privacy of all the health and human services clients we serve. Our policies and procedures comply with applicable HIPAA privacy and security rules and standards, DVHA's own security policies, MAXIMUS security requirements, and other applicable state and federal mandates.

Our comprehensive approach to security is based on our experience in implementing security policies and protocols that cover physical and electronic access to confidential information. We understand data security requirements, the need for confidentiality, the rights of clients, and associated privacy and confidentiality laws and regulations. We will use this knowledge and experience to provide a secure operating environment for all confidential information.

**DVHA can count on MAXIMUS to continue to provide services in Vermont that comply with HIPAA and other confidentiality and security standards.**

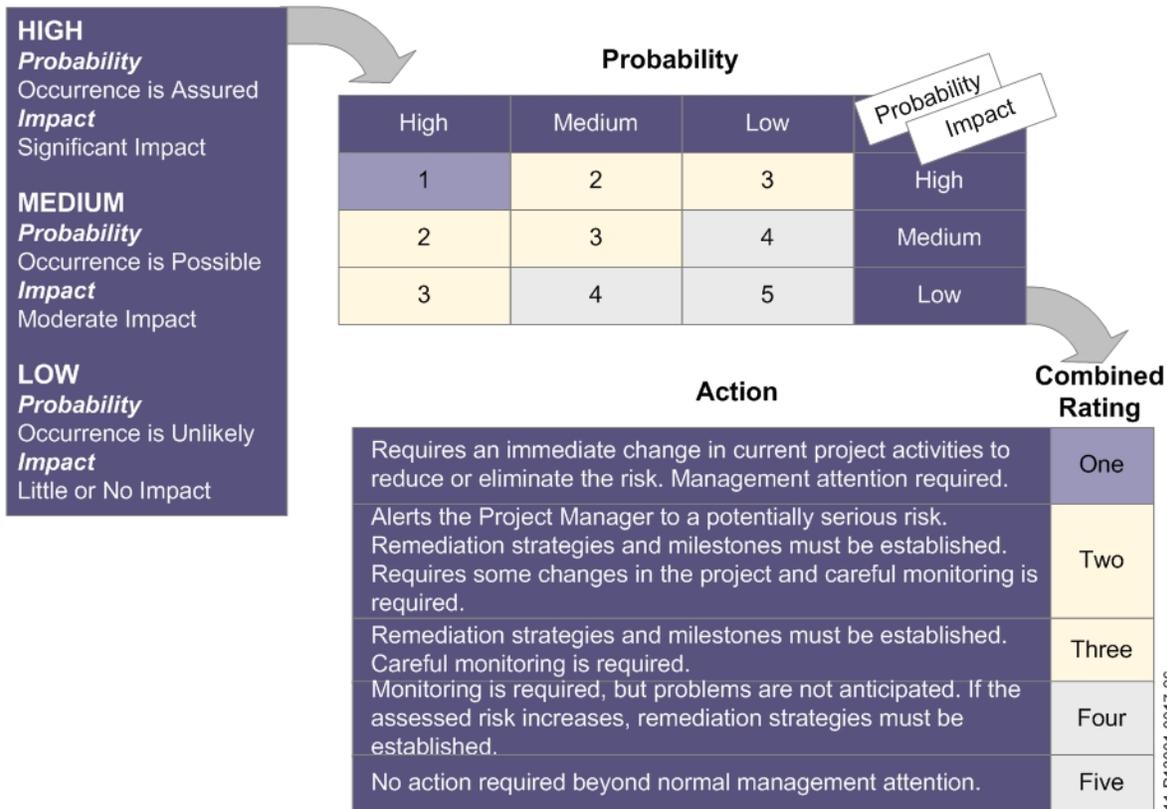
As part of HIPAA compliance, we are clearly committed to safeguarding and protecting all data designated Protected Health Information (PHI) and Electronic PHI (EPHI) under HIPAA regulations. We adhere to HIPAA Standards for Electronic Transactions in our current enrollment broker project operations, and we will continue to do so for Green Mountain Care Member Services.

Most of the systems we support are hosted in our corporate data centers located in Reston, Virginia—including the MAXSTAR application used by our Green Mountain Care Member Services, and Rancho Cordova, California. We manage numerous systems and applications within our data centers that handle sensitive and confidential records. Our comprehensive

*Exhibit 9.5-2: HIPAA Training Slides* shows some of the training we have developed for this important topic.

<h3>What is Protected Health Information?</h3> <ul style="list-style-type: none"> <li>Protected health information includes all information related to health care, including payment for health care, that is <b>individually identifiable</b>.                     <ul style="list-style-type: none"> <li>Insurance coverage or enrollment/disenrollment information</li> <li>Diagnostic information</li> <li>Medical, dental or Rx records</li> <li>Address, date of birth, social security number</li> <li>Verifying coverage</li> <li>Most information used by MAXIMUS involves protected health information</li> </ul> </li> </ul> <p>MAXIMUS  <small>MAXIMUS CORPORATION</small>          HIPAA 2011 6</p>	<h3>Never Release PHI</h3> <ul style="list-style-type: none"> <li>With other companies for marketing or other purposes</li> <li>For any work that is not defined by our project contract</li> <li>With anyone who does not have the right to know</li> </ul>  <p>MAXIMUS  <small>MAXIMUS CORPORATION</small>          HIPAA 2011 10</p>
<h3>HIPAA</h3> <ul style="list-style-type: none"> <li>We can use PHI to conduct the work we do for beneficiaries as defined by our contract                     <ul style="list-style-type: none"> <li>Share with the beneficiary, who the information is about</li> <li>Share with other entities when MAXIMUS has received <u>appropriate</u> permission from the bfy</li> <li>Share with law enforcement, government investigations, or when state laws require it</li> <li>Share with personal representatives, parents, and providers who have obtained appropriate permission from the bfy</li> </ul> </li> </ul> <p>MAXIMUS  <small>MAXIMUS CORPORATION</small>          HIPAA 2011 8</p>	<h3>HIPAA Compliance: Best Practices</h3>  <ul style="list-style-type: none"> <li>Access the minimum information necessary to do the job</li> <li>Share the minimum amount of information with only those individuals authorized and necessary to perform your job</li> <li>Do not discuss beneficiary information in public spaces</li> <li>Log off computers except during brief absences</li> <li>Protect passwords and user ids. Never divulge yours, or use someone else's to access information</li> </ul> <p>MAXIMUS  <small>MAXIMUS CORPORATION</small>          HIPAA 2011 11</p>
<h3>What Rights Do Individuals Have Under HIPAA?</h3> <ul style="list-style-type: none"> <li>Right to written notice of information practices from health care plans and providers (privacy notice)</li> <li>Right to access and correct protected health information</li> <li>Right to request restrictions on use and disclosure of protected health information</li> <li>Right to request confidential communication of protected health information</li> <li>Right to obtain an accounting of who has accessed their protected health information</li> <li>Established complaint procedures</li> </ul> <p>MAXIMUS  <small>MAXIMUS CORPORATION</small>          HIPAA 2011 7</p>	<h3>Accidental Disclosure</h3> <ul style="list-style-type: none"> <li>If you accidentally disclose PHI                     <ul style="list-style-type: none"> <li>Email the details of the incident to the Project Manager</li> <li>Document in MANA/NOTES</li> </ul> </li> <li>If a bfy reports a HIPAA violation                     <ul style="list-style-type: none"> <li>Ex. Receives another bfy's notice</li> <li>Email the details of the incident to the Project Manager</li> <li>Document in MANA/NOTES</li> </ul> </li> </ul>  <p>MAXIMUS  <small>MAXIMUS CORPORATION</small>          HIPAA 2011 17</p>

**Exhibit 9.5-2: HIPAA Training Slides.** *Our comprehensive training program has served us well in successfully adhering to HIPAA regulations, and it is uniquely tailored to Vermont-specific issues.*



**Exhibit 9.5-7: Risk Assessment Model.** *By carefully analyzing risk, we can build comprehensive risk mitigation strategies to prevent security breaches and other disastrous situations when possible and respond and recover quickly when unavoidable. This model is flexible and serves both our security management and disaster recovery planning efforts.*

The combined risk rating categories include:

- **Intolerable Risk:** A high probability of occurrence and the consequence would have significant impact on schedule, and/or project outputs and objectives. These risks constitute the top priority for the project and require an immediate change in current program activities to reduce or eliminate the risk. Immediate management attention is required.
- **High Risk:** A high probability of occurrence and the consequence would negatively affect project objectives and schedule. The probability of occurrence is high enough to require close control of all contributing factors, the establishment of risk actions, and an acceptable fallback position. High risk alerts the Project Director to a potentially serious risk. Mitigation strategies and milestones are established. Program changes and careful monitoring are required.
- **Medium Risk:** Probability of occurrence is high enough to require close control of all contributing factors. Mitigation strategies and milestones are established along with careful monitoring.
- **Low Risk:** Minor effects on project objectives and operations, and the probability of occurrence is sufficiently low to cause only minor concern. Problems are not anticipated, but monitoring is required. If the risk assessment increases, mitigation strategies are established.

- **Tolerable:** Risk is identified as having little or no effect or consequence on project objectives and the probability of occurrence is low enough to cause little or no concern. No action is required beyond normal management attention.

We identify vulnerabilities, threats, and risks to maintaining a secure environment that conforms to state and federal requirements for confidentiality and security of PHI and EPHI. We categorize risks as to level of tolerance, probability of occurrence, and impact on operations. After analyzing these risks, we develop appropriate mitigation strategies to help us prevent security issues, if possible, and react swiftly when necessary.

Our corporate Office of Quality and Risk Management supports projects as they develop their risk assessment and mitigation strategies in response to both security and disaster recovery needs.

### 9.5.2 Submitting Final Security Plan

We will finalize our existing security plan, incorporating all state, federal, and HIPAA requirements, and submit for DVHA approval prior to contract execution.

### 9.5.3 Security Checks

We understand that DVHA may wish to conduct security checks from time to time, and you will have our full cooperation in helping ensure that beneficiaries' confidential information is safeguarded against unauthorized electronic and physical access.



**We encourage DVHA representatives to conduct security checks, as you deem appropriate, and we will cooperate fully to help ensure all security protocols are being met.**

## 9.6 DISASTER RECOVERY AND BUSINESS CONTINUITY PLAN

RFP Section 10.15.6, page 40

In the event of a natural disaster and unnatural disasters, including but not limited to hacking and acts of terrorism, the bidder must have procedures for assuring completion of the Scope of Work. In the response to the RFP, bidder must describe its general approach to disaster recovery and business continuity. During implementation, Bidder must submit for approval to State a Disaster Recovery and Business Continuity plan that is suitable to the services being provided.

Comprehensive planning for responding to disasters and emergencies is not optional for our health and human services projects. The Department of Vermont Health Access (DVHA) has recognized the importance of having a Disaster Recovery/Business Continuity (DR/BC) Plan in place to continue to provide important member services under this contract, and MAXIMUS is in full compliance with these requirements.

Being able to access health care programs during difficult circumstances brought on by natural or manmade disasters is extremely important and critical to Vermont beneficiaries and to DVHA as they embark upon new initiatives for Green Mountain Care. MAXIMUS has the expertise, experience, and commitment to provide a comprehensive DR/BC Plan to address DVHA's concerns and requirements.

### Procedures for Completing Scope of Work

DVHA has come to understand the importance of developing appropriate responses for continuity of operations for Green Mountain Care Member Services, and MAXIMUS meets your requirements with established best practices, corporate support, and proven strategies, summarized in *Exhibit 9.6-1: Approach to DR/BC for Scope of Work*.

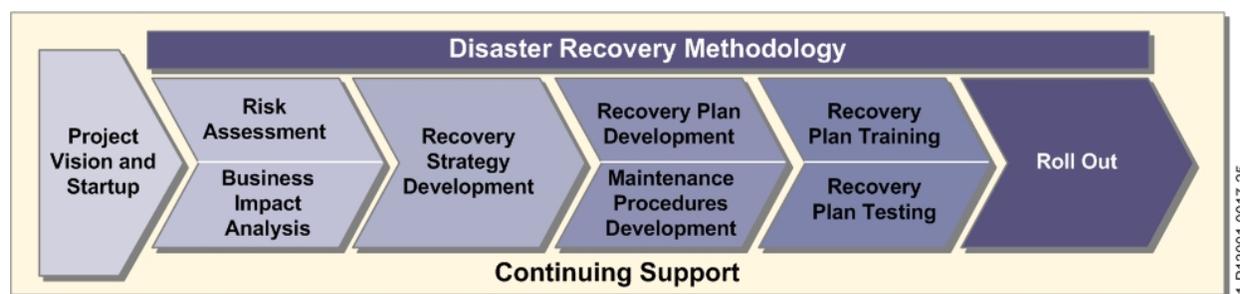


**Careful, thorough disaster recovery and business continuity planning provides a foundation for prevention and appropriate response to service disruptions that could affect Vermont beneficiaries.**

them is nothing short of a meticulously planned strategy for preventing, responding to, and recovering from catastrophic events of all degrees. Our corporate best practices dictate that our corporate office, data centers, and project offices maintain valid DR/BC Plans. We will use our considerable expertise, resources, and experience to further develop and finalize our existing Plan for Green Mountain Care Member Services.

### 9.6.1.1 Plan Creation Methodology

Our DR/BC Plan creation methodology minimizes risks by combining thorough planning with an analysis of mission-critical business processes and requirements. This methodology has been used in formulating DR/BC Plans for our health and human services projects, providing the strategies to support critical business functions and recovery following a declaration of a disaster, as illustrated in *Exhibit 9.6-2: Disaster Recovery Planning Methodology*.



**Exhibit 9.6-2: Disaster Recovery Planning Methodology.** Our methodology is based on an industry-standard approach, providing DVHA a realistic approach to a comprehensive plan for continuity of operations and recovery following disaster.

The components of our DR/BC methodology include:

- Our DR/BC planning begins with the *Project Vision and Startup* phase. In this phase, we work with our clients—in this case DVHA—to define expectations, requirements, and objectives that make up the contract scope. We carefully review the agreed-upon scope to understand the key functions that must be included in the DR/BC Plan.
- During *Risk Assessment* and *Business Impact Analysis*, we perform a thorough risk assessment in order to identify existing and potential physical, environmental, and operational issues that could threaten operations or result in a declaration of disaster. We determine what hardware and software assets, functions, activities, and personnel resources are required to sustain operations until service is restored. We identify vulnerability, threats, and risks, and we quantify the impact of an outage or catastrophe on project operations. This phase is within the generally accepted review process, as endorsed by the Disaster Recovery Institute and Association of Contingency Planners and specified in NFPA 1600. We follow the same methodology for analyzing risks, as presented in *Section 9.5: Security Plan*, for evaluating and assessing risks associated with disastrous events and outages.
- Following the risk assessment is a phase commonly referred to as *Recovery Strategy Development*, during which specific alternatives are outlined and discussed with senior management and DVHA. During this phase, each element of the risk assessment document is reviewed and options for recovery are detailed with resource level requirements defined for each alternative. This document is then used by management and our state client to determine what level of response is appropriate for each potential risk factor.

- In *Recovery Plan Development*, we produce a Plan that guides the project through the recovery of critical business activities in the event of a major disruption or emergency event. Deliverables include processes and procedures to support disaster recovery, such as response procedures, assessment requirements, operational requirements, restoration procedures, and details regarding recovery teams and specific tasks for each team.
- During *Maintenance Procedures Development*, we develop and document events to trigger recovery plan options, develop and document recovery plan update procedures and responsibilities, develop testing strategies, and integrate with change management procedures.
- We develop training materials, conduct recovery team training, and conduct staff awareness and management training as part of *Recovery Plan Training*. Employee Emergency Response Training includes:
  - Emergency response contact lists and telephone lists
  - Employee roles and responsibilities, including a well-defined chain of command
  - Facility maps and evacuation plans and procedures for accounting for all personnel and visitors upon completion of evacuation
  - Rescue and medical duties for assigned personnel and procedures for reporting medical emergencies
  - Procedures for employees responsible for shutting down critical applications or equipment
  - Procedures for contacting outside organizations, such as 911, utility companies, equipment vendors, and data and voice services vendors
  - Schedules for Plan testing and evacuation/emergency response drills
- *Recovery Plan Testing* provides testing to verify that the Plan works in scenarios that approximate real potential events.
- In the final phase, we *rollout* our DR/BC Plan during the implementation phase. We make our DR/BC Plan available to key personnel and DVHA, and store electronic and hard copies of it offsite, including at our corporate office and the homes of key management staff. In addition, we make it available online to our staff on the Knowledge Base (KB) system.



**Training our staff on DR/BC procedures, their roles and responsibilities during a crisis situation, and emergency and safety measures helps us ensure appropriate actions are taken in response to disruptive events.**

### 9.6.1.2 Plan Components

Our DR/BC Plans contain several components that are key to addressing project and contractual requirements for handling disruptive events and outages. These will all be customized to specifically meet DVHA requirements and include:

- **Prevention Strategies.** Part of our DR/BC planning process is developing a comprehensive strategy to prevent or avoid those events that are within our control to do so, thereby allowing us to maintain the trust of and continuity of services to Vermont beneficiaries and

applicants. By focusing on prevention, we can mitigate risks to data and network security for Green Mountain Care Member Services, such as virus attacks, security breaches, intentional or unintentional damage, and loss of data. Some of our prevention strategies include:

- **Security Measures.** As presented in *Section 9.5: Security Plan*, policies regarding physical and data access levels, virus protection, user account management, network monitoring, and environmental controls and alarms for data center equipment all contribute to a reduced potential for disastrous events that we have some control over preventing.
- **Data and Equipment Backup.** Key to our ability to recover from a disruption in operations is a comprehensive backup and recovery strategy that covers mission-critical data, systems, services, and facilities. After identifying critical roles, processes, and technologies, and ranking them according to priority for recovery, we define specific backup and recovery actions and timeframes for each. Our backup strategies for all mission-critical systems and servers provide some level of prevention in that key files that may be accidentally or intentionally destroyed or corrupted can be quickly retrieved without suffering any undue "down time" or degradation to service delivery.
- **Staff Education.** Educating our staff on the importance of preventing and mitigating potential risks to operations provides us with observational insight into the daily activities of all departments of the Green Mountain Care Member Services. All staff, as well as the corporate employees who provide additional systems and infrastructure support, are trained to spot signs of potential trouble and report it to project management. Employees and contractors are also trained to understand the most appropriate response—early on—to help minimize damage, data loss, or other risk.
- **Threat assessment.** A key step in fully developing our response to potential causes of service disruption to Green Mountain Care Member Services operations is threat assessment. *Exhibit 9.6-3: Threat Assessment Matrix Pinpoints Potential Threats* summarizes the types of threats we analyze for many of our projects that are similar in scope to Green Mountain Care Member Services. This will be used as a model for developing a similar assessment for the project and made part of our final DR/BC Plan.



**Maintaining continuity of operations during outages, service disruptions, and other threats to service delivery requires careful planning, collaboration, technical design expertise, training, testing, and effective risk management strategies.**



## MAXIMUS is prepared

*Our call centers have been tested by real-life disasters including the 9/11 terrorist attacks in New York and Hurricane Isabel in Virginia*

On September 11, 2001, MAXIMUS employees were at work a few blocks away from the World Trade Center at our New York Medicaid CHOICE project. Our Disaster Recovery Plan was immediately activated, and all 220 employees were safely evacuated from the area. The very next day, senior project staff worked with corporate staff to transfer call center phone lines, move computers and other equipment, and establish an alternate site in Brooklyn. By September 13, MAXIMUS had relocated much of the project team to the new site and continued to provide the same performance, high quality service delivery until we could return to our office in Manhattan.

In September 2003, Hurricane Isabel disabled our Virginia Enrollment Broker Services office in Richmond, Virginia. All power was lost for several days and streets were impassable due to flooding and debris. Using a previously tested Disaster Recovery Plan, all customer service calls were routed to the designated disaster recovery call center site where previously-trained Customer Service Representatives were able to assist callers and access the necessary Virginia state systems.

Our comprehensive analysis, planning, risk mitigation and appropriate responses to threats and disruptions in business have been tested and proven. Lessons learned from these disasters are now included in our standard Disaster Recovery Plans, but, more importantly, our people have demonstrated our firm commitment to uninterrupted service to our customers.

**Exhibit 9.6-7: MAXIMUS Disaster Recovery Experience.** *Our disaster recovery experience makes us a reliable source for providing support to disaster recovery efforts.*

In addition to our response to disasters affecting our projects, we have also helped our state clients during some catastrophic situations. For example, when Hurricane Ike struck Texas coastal areas in 2008, MAXIMUS employees in our Texas Eligibility Support Services project rallied to make certain that services to the Texas consumers we serve continued without interruption. Our document processing employees worked throughout the weekend to process mail and image, ensuring that the Hurricane Food Stamps applications were processed in an expedited fashion, helping victims of the hurricane as they struggled to deal with the devastating event.

### Summary

Our DR/BC approach for Vermont is to enhance and finalize our existing Plan during the implementation phase to help ensure that it meets the agreed upon recovery time objectives while

minimizing the disruption in services to Green Mountain Care beneficiaries. We look forward to DVHA's input and collaboration on the DR/BC Plan.

As your current partner in providing these important services, we are the lowest risk choice because we already know how the program works and have identified and understand what can go wrong and what is risky in terms of threats to our operations. We have strong corporate support, established best practices, and a proven solution for helping to ensure continuity of operations. These are key elements that provide DVHA the peace of mind to go forward with upcoming challenges without having to worry about operations for Green Mountain Care Member Services.

## 9.7 DATA MANAGEMENT AND USE

Successfully managing and exchanging data with the State and other key contractors is an important consideration for providing Green Mountain Care Member Services. Maintaining data integrity and security are of primary importance, and we take this responsibility seriously. Serving Vermont beneficiaries in a timely fashion, with accurate data, can mean the difference between having or not having access to health care services. MAXIMUS knows the State systems currently in use, and will continue to help beneficiaries obtain the services for which they are eligible.

### 9.7.1 Receiving and Protecting Data

RFP Section 10.15.7, page 40

Contractor will be accessing and managing large volumes of confidential and sensitive data. State will authorize user access to eligibility, claim, and provider information in the Eligibility Determination, MMIS and PBM systems. Contractor will also be in receipt of data files comprised of large volumes of confidential data from multiple systems. At a minimum, but not necessarily limited to.

- a. State will electronically transmit to the Contractor a daily notice file that will include notification of initial enrollment, reminder for outreach, enrollment, non-enrollment, auto assignment, reinstatement, transfer, Primary Care Plus PCP change, open enrollment and disenrollment notifications.
- b. State will electronically transmit a monthly cohort file to the Contractor of individuals being asked to join managed care.
- c. Contractor will receive from Vermont's Fiscal Agent Contractor electronically transmitted files of providers, including PCP's and specialists.
- d. Contractor will receive from DVHA an electronically transmitted file of Green Mountain Care Outreach Contacts.
- e. Vermont data cannot be made available to anyone without specific authorization from the State.

MAXIMUS acknowledges the security requirements of the State and associated systems for providing Green Mountain Care Member Services. In partnership with the State since 1996, MAXIMUS has established protocols for accessing and managing confidential and sensitive data. Whether accessing data directly or receiving files using secure File Transfer Protocol

### Katie's Story

Due to a delay with her address updates, Katie, of Burlington, never received her 6-Week Eligibility notice or her Second Reminder notice. She had responded to all other requests for information. Her coverage was set to close in less than one week for failure to review. Our staff noticed the pending closure, as well as the failure of the Notices to be sent. She alerted her supervisor to contact the State's Administrative Operations (AOPS) to request an eligibility extension to prevent a lapse in coverage. The issue was resolved within 35 minutes, and Katie's coverage continued without interruption.

(FTP), we successfully receive, and will continue to receive, the data necessary to maintain the processing and delivery of benefits to Vermont beneficiaries.

## 9.7.2 Accessing and Receiving Data

RFP Section 10.15.7, page 41

Bidder must describe:

- a. the data that will be needed to perform the Scope of Work, how it will be used and by whom.
- b. whether Bidder anticipates accessing the data through user accounts on other systems or by receiving data to populate Bidder's database.
- c. for data received into Bidder's system:
  - where the data will be physically stored
  - how Bidder will validate the data received
  - how the State's data will be segmented and isolated from other data
  - who will have access to the data
  - how the data will be secured and backed up
  - how the data will be turned over to State at the end of the engagement
  - how Bidder will purge all record of the data from its systems at the end of the engagement.

Note: As appropriate in answering the above questions Bidder may reference its Security and/or Disaster Recovery and Business Continuity Plans, but all responses must be easily found and readily available for evaluation of proposals, and clear and pertinent as they relate to this engagement.

In this section we present our approach for using, accessing, and managing data for Green Mountain Care Member Services.

### 9.7.2.1 Data Needed to Perform the Scope of Work

The data needed to perform the Scope of Work is predominantly in the eligibility determination system known as ACCESS, the Medicaid Management Information System (MMIS), and the Pharmacy Benefits Management system (PBM). Our MAXSTAR system serves as a transfer intermediary for files that are sent back and forth to the State of Vermont and the fiscal agent. The notices file from ACCESS and provider file from the MMIS are loaded into MAXSTAR. Customer tracking information is also in MAXSTAR. We use this data to perform education, enrollment and other member services functions. *Exhibit 9.7-1: Data Used to Perform the Scope of Work* summarizes the data used by Green Mountain Care Member Services, the source of the data, how it is used, and who uses it.

### **9.7.2.3.2 How We Validate the Data Received**

When we receive files, we perform validation checks to determine if there was a problem with the transmission. These validation checks include:

- Date in filename
- Trailer record present
- Number of records in trailer record match number of records in file
- Processing date in the trailer matches date in file name
- Data records match provided format

These checks are run in MAXSTAR, and if any discrepancies are noted, they are manually checked for accuracy. All incoming data checks are logged by the Systems Administrator and/or the Mailing Coordinator and any legitimate discrepancies are brought to the attention of either the Systems Administrator or the Project Director for review and remediation.

### **9.7.2.3.3 How the State's Data Will Be Segmented and Isolated From Other Data**

We access most State data directly within State or State contractor systems. This method of accessing data provides the State with control over how data is segmented. We use our customized desktop integration software, MAXDash, to provide a front-end for accessing multiple State databases and systems.

Only limited State data is stored in MAXSTAR. We developed and customized MAXSTAR to serve as a database management system. The management features of MAXSTAR allow us to maintain the State's data in separate sections of the MAXSTAR database. The information is protected from access by unauthorized individuals and is kept separate from information that is not a part of Green Mountain Care Member Services operations.

### **9.7.2.3.4 Who Will Have Access to the Data**

Only authorized Green Mountain Care Member Services staff has access to the State's data. Limited access is also granted to selected, authorized corporate OIS staff solely for the purposes of maintaining the system in Reston. Staff access to customer data in MAXSTAR is based on job responsibilities and is administered based on user login and password.

Access to external data also requires a separate user login and password. Our integrated desktop tool, MAXDash, requires staff to enter individual login credential for each system to be accessed. In

*Section 9.5: Security Plan*, we present further information about how we limit access to data. Our established policies and procedures govern access to Protected Health Information (PHI) and Electronic PHI (EPHI) in accordance with DVHA, State, Federal, including HIPAA, and other applicable requirements.



**Only authorized staff members are allowed access to Green Mountain Care Member Services data, including PHI and EPHI**

### **9.7.2.3.5 How the Data will be Secured and Backed Up**

All data transmitted to the State is over our secure connection through our corporate network to the Internet, using Virtual Private Network (VPN) tunnels. Our corporate network is protected

using firewalls and stringent Internet border security. Additionally, there are two Checkpoint NGX R65 firewall servers at our Burlington office to protect our internal network as an additional safeguard for protection of PHI. Our network is further divided into three separate virtual LANs, with our local firewall directing traffic between them. Network servers, telecom servers, and the users are on separate networks in order to further isolate and minimize the effects of any potential security breach. Firewall security and rules are maintained by our corporate OIS Security and Audit team.

When connecting to State systems that contain PHI, we employ a site-to-site VPN to maintain the security of that data. Our VPN uses IPsec to create an encrypted tunnel between MAXIMUS and the State of Vermont's network through the Internet. The tunnel is encrypted with 256-bit AES algorithm, the standard used for the U.S. government for securing classified information. This connection is managed and maintained by State network security staff and by our own OIS network security staff.

Finally, for additional security we employ Palo Alto web-blocking software. This software blocks thousands of websites that could both potentially harm computers via malware, and allows us to minimize our bandwidth overhead by removing things such as streaming media from the network.

All networked systems located at Green Mountain Care Member Services are joined to the Active Directory network. From there, they are centrally managed via Group Policy to adhere to strict MAXIMUS security protocols and standards. As they are all on the same network, we can quickly update security settings in the event modifications are needed.

For enhanced security our domain controllers also run Windows Server Update Services (WSUS). WSUS, in conjunction with Group Policy, allow us to push security updates out to workstations on demand, quickly fixing potential security risks. Updates are reviewed daily and pushed to workstations when applicable.

One advantage of hosting our MAXSTAR system, as well as our KB system, at our corporate headquarters is that nightly backups are automatically performed and stored at a secure, offsite storage facility. Backup success is monitored by corporate technical staff, and any issues are addressed upon discovery. In addition to nightly backups, we have weekly and monthly backups for purposes of archival and quick restoration, as needed.

Further information about security and back up can be found in *Section 9.5: Security Plan* and *Section 9.6: Disaster Recovery and Business Continuity Plan*.

#### **9.7.2.3.6 How the Data will be Turned over to State at the End of the Engagement**

MAXIMUS project management policies require that every project that has reached the end of its lifecycle create a close-out plan. As part of the plan, we determine a budget that is approved

#### **Web Page Blocked**

Access to the web page you were trying to visit has been blocked in accordance with company policy. If you believe you have received this message in error, please submit a FixProb ticket to report the problem and include a screenshot, the URL, and a brief explanation of why the category is incorrect. You may also call the MAXIMUS Hotline at 888.349.7762.

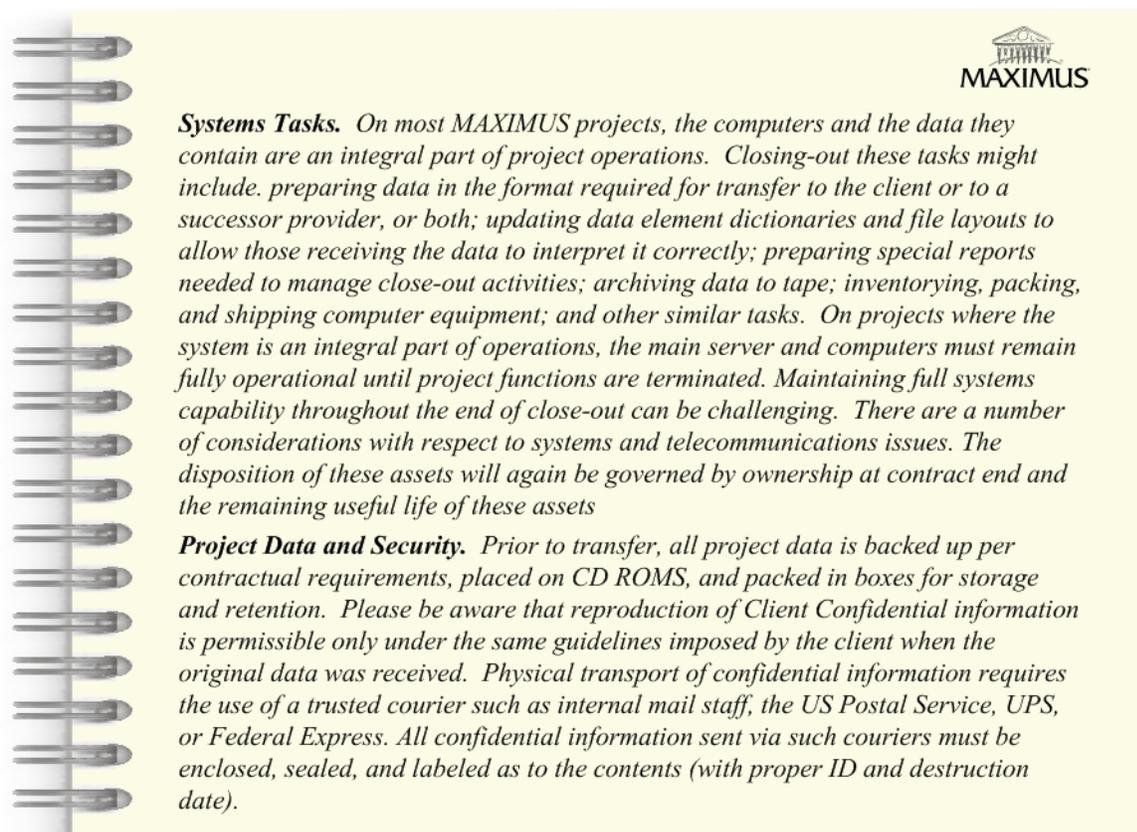
User: maximus\09023

URL: www.facebook.com/

Category: block-ist

**We use Palo Alto software to help us block sites which may be the source of malware or other security risks to our network.**

by both the State and MAXIMUS management. As shown in *Exhibit 9.7-2: Corporate Project Close-Out Policy*, MAXIMUS has set guidelines for closing out a project.



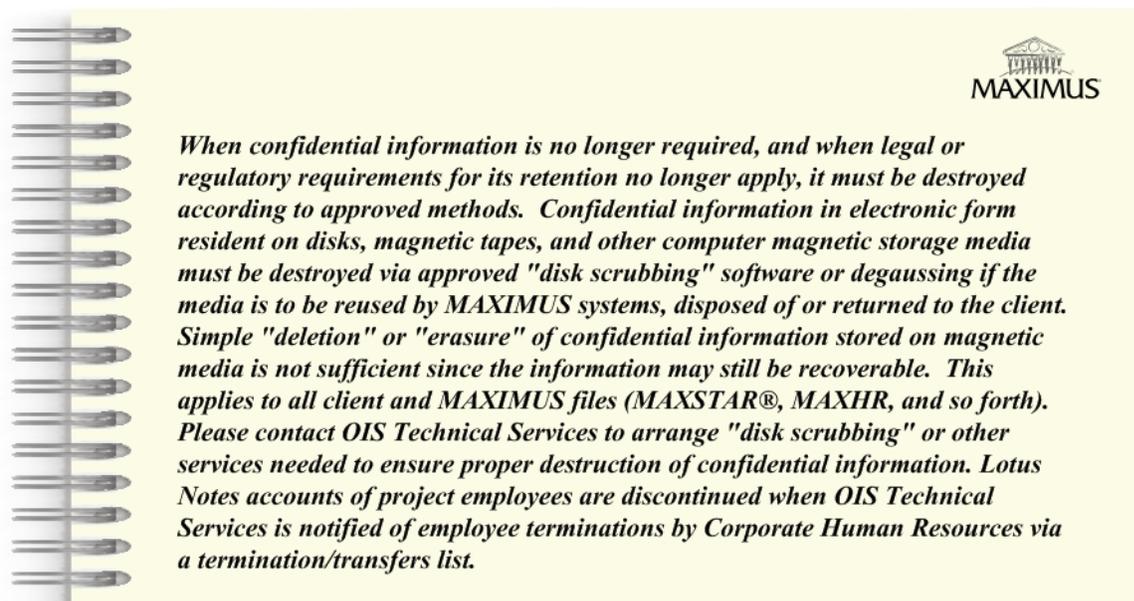
**Exhibit 9.7-2: Corporate Project Close-Out Policy.** MAXIMUS has clearly defined guidelines for how to close out a project, including turning data over to the State.

While we store minimal data in our systems presently, we understand that data turnover must conform with any additional contract requirements and state and federal laws. Consideration is given to any need for retention of data pertaining to ongoing litigation or audits. We will collaborate with DVHA to turning over required Green Mountain Care Member Services data at the end of the contract.

#### **9.7.2.3.7 How Bidder Will Purge All Record of the Data From Its Systems at the End of the Engagement**

In line with federal regulations concerning PHI and EPHI, MAXIMUS will destroy, or return to the State, all PHI, EPHI, and other data associated with providing Green Mountain Care Member Services, as deemed appropriate by DVHA, within 30 days following the end of the contract. We will provide written certification that we have returned or destroyed all PHI and EPHI.

MAXIMUS maintains corporate procedures for purging data. *Exhibit 9.7-3: Corporate Data Purging Policy* displays MAXIMUS procedures and policies as stated in our Project Management Manual.



**Exhibit 9.7-3: Corporate Data Purging Policy.** Having a previously created policy for purging data at the end of a contract facilitates a smooth turnover process.

This policy aligns with our Information Security Policy. In collaboration with DVHA, MAXIMUS will define Vermont-specific procedures for purging data at the end of the engagement.

#### 9.7.2.4 Referring to Other Sections

This proposal section provides our response to RFP Section 10.15.7: Data Management and Use. To provide more detail about some points, we have referred readers to other sections within our proposal. Specifically, we refer to the following sections:

- *Section 9.3: Software and Database Management System (DBMS)*
- *Section 9.4: Network Connectivity, State System Access and Interfaces*
- *Section 9.5: Security Plan*
- *Section 9.6: Disaster Recovery and Business Continuity Plan*

All of our responses are clearly documented and readily available.

division brings expertise in multiple development platforms, including J2EE, .NET, and Oracle Forms.

### 9.8.3 State Human Resources to Support Technology

As your reliable partner, MAXIMUS proudly supports Vermont's ongoing mission to transform State health care to contain costs and provide comprehensive, affordable, high-quality, health care coverage for all Vermont residents. However, we also recognize that achieving health care reform through complex coordinated efforts places an extremely high demand on limited State resources, including IT human resources. Our team is able to problem solve within the project setting to increase efficiency, using the tools we already have to better our technology solution and doing so without the use of State human resources. Having already established and tailored Green Mountain Care Member Services systems infrastructure and operation to Vermont's programs, MAXIMUS demands on State human resource and IT support will be at an absolute minimum.

Our MAXSTAR system already incorporates the functionality desired by DVHA, having been tailored to fit Vermont's work flow and unique business rules. We have been able to adapt MAXSTAR through modification of business rules and data tables for any requests from the State and will continue to do so to meet requirements in the new contract period. Our plans to relocate MAXSTAR hosting to our corporate offices in Reston likely requires some work with State IT resources, but we anticipate this effort will take no more than two weeks and will require short-term support from only one or two State staff resources.

**Having an established and tailored Green Mountain Care Member Services systems infrastructure and operation, MAXIMUS demands on State human resources will be at an absolute minimum.**

MAXIMUS has gained an appreciation of the importance of a flexible and modern technology platform. We have also learned the importance of using an advanced technology platform effectively. By closely aligning technology and business operations, we achieve the efficient technical improvements and staff realignments needed to provide cost-effective, yet customer-focused service delivery. If effective performance of the project's ongoing scope of work necessitates involvement of State resources for any technology-related tasks, the MAXIMUS Vermont project experience and systems expertise enables us to the reduce the burden on State staff, optimize limited resources, and identify tactical ways for the State to save money.

### 9.9.3 Monitoring Performance

RFP Section 10.15.8.c, page 42

methods to be employed for measuring and monitoring metrics, and for reporting to State system problems which negatively impact performance of the Scope of Work along with Bidder's approach to remediating performance problems.

Our OIS Security and Audit team within the Reston data center is responsible for continuous network monitoring and intrusion testing, anti-virus protection, data security, and comprehensive data archival processes. This team's role includes system security administration as well as security assessments and reviews to ensure that corporate data assets are safeguarded. The team continuously evaluates and assesses our capabilities and requirements to ensure the security of client data entrusted to MAXIMUS. Our data center physical security and environmental controls have passed numerous operational reviews that include the Statement on Auditing Standards Number 70 (SAS-70), Defense Information Technology Security Certification and Accreditation Process (DITSCAP), and Sarbanes-Oxley audits.

Monitoring of data connectivity and mission-critical servers is another important component of our plan for maintaining the highest level of productivity for the Green Mountain Care Member Services. Our OIS Network Operations staff uses Computer Associates eHealth to monitor data circuits to and from the Burlington office 24x7 for connectivity, bandwidth utilization, and other key performance indicators. Key operations technicians and management receive cell phone text messages and email notifications when our monitoring service detects connectivity issues with the network data circuits and routers in Burlington. This service allows us to respond quickly at any time, so that we can maintain our offices at a high level of operation.

We also use the Computer Associates eHealth software suite to establish a baseline for network activity and bandwidth usage for each location on our network backbone. Each project site automatically generates reports on a weekly basis, which our Cisco-certified network engineers analyze. These reports allow us to determine proactively the best operational bandwidth and usage for each location, based on historical trending data, and to plan accordingly for upgrades or changes to the network. We perform all non-routine maintenance and file updating activities before or after business hours and on weekends to avoid the potential for disrupting network and system operations.

MAXIMUS understands that when problems occur that may affect system accessibility, communication with DVHA is our highest priority. We follow approved protocols for notifying DVHA of any unplanned, unscheduled call center down time that negatively affects our performance and prevents us from fulfilling the contractual scope of work. In the event of any issues that affect callers' ability to contact the call center, our Systems Administrator and Operations Manager keep the Project Director informed. The Project Director notifies the appropriate DVHA Contract Manager and other pertinent stakeholders throughout the duration of any interruptions in services until they are fully resolved. Any such issues are documented in our weekly/monthly reports to the State.

We also follow a structured approach for remediating performance problems that entails developing a remediation plan to address and mitigate any threats to our systems. For example, we use remediation tools to automate the delivery of patches and hot fixes to ensure that threats and vulnerabilities are addressed promptly. Mitigation efforts are monitored and evaluated by the OIS Security and Audit team to assess their effectiveness.

# MAXIMUS INC (MMS)

## 10-K

Annual report pursuant to section 13 and 15(d)

Filed on 11/19/2010

Filed Period 9/30/2010



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**UNITED STATES  
SECURITIES AND EXCHANGE COMMISSION**  
Washington, D.C. 20549

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**FORM 10-K**

**ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF  
THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended September 30, 2010

Commission file number: 1-12997

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**MAXIMUS, INC.**

(Exact name of registrant as specified in its charter)

**VIRGINIA**

(State or other jurisdiction of incorporation or organization)

**54-1000588**

(I.R.S. Employer Identification No.)

**11419 Sunset Hills Road, Reston, Virginia**  
(Address of principal executive offices)

**20190**  
(Zip Code)

Registrant's telephone number, including area code: **(703) 251-8500**

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Name of each exchange on which registered
Common Stock, no par value	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: **None**

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes  No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes  No

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes  No

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes  No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K.

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, or a non-accelerated filer. See definition of "accelerated filer and large accelerated filer" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer

Accelerated filer

Non-accelerated filer   
(Do not check if a smaller reporting company)

Smaller reporting company

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes  No

The aggregate market value of outstanding voting stock held by non-affiliates of the registrant as of March 31, 2010 was \$925,056,016 based on the last reported sale price of the registrant's Common Stock on The New York Stock Exchange as of the close of business on that day.

There were 17,210,381 shares of the registrant's Common Stock outstanding as of November 1, 2010.

**DOCUMENTS INCORPORATED BY REFERENCE**

Portions of the registrant's definitive Proxy Statement for its 2011 Annual Meeting of Shareholders to be held on March 18, 2011, which definitive Proxy Statement will be filed with the Securities and Exchange Commission not later than 120 days after the end of the registrant's fiscal year, are incorporated by reference into Part III of this Form 10-K.

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MAXIMUS, Inc.  
Form 10-K  
September 30, 2010

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## PART I

### ITEM 1. *Business.*

#### General

We provide business process outsourcing services to government health and human services agencies under our mission of *Helping Government Serve the People*.<sup>®</sup> Our business is primarily focused on administering government-sponsored programs such as Medicaid, the Children's Health Insurance Program (CHIP), health care reform, welfare-to-work, Medicare, child support enforcement and other government programs. Founded in 1975, we are one of the largest pure-play health and human services administrative providers to governments in the United States, Australia, Canada and the United Kingdom. We use our expertise, innovative business processes and advanced technological solutions to help government agencies run efficient, cost-effective programs and to improve program accountability, while enhancing the quality of services provided to beneficiaries.

Our core health and human services business has benefited from steady demand over the last five years. We have not experienced any material adverse change in demand as a result of government budgetary pressures. We believe the critical nature of our services in helping governments provide and administer important safety net programs in the United States, such as Medicaid, welfare-to-work and CHIP, to the most vulnerable populations helps insulate our services from significant downward pressure, particularly during an economic downturn. We also administer several international government-sponsored health and human services programs, most notably welfare-to-work, to help people find employment and achieve self-sufficiency in Australia and the United Kingdom. Favorable legislation and austerity measures that seek to help governments run more efficiently and cost effectively will continue to create demand for our core services.

During fiscal 2010, the Company acquired DeltaWare, an eHealth business in Canada, and sold the non-strategic ERP business unit. In fiscal 2008, MAXIMUS acquired a workforce services business in the United Kingdom and divested five non-core business units. These transactions were designed to allow the Company to better focus on its core health and human services businesses, as well as expand our geographic presence and enhance our service offerings through complementary acquisitions. For more details on these transactions, see "Note 3. Acquisition" and "Note 21. Discontinued Operations" within Item 8 of this Form 10-K.

For the fiscal year ended September 30, 2010, we had revenue from continuing operations of \$831.7 million and net income from continuing operations of \$69.4 million.

#### Market Overview

We expect that demand for our core health and human services offerings will continue to increase driven by new legislation, austerity measures and increasing caseloads as governments strive to deliver more services with fewer resources. New legislation such as the Affordable Care Act (ACA) in the United States and welfare reform initiatives abroad has created increased demand for our services and should continue to create increased demand for our services over the next several years. We believe that we remain well-positioned to benefit from this increasing demand as governments look for ways to improve overall program efficiency and achieve value for funds spent on social programs.

Demand for our services is contingent upon factors that affect government, including:

- The need for state governments, which run federally mandated and federally funded programs such as Medicaid and CHIP, to deliver efficient, cost-effective services to program beneficiaries while meeting requirements to maintain federal matching funds.
- The requirement of state governments to implement federal initiatives, such as the ACA (health care reform), which will expand health insurance coverage to millions of Americans.
- The impact of continued budgetary pressures, which compels governments to operate more programs with the same level of resources and/or implement austerity measures as a method to address rising costs associated with social benefits programs.
- The need to improve business processes, innovate, and update technology. In the United States, governments are likely to seek outside sources as they face the possibility of an increasing number of government workers eligible for retirement, coupled with the stovepipe systems and antiquated processes that cannot scale effectively to support projected caseload growth.

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As a result, governments utilize business process outsourcing companies, such as MAXIMUS, to help them deliver efficient, cost-effective services to beneficiaries on their behalf. MAXIMUS possesses the knowledge and resources to efficiently operate government health and human programs and maintain requirements to achieve the maximum ongoing federal funding. With the ability to tightly balance resources with demand, MAXIMUS also offer flexibility and scalability that governments do not always possess.

### *Health Services Market Environment*

Over the past decade, health care costs have substantially risen in the United States, a trend likely to continue over the long term. U.S. health care spending, among the highest of all industrialized countries, is increasing at a rate that outpaces inflation and national income growth. Stemming these costs as well as improving quality and access to health care is a major policy priority for government.

As a result, in March 2010, Congress passed the Affordable Care Act (ACA), a comprehensive overhaul of the health insurance system in the United States that initially seeks to expand beneficiaries' access to health care, while ultimately improving quality and reducing overall costs of health care delivery. Most notably, ACA aims to expand health insurance coverage to over 30 million Americans in 2014 and beyond, primarily by expanding the Medicaid program through federal matching funds to cover more low-income individuals and families. In the interim, state fiscal realities have also prompted the expansion of Medicaid managed care to new populations — including the aged, blind and disabled populations — that have historically been served through fee-for-service Medicaid. Although these populations represent only 30% of the Medicaid population, they are responsible for approximately 70% of the costs. We believe we are well-positioned to benefit from the expected volume increases associated with Medicaid expansion due to our existing client base of states where we serve as the administrative enrollment vendor for 13 Medicaid managed care programs, which is 64% of the market served by third party administrators. ACA also extends CHIP through 2019, provides increased matching federal funds, and guarantees funding through 2015. We currently serve as the administrative vendor for CHIP in five states, which comprises approximately 68% of the market served by third party administrators.

The law also promotes the integration of new health insurance exchanges with existing state Medicaid and CHIP programs to provide for “no wrong door” of entry for program beneficiaries. A health insurance exchange is an insurance marketplace where individuals and small businesses can shop, compare and buy affordable and qualified health benefit plans. As a consequence, and in light of persistent budget pressures, state priorities now include the modernization of eligibility and enrollment processes for public health insurance programs such as Medicaid and CHIP. The goal of these modernization efforts is to improve access to health insurance for beneficiaries by simplifying and streamlining the eligibility and enrollment process, and allow for the seamless movement of subsidized populations among the various programs. We are currently supporting efforts in Colorado and New York to modernize their eligibility and enrollment processes for their subsidized health insurance programs. These programs may serve as the model as these states seek to set up their health insurance exchange to meet the ACA requirement of establishing an operational health insurance exchange by January 1, 2014. Many of the functions of a health insurance exchange are similar to the functions that we provide under Medicaid and CHIP: consumer outreach and education, eligibility and enrollment, customer contact centers, and comprehensive business process managed services to help beneficiaries navigate the new health insurance exchanges.

Other important features of ACA include funding for long-term care allowing states to offer home and community based services to elderly and disabled individuals through Medicaid rather than institutional care in nursing homes. As the population continues to age there is an increasing demand for quality and cost effective, long-term care in the least restrictive environment.

ACA also includes enhanced consumer protections for health insurance appeals. The law requires an independent, evidence-based external review process and the option for individuals to appeal coverage determinations or claims to insurance companies. This expands the requirement to ERISA plans which previously were not required to have an objective independent health appeals process. We are one of the largest providers of evidence-based health insurance appeals to Medicare and over 30 state agencies.

We believe the current health environment positions us to benefit from demand as governments must meet the requirements established under ACA. We believe states may be challenged to achieve these requirements and, as a result, are turning to business process outsourcers such as MAXIMUS to provide repeatable processes, proven solutions and consumer-friendly services. Overall, we expect the underlying demand for our services to increase due to the fundamental need for governments to provide these services to beneficiaries on an expanding and ongoing basis.

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### *Human Services Market Environment*

The Human Services market has experienced increased demand driven by the need for governments to reduce costs and improve efficiency. The most dynamic portion of the market is in the welfare-to-work area where governments worldwide are seeking to model new welfare reforms after the Wisconsin Works (W-2) program. Since 1997, we have provided welfare-to-work services in Wisconsin when the W-2 program was launched and we continue to serve as one of its vendor agencies today. W-2 is considered to be one of the most ambitious and comprehensive welfare reform initiatives undertaken and is credited with breaking the cycle of poverty and beneficiaries remaining on welfare for life. The "Wisconsin Model" also paved the way for privatization of welfare-to-work programs and demanded accountability from its vendor partners through performance-based measures and employment outcomes. This model, with which MAXIMUS has a substantial amount of knowledge and expertise, is being emulated around the world and privatized, with MAXIMUS being a leading provider.

We believe we are well positioned to compete for these global welfare-to-work opportunities because of our established presence, strong brand recognition and ability to achieve the requisite performance requirements and outcomes outlined in the new reform measures. We offer clients demonstrated results and over twenty years of proven experience in administering welfare-to-work programs. MAXIMUS provides welfare-to-work services in several states and countries. In Australia, MAXIMUS is one of the largest and highest rated welfare-to-work providers where we operate 74 sites and 40 outreach locations. We also have an established presence in the U.K.'s welfare-to-work market and presently provide employment and job training services under the UK's previous Flexible New Deal program which is planned to be consolidated into the new Work Programme. We believe reform initiatives coupled with our experience, expertise and proven solutions will continue to drive demand for our welfare-to-work services.

In 2010, the United Kingdom's coalition government unveiled an austerity program to reduce mounting debt. A key feature of the plan involves comprehensive system-wide welfare reform, which is expected to yield a total savings of approximately £18 billion each year by 2014-2015. Under the Department of Work and Pensions (DWP), the welfare system overhaul will be complemented by the new Work Programme. The new Work Programme consolidates many of the U.K.'s disparate welfare-to-work programs — including the Flexible New Deal, Pathways to Work and Work Choice — into a single back-to-work program. Eligible providers must bid onto the Buying Framework prior to bidding for the 11 regional lots. DWP expects to appoint between three to eight organizations to each of the 11 regional lots and use the Buying Framework to identify organizations that have the capacity and expertise to deliver not only the Work Programme, but other potential employment related support services contracts, including those that may attract European Social Fund (ESF) support.

In addition to welfare reform, we have seen an increase in initiatives to utilize private firms for children's services such as child support enforcement. MAXIMUS currently provides services to the Family Maintenance Enforcement Program in British Columbia as well as several jurisdictions' throughout the United States including Shelby County, Tennessee, which was one of the largest child support privatization efforts in the United States.

As a result of measures to reduce costs and improve efficiency, coupled with our established presence, we believe we are well-positioned to benefit from an increase in demand for our core human services business across several geographies.

### **Our Clients**

Our primary customers are government agencies at the federal and state level and, to a lesser extent, at the county and municipal level. In the United States, while certain of our direct customers may be state governments, a significant amount of our revenue from states is ultimately provided by the federal government in the form of cost sharing arrangements with the states, such as is the case with Medicaid programs. In fiscal 2010, approximately 59% of our total revenue was derived from state and local government agencies whose programs received significant federal funding, 27% from foreign government agencies, 9% from U.S.-based federal government agencies, and 5% from other sources (such as municipal or commercial customers).

For the year ended September 30, 2010, we derived approximately 12% and 18% of our consolidated revenue from contracts with the States of California and Texas, respectively, and 16% of our consolidated revenue from the Government of Australia.

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We typically contract with government clients under four primary contract types including performance based, cost plus, fixed fee for service, and time and materials. For the year ended September 30, 2010, 47% of our contracts were performance based, 29% were cost plus, 21% were fixed fee for service, and 3% were time and materials.

Generally, the relationships with our clients are long-term multi-year contracts, subject to option years and periodic rebids. See below under “Backlog” for more details.

### **Our Business Segments**

During the fourth quarter, the Company aligned its organization of the business to reflect its focus on the administration of government health and human services programs. As a result of this organizational realignment, the Company has reclassified its segment financial information to reflect the two new operating segments of Health Services and Human Services. The results of the segments have been reclassified for all periods shown. For more information concerning our segment presentation, including comparative revenue, gross profit, operating profit, identifiable assets and related financial information for the 2008, 2009 and 2010 fiscal years, see “Note 19. Business Segments” within Item 8 of this Form 10-K.

#### *Health Services Segment*

Our Health Services Segment generated 62% of our total revenue in fiscal 2010. The Health Services Segment provides a variety of business process outsourcing (BPO) and administrative support services, as well as consulting services for state, provincial, and federal government programs, such as: Medicaid, CHIP, SNAP (Supplemental Nutrition Assistance Program), Medicare and Health Insurance BC (British Columbia). The segment’s services help improve the efficiency, cost effectiveness, quality and accountability of government sponsored health benefit programs. Our BPO services are centered on legislative initiatives and mandated programs such as the Affordable Care Act (Health Care Reform), Medicaid, CHIP, Medicare and Long-term Care. In this segment, our BPO and consulting services include:

- Comprehensive government health insurance program administration
- Health insurance program eligibility and enrollment services to improve access to health care for citizens and help beneficiaries make the best choice for their health insurance coverage
- Eligibility and enrollment modernization for government health benefit programs
- Consumer outreach and education to support government health insurance programs and provide multi-channel self-service options, including consumer friendly toll-free phone numbers, Websites and Web-based portals for easy enrollment
- Application assistance and enrollment counseling to beneficiaries
- Premium payment processing and administration such as invoicing and reconciliation
- Multilingual customer contact centers
- Objective, evidence-based health appeals
- Comprehensive eHealth solutions with the Medigent® product suite
- Independent medical reviews
- Health plan oversight
- Medicaid Management Information System (MMIS) planning and oversight
- Specialized program consulting services

#### *Human Services Segment*

Our Human Services Segment generated 38% of our total revenue in fiscal 2010, with over half generated outside the United States, primarily in Australia and the United Kingdom. The Human Services Segment provides a variety of administrative support and case management services for federal, national, state and county human services agencies including welfare-to-work programs, child support enforcement, higher education services and K-12 special education services. Our services include:

- Comprehensive workforce services — including eligibility determination, case management, job-readiness preparation, job search and employer outreach, job retention and career advancement, and selected educational and training services — to help disadvantaged individuals transition from government assistance programs to employment
- Full and specialized child support case management services, call center operations, and program and systems consulting services
- Management tools and professional consulting services for higher education institutions
- K-12 special education case management solutions

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- Program consulting services including independent verification and validation, cost allocation plans, and repeatable management services and other specialized consulting offerings
- Business and tax credit services for employers

### *Foreign Operations*

The Company operates in the United States, Australia, Canada, the United Kingdom and Israel. The distribution of revenues and assets between the United States, Australia and the rest of the world are included in “Note 19. Business Segments” within Item 8 of this Form 10-K.

### **Competitive Advantages**

We offer a private sector alternative for the administration and management of critical government-funded health and human services programs. Our reputation and extensive experience over the last 35 years give us a competitive advantage as governments value the level of expertise and brand recognition that MAXIMUS brings to its customers. The following are the competitive advantages that allow us to capitalize on various market opportunities:

*Proven track record and exceptional brand recognition.* Since 1975, we have successfully assisted governments in delivering cost-effective services to beneficiaries on government programs. We operate large-scale program management operations on behalf of government agencies, improving the quality of services provided to beneficiaries, which has further enhanced our brand recognition with government agencies.

*Subject matter expertise.* Our workforce includes many individuals who possess substantial subject matter expertise in areas critical to the successful design, implementation, administration, and operation of government health and human services programs. Many of our employees have worked for governments in management positions and are better able to understand and advance service capabilities that are of the most value, practical, and effective for our clients.

*Intellectual property that supports the administration of government programs.* We have proprietary case management solutions to support our health and human services business lines. By leveraging a common framework, MAXIMUS shortens, and sometimes eliminates, the development lifecycle to enable configuration for accelerated takeover of operations, providing clients with a significant amount of flexibility and support. By taking advantage of a large number of shared technical and business components, we reduce development costs and deliver clients increased capabilities and efficiencies related to workflow, calendaring and action plan management. As a market-share leader in CHIP and enrollment Broker, our shared core infrastructure provides price competitive advantages over other potential competitors. We have deployed these proven product solutions across several health and human services projects for clients such as Pennsylvania, New York and the United Kingdom. We have also made investments in business process modeling and monitoring tools to further enhance our operational efficiency. These assets, when combined with our subject matter expertise offer clients significant advantages over pure service providers who depend on third-party software.

*Financial strength.* We maintain a strong balance sheet, generate consistent annual cash flow, and have minimal long-term debt. We possess the financial flexibility and sufficient cash on-hand to support client operations including ongoing technology investments and working capital for high-profile public health and human services programs.

*Focused portfolio of services with a single-market emphasis.* We are one of the largest publicly traded companies that provide a portfolio of BPO health and human services specifically to government customers. Our government program expertise differentiates us from other firms and non-profit organizations with limited resources and skill sets, as well as from large consulting firms that serve multiple industries but lack the focus necessary to manage the complexities of pursuing opportunities and serving health and human services government agencies efficiently. Our focused portfolio offers clients a continuum of service capabilities from consulting engagements to component services to full-service solutions.

*Established international presence.* International governments are seeking to implement austerity measures as a means to improve government-sponsored health and human services programs and contain costs. We have an established presence in Australia, Canada and the United Kingdom with a focus on delivering cost effective welfare-to-work and health insurance eligibility and enrollment services to beneficiaries on behalf of governments.

*Expertise in competitive bidding.* Government agencies typically award contracts through a comprehensive, complex and competitive Requests for Proposals (RFPs) and bidding process. With over 35 years of experience in responding to RFPs, we have the necessary experience to navigate government procurement processes. We possess the expertise and experience to assess and allocate the appropriate resources necessary for successful project completion in accordance with contractual terms.

## Competition

The market for providing our services to government agencies can be competitive and subject to rapid change. However, given the specialized nature of our services and the programs we serve, the market is difficult for new, unknown competitors. The complex nature of competitive bidding and required investment in subject-matter expertise, repeatable processes, and support infrastructure creates significant barriers to entry for potential new competitors unfamiliar with the nature of government procurement.

Our primary competitors in the Health Services Segment in the United States are ACS, a Xerox Company (ACS); EDS, an HP Company and specialized private service providers. Our primary competitors in the Human Services Segment market include Serco, Atos Origin, private services and specialized consulting companies and non-profit organizations.

## Business Growth Strategy

Our goal is to enable future growth by remaining a leading provider of operations program management and consulting services to government agencies. The key components of our business growth strategy include the following:

- *Pursue new domestic and international business opportunities and expand our customer base.* With over 30 years of business expertise in the government market, we continue to be a leader in developing innovative solutions to meet the evolving needs of government agencies. We seek to grow our domestic and international base business by leveraging our existing core capabilities and pursuing opportunities with new and current clients.
- *Grow long-term, recurring revenue streams.* We seek to enter into long-term relationships with clients to meet their ongoing and long-term business objectives. As a result, long-term contracts (three to five years with additional option years) are often the preferred method of delivery for customers and are also beneficial to the Company.
- *Pursue strategic acquisitions.* We will selectively identify and pursue strategic acquisitions. Acquisitions can provide us with a rapid, cost-effective method to enhance our services, obtain additional skill sets, expand our customer base, cross-sell additional services, enhance our technical capabilities, and establish or expand our geographic presence.
- *Continue to optimize our current operations and drive innovation and quality to customers.* MAXIMUS continues to seek efficiencies and optimize operations in order to achieve sustainable, profitable growth. We will continue to drive improved business process managed services to clients to improve cost effectiveness, program efficiency and overall program scalability as governments deal with rising demand and increasing caseloads.
- *Recruit and retain highly skilled professionals.* We continually strive to recruit motivated individuals including top managers from larger organizations, former government officials, and consultants experienced in our service areas. We believe we can continue to attract and retain experienced personnel by capitalizing on our single-market focus and our reputation as a premier government services provider.
- *Focus on core health and human services business lines.* We have focused our core business offerings around delivering business process managed services to government health and human services agencies. Our sharpened focus and established presence positions us to benefit from Health Care Reform in the United States and Welfare Reform initiatives abroad.

See Exhibit 99.1 of this Annual Report on Form 10-K under the caption "Special Considerations and Risk Factors" for information on risks and uncertainties that could affect our business growth strategy.

## Marketing and Sales

We generate new business opportunities by establishing and maintaining relationships with key government officials, policy makers and decision makers to understand the evolving needs of government agencies as they seek to optimize their programs. We have a team of business development professionals who ensure that we understand the needs, requirements, legislative initiatives, and priorities of our current and prospective customers. In conjunction with our subject matter experts and marketing consultants, our business development professionals create and identify new business opportunities and ensure that we proactively introduce our solutions and services early in the procurement cycle. As part of the procurement, we respond to competitive requests for bids through the government procurement process.

## Legislative Initiatives

MAXIMUS actively monitors legislative initiatives and responds to opportunities as they develop. Over the past several years, legislative initiatives created new growth opportunities and potential markets for MAXIMUS. Legislation passed in the United States and in the United Kingdom have large public policy implications for all levels of government and present viable business opportunities in the health and human services arena. MAXIMUS is well-positioned to meet the operations program management and consulting needs resulting from legislative actions and subsequent regulatory and program implementation efforts.

Some recent legislative initiatives that have created new growth opportunities for us in the government market include the following:

*Affordable Care Act.* In March 2010, the United States enacted comprehensive health care reform, known as the Affordable Care Act (ACA). This new law expands access to health coverage to more than 30 million Americans, protects consumer rights, controls health care costs, and improves the overall health care delivery system over the course of the next four years and beyond. Many components of the ACA will require states to pass legislation and create program regulations. The law presents several business opportunities for MAXIMUS to offer our expertise in the administration of public programs, including:

- Establishment of Exchanges, insurance marketplaces where individuals and small businesses can buy affordable and qualified health benefit plans.
- Expansion of Medicaid where states will receive federal matching funds to cover more low-income individuals and families.
- Extension of CHIP through 2019 and the extension of funding through 2015, which is two additional years beyond the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 .
- Modernization of eligibility and enrollment processes for public health insurance programs.
- Development of consumer-friendly education and outreach materials, including easy-to-use Websites, so beneficiaries with varying literacy levels can compare options and select the appropriate health insurance coverage.
- Funding for long-term care allowing states to offer home and community based services to elderly and disabled individuals through Medicaid rather than institutional care in nursing homes.
- Creation of Pre-Existing Condition Insurance Plans (PCIP) to provide health coverage to individuals, who have been denied health insurance by private insurance companies because of a pre-existing condition, through high risk pools.
- Consumer protection through an external review process and the option for individuals to appeal coverage determinations or claims to insurance companies.
- Implementation of eHealth requirements for a secure, confidential and electronic exchange of health information.

*Education, Jobs and Medical Assistance Act.* Signed into law in August 2010, this act extends the 6.2% increase in the Federal Medical Assistance Percentage (FMAP) set by the American Recovery and Reinvestment Act (ARRA) through June 30, 2011. The passage of this bill has both preserved and expanded Medicaid potential business for MAXIMUS.

*Children's Health Insurance Program Reauthorization Act (CHIPRA).* CHIPRA was signed into law on February 2, 2009, extending the previous SCHIP program. As part of the Affordable Care Act of 2010 (ACA), CHIP has been extended through 2019 and funding has been extended through 2015, which is two additional years beyond the original CHIPRA Act. By expanding state options to find and enroll eligible children through "express lane eligibility" and "auto enrollment," CHIPRA has presented MAXIMUS with an opportunity to expand our partnerships with states for the administration of CHIP programs.

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*Work Programme in the United Kingdom.* The Work Programme, part of the new Coalition government’s austerity and debt reduction measures, is a new government-sponsored welfare-to-work model that consolidates several existing employment programs into a single comprehensive back-to-work program in an effort to achieve higher quality, longer-term and sustainable employment outcomes for job seekers in the United Kingdom. MAXIMUS previously performed work under the Flexible New Deal. In 2010, the Department of Work and Pensions notified all FND vendors and vendors under several other welfare-to-work programs that all current contracts will expire on June 30, 2011 and that vendors may bid for a spot on a contract vehicle called the Buying Framework for the new Work Programme. Vendors who successfully bid to be a qualified vendor on the Buying Framework will then be eligible to bid for the estimated 11 regions throughout the United Kingdom, where it is expected that these 11 regions will be served by three to eight vendor organizations in each region.

*American Recovery and Reinvestment Act of 2009 (ARRA).* ARRA provides states with opportunities to accelerate the adoption of health information technology under the Health Information Technology for Economic and Clinical Health (HITECH) provisions. ARRA also contains an expansion of HIPAA (Health Information Portability and Accountability Act) rules beyond “covered entities” to include business associates of covered entities. These provisions provide MAXIMUS with business opportunities in the health information technology and eHealth market.

*Deficit Reduction Act of 2005 (DRA).* Enacted in the spring of 2006, the DRA reauthorized the TANF program of 1996 through 2010. On September 30, 2010, a TANF block grant was signed as part of a continuing resolution that extends government funding of programs through December 3, 2010. The DRA includes a number of key health and human service issues important to the MAXIMUS core health and human service businesses in the United States. The DRA requires states to engage more TANF cases in productive activities to find employment in order to achieve self-sufficiency, as well as establish and maintain work participation rates and verification procedures. The DRA also provides states with additional flexibility to make reforms to their Medicaid programs.

**Backlog**

At September 30, 2010, we estimated that we had approximately \$2.1 billion of revenue in backlog. Backlog represents an estimate of the remaining future revenue from existing signed contracts and revenue from contracts that have been awarded, but not yet signed. Our backlog estimate includes revenue expected under the current terms of executed contracts and revenue from contracts in which the scope and duration of the services required are not definite but estimable (such as performance-based contracts), but does not assume any contract renewals.

Increases in backlog result from the awarding of new contracts or the extension or renewal of existing contracts and option periods. Reductions come from fulfilling contracts and early termination of contracts. Increases and decreases can follow from changes in estimates.

Our contracts typically contain provisions permitting government customers to terminate the contract on short notice, with or without cause. The backlog associated with our performance-based contracts are generally estimates based upon management experience of case loads and similar transaction volume from which actual results may vary.

We believe that period-to-period backlog comparisons are difficult and do not necessarily accurately reflect future revenue we may receive. The actual timing of revenue receipts, if any, on projects included in backlog could change for any of the aforementioned reasons. The dollar amount by segment of our backlog as of September 30, 2009 and 2010, were as follows:

	As of	
	September 30,	
	2009	2010
	(In millions)	
Health Services	\$ 1,050	\$ 1,515
Human Services	750	585
Total	\$ 1,800	\$ 2,100

The Company’s BPO businesses typically involve contracts covering a number of years. At September 30, 2010, the average weighted life of these contracts was in excess of five years, including options. Although the exercise of options is uncertain, we believe the incumbent enjoys significant advantages. The longevity of these contracts assists management in predicting revenues, operating income and cash flows. The Company expects approximately 41% of the backlog balance to be recognized in fiscal 2011 and expects backlog, in addition to anticipated option period renewals, to represent 97% of estimated 2011 revenues.

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**Seasonal Nature of Business**

We may experience seasonality in our business particularly in our fourth fiscal quarter as a result of tax credit work in the Human Services Segment. In addition, the summer and winter holiday vacations can impact the financial results for all of our segments. Specifically, reductions in working days due to holidays and vacations may impact our sales and accounts receivable, primarily in our first fiscal quarter.

**Employees**

As of September 30, 2010, we had 6,834 employees, consisting of 4,470 employees in the Health Services Segment, 2,187 employees in the Human Services Segment and 177 corporate administrative employees. Our success depends in large part on attracting, retaining, and motivating talented, innovative, and experienced professionals at all levels.

As of September 30, 2010, 343 of our employees in Canada were covered under three different collective bargaining agreements, each of which has different components and requirements. There are 184 employees covered by the MAXIMUS BC Health Benefits Operations, Inc. collective bargaining agreement with the British Columbia Government and Services Employees' Union ("BCGEU"). Within our subsidiary Themis Program Management and Consulting Limited, we have two agreements. Under the first agreement, 148 employees are covered by a collective bargaining agreement with the BCGEU and, under the second agreement, 11 employees are covered by a collective bargaining agreement with the Professional Employees Association ("PEA"). These collective bargaining agreements expire on March 31, 2011.

As of September 30, 2010, 1,019 of our employees in Australia were covered under a Collective Agreement, which is similar in form to a collective bargaining agreement. The Collective Agreement is renewed annually.

None of our other employees are covered under any such agreement. We consider our relations with our employees to be good.

**Website Access to U.S. Securities and Exchange Commission Reports**

Our Internet address is <http://www.maximus.com> and includes access to our corporate governance materials and our code of business conduct and ethics. Through our website, we make available, free of charge, access to all reports filed with the U.S. Securities and Exchange Commission (SEC) including our Annual Reports on Form 10-K, our Quarterly Reports on Form 10-Q, our Current Reports on Form 8-K, Section 16 filings by our officers and directors, as well as amendments to these reports, as filed with or furnished to the SEC pursuant to Section 13(a) or 15(d) of the Securities Exchange Act of 1934, after we electronically file such material with, or furnish it to, the SEC. Copies of any materials we file with, or furnish to, the SEC can also be obtained free of charge through the SEC's website at <http://www.sec.gov> or at the SEC's Public Reference Room at 100 F St., N.E., Washington, DC 20549. You may obtain information on the operation of the Public Reference Room by calling the SEC at 1-800-SEC-0330.

**ITEM 1A. Risk Factors.**

Our operations are subject to many risks that could adversely affect our future financial condition and performance and, therefore, the market value of our securities. See Exhibit 99.1 of this Annual Report on Form 10-K under the caption "Special Considerations and Risk Factors" for information on risks and uncertainties that could affect our future financial condition and performance. The information in Exhibit 99.1 is incorporated by reference into this Item 1A.

**ITEM 2. Properties.**

We own a 60,000 square foot office building in Reston, Virginia. We also lease offices for management and administrative functions in connection with the performance of our services. At September 30, 2010, we leased 67 offices in the United States totaling approximately 1,055,000 square feet. In four countries outside the United States, we leased 113 offices containing approximately 430,000 square feet. The lease terms vary from month-to-month to seven-year leases and are generally at market rates.

We believe that our properties are maintained in good operating condition and are suitable and adequate for our purposes.

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**ITEM 3. *Legal Proceedings.***

The Company is involved in various legal proceedings, including the matters described below, in the ordinary course of its business.

In March 2009, a state Medicaid agency asserted a claim against MAXIMUS in the amount of \$2.3 million in connection with a contract MAXIMUS had through February 1, 2009 to provide Medicaid administrative claiming services to school districts in the state. MAXIMUS entered into separate agreements with the school districts under which MAXIMUS helped the districts prepare and submit claims to the state Medicaid agency which, in turn, submitted claims for reimbursement to the Federal government. No legal action has been initiated. The state has asserted that its agreement with MAXIMUS requires the Company to reimburse the state for the amounts owed to the Federal government. However, the Company's agreements with the school districts require them to reimburse MAXIMUS for such payments and therefore MAXIMUS believes the school districts are responsible for any amounts disallowed by the state Medicaid agency or the Federal government. Accordingly, the Company believes its exposure in this matter is limited to its fees associated with this work and that the school districts will be responsible for the remainder. During the second quarter of fiscal 2009, MAXIMUS recorded a \$0.7 million reduction of revenue reflecting the fees it earned under the contract. MAXIMUS has exited the Federal healthcare claiming business and no longer provides the services at issue in this matter.

In August 2010 the Company received a draft audit report prepared on behalf of one of its former SchoolMAX customers. The SchoolMAX business line was sold as part of the divestiture of the MAXIMUS Education Systems division in 2008. The draft audit report recommends a refund of approximately \$11.6 million primarily arising out of the alleged failure of MAXIMUS and the buyer of the division to observe the most favored customer pricing term of the contract. MAXIMUS believes the audit report is incorrect and that no amounts are owed as a refund. The Company is working with the customer to resolve this matter before the audit report is finalized. To the extent that a resolution is not reached, MAXIMUS will contest the matter through the dispute resolution process set forth in the contract.

**PART II**

**ITEM 5. Market for Registrant’s Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities.**

Our common stock trades on the New York Stock Exchange under the symbol “MMS.” The following table sets forth, for the fiscal periods indicated, the range of high and low sales prices for our common stock and the cash dividends per share declared on the common stock.

	Price Range		Dividends
	High	Low	
<b>Year Ended September 30, 2009:</b>			
First Quarter	\$ 37.02	\$ 25.94	\$ 0.10
Second Quarter	40.93	32.78	0.12
Third Quarter	43.61	37.27	0.12
Fourth Quarter	48.49	39.10	0.12
<b>Year Ended September 30, 2010:</b>			
First Quarter	\$ 51.28	\$ 43.41	\$ 0.12
Second Quarter	62.01	47.57	0.12
Third Quarter	65.21	57.00	0.12
Fourth Quarter	62.25	53.52	0.12

As of October 31, 2010, there were 63 holders of record of our outstanding common stock. The number of holders of record is not representative of the number of beneficial owners due to the fact that many shares are held by depositories, brokers, or nominees. We estimate there are approximately 11,075 beneficial owners of our common stock.

We declared quarterly cash dividends on our common stock at the rate of \$0.10 per share beginning with the quarter ended March 31, 2005, increasing the rate to \$0.12 per share beginning with the period ended March 31, 2009. We expect to continue our policy of paying regular cash dividends, although there is no assurance as to future dividends. Future cash dividends, if any, will be paid at the discretion of our Board of Directors and will depend, among other things, upon our future operations and earnings, capital requirements and surplus, general financial condition, contractual restrictions and such other factors as our Board of Directors may deem relevant.

The following table sets forth the information required regarding repurchases of common stock that we made during the three months ended September 30, 2010:

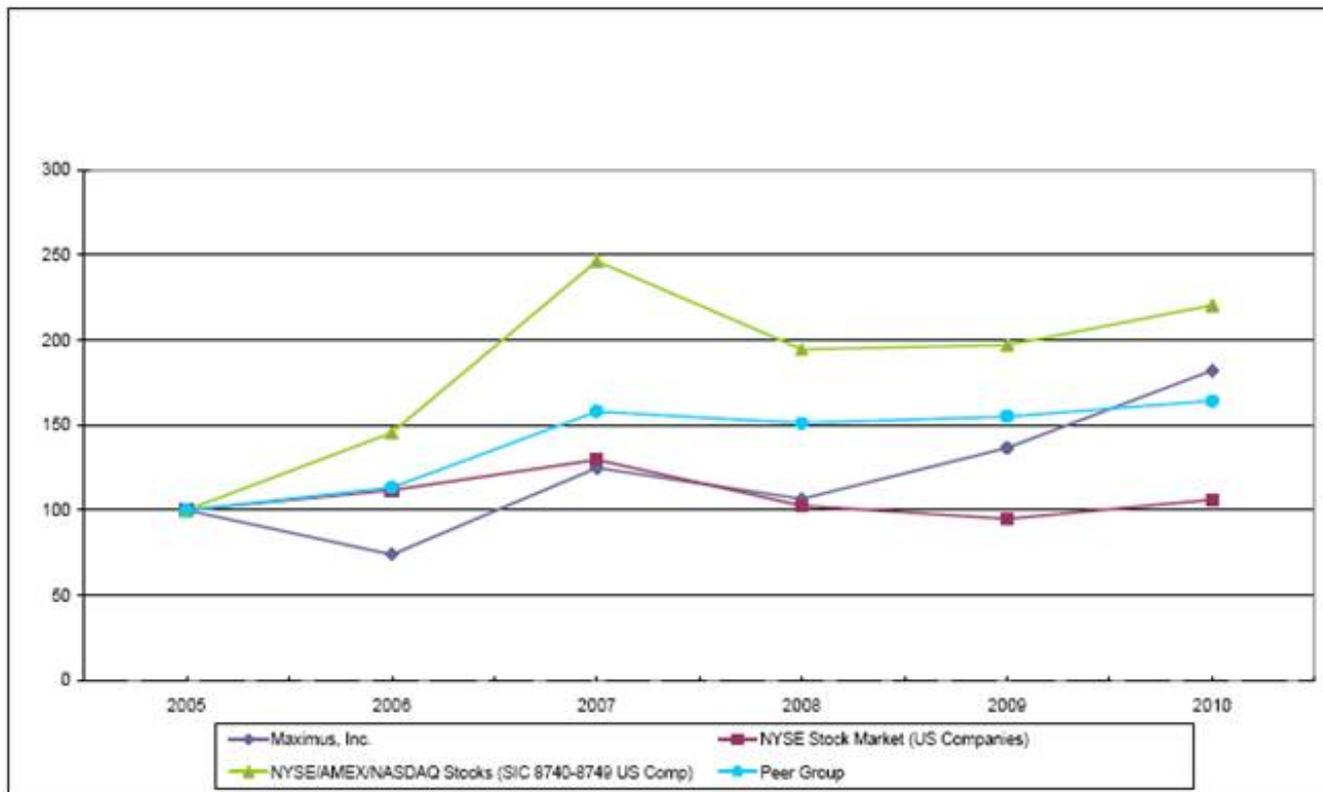
Period	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans (1)	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Plan (in thousands)
Jul. 1, 2010 — Jul. 31, 2010	40,000	\$ 57.23	40,000	\$ 36,116
Aug. 1, 2010 — Aug 31, 2010	239,752	56.35	239,752	\$ 23,813
Sep. 1, 2010 — Sep. 30, 2010	28,235	56.46	28,235	\$ 122,755
<b>Total</b>	<b>307,987</b>	<b>\$ 56.48</b>	<b>307,987</b>	

(1) Under a resolution adopted on July 22, 2008, which rescinds and supersedes all previous resolutions, the Board of Directors has authorized the repurchase, at management’s discretion, of up to an aggregate of \$75.0 million of the Company’s common stock. The resolution also authorized the use of option exercise proceeds for the repurchase of the Company’s common stock. In September 2010, a further board resolution increased the authorized purchases by an additional \$100 million. The Board of Directors has not set an expiration date for this authorized repurchase.

**Stock Performance Graph**

The following graph compares the cumulative total shareholder return on our common stock for the five-year period from September 30, 2005 to September 30, 2010, with the cumulative total return for the NYSE Stock Market (U.S. Companies) Index and a peer group comprising Accenture, CGI, Hewlett Packard, IBM and Xerox. The peer group companies represent a mix of information technology, outsourcing and management consultancy businesses and reflect a cross section of businesses against whom the Company competes for business and executive talent. The peer group is weighted by market capitalization. In prior years, the cumulative shareholder return of our stock has been compared with the NYSE/AMEX/NASDAQ Stocks (SIC 8740–8749 U.S. Companies) Management and Public Relations Services Index. As MAXIMUS has divested a number of businesses, the index is no longer seen as an appropriate gauge against which to monitor the Company’s performance. It has been included below for reference. This graph assumes the investment of \$100 on September 30, 2005 in our common stock, the NYSE Stock Market (U.S. Companies) Index, our peer group and the NYSE/AMEX/NASDAQ Stocks (SIC 8740–8749 U.S. Companies) Management and Public Relations Services Index and assumes dividends are reinvested.

**Comparison of Five-Year Cumulative Total Returns  
Performance Graph for  
MAXIMUS, INC.**



Notes:

- A. The lines represent index levels derived from compounded daily returns that include all dividends.
- B. The indexes are reweighted daily, using the market capitalization on the previous trading day.
- C. If the monthly interval, based on the fiscal year-end, is not a trading day, the preceding trading day is used.
- D. The index level for all series was set to \$100.0 on 09/30/2005.

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**ITEM 6. Selected Financial Data.**

We have derived the selected consolidated financial data presented below, as adjusted for discontinued operations, from our consolidated financial statements and the related notes. The revenue and operating results related to the acquisition of companies using the purchase accounting method are included from the respective acquisition dates. The selected financial data should be read in conjunction with “Management’s Discussion and Analysis of Financial Condition and Results of Operations” included as Item 7 of this Annual Report on Form 10–K and with the Consolidated Financial Statements and related Notes included as Item 8 of this Annual Report on Form 10–K. The historical results set forth in this Item 6 are not necessarily indicative of the results of operations to be expected in the future.

	<b>Year Ended September 30.</b>				
	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>
	(In thousands, except per share data)				
<b>Statement of Operations Data:</b>					
Revenue	\$ 557,974	\$ 584,586	\$ 699,552	\$ 720,108	\$ 831,749
Legal and settlement expense (recovery), net (1)	9,394	44,438	38,358	(4,271)	(5,351)
Write-off of deferred contract costs (2)	17,109	—	—	—	—
Gain on sale of building (3)	—	—	3,938	—	—
Operating income (loss) from continuing operations	(13,590)	(7,146)	46,028	88,589	107,406
Income (loss) from continuing operations	(4,053)	(10,954)	29,462	53,841	69,397
Income (loss) from discontinued operations (4)	6,513	2,699	(22,785)	(7,301)	1,012
Net income (loss) (5)	<u>\$ 2,460</u>	<u>\$ (8,255)</u>	<u>\$ 6,677</u>	<u>\$ 46,540</u>	<u>\$ 70,409</u>
<b>Basic Earnings (loss) per share:</b>					
Income (loss) from continuing operations	\$ (0.19)	\$ (0.50)	\$ 1.55	\$ 3.06	\$ 3.99
Income (loss) from discontinued operations	0.30	0.12	(1.20)	(0.41)	0.05
Basic earnings (loss) per share	<u>\$ 0.11</u>	<u>\$ (0.38)</u>	<u>\$ 0.35</u>	<u>\$ 2.65</u>	<u>\$ 4.04</u>
<b>Diluted Earnings (loss) per share:</b>					
Income (loss) from continuing operations	\$ (0.19)	\$ (0.50)	\$ 1.53	\$ 3.01	\$ 3.86
Income (loss) from discontinued operations	0.30	0.12	(1.18)	(0.41)	0.06
Diluted earnings (loss) per share	<u>\$ 0.11</u>	<u>\$ (0.38)</u>	<u>\$ 0.35</u>	<u>\$ 2.60</u>	<u>\$ 3.92</u>
Weighted average shares outstanding:					
Basic	21,465	21,870	19,060	17,570	17,413
Diluted	21,465	21,870	19,305	17,886	17,965
Cash dividends per share of common stock	\$ 0.40	\$ 0.40	\$ 0.40	\$ 0.46	\$ 0.48

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	<u>At September 30,</u>				
	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>2010</u>
	<u>(In thousands)</u>				
<b>Balance Sheet Data:</b>					
Cash, cash equivalents, and marketable securities	\$ 156,860	\$ 196,682	\$ 119,605	\$ 87,815	\$ 155,321
Working capital	254,811	267,145	149,966	164,646	191,461
Total assets	558,501	564,464	454,954	433,234	527,741
Long-term debt, including capital lease obligations	2,044	417	—	—	1,411
Total shareholders' equity	404,899	409,400	275,706	297,128	338,789

- (1) Legal and settlement expense (recovery), net consists of costs, net of reimbursed insurance claims, related to significant legal settlements and non-routine legal matters, including future probable legal costs estimated to be incurred in connection with those matters. Legal expenses incurred in the ordinary course of business are included in selling, general and administrative expense. See "Note 17. Legal and Settlement Expense (Recovery), Net" to our consolidated financial statements for additional information.
- (2) During the quarter ended June 30, 2006, we determined that the estimated undiscounted cash flows associated with the Texas Integrated Eligibility project over its remaining term were insufficient to recover the project's deferred contract costs. As a result, we recognized a non-cash impairment charge of \$17.1 million to write off the full unamortized balance of the project's deferred contract costs.
- (3) During the year ended September 30, 2008, the Company sold a 21,000 square foot administrative building in McLean, Virginia and recognized a pre-tax gain on the sale of \$3.9 million. This gain has been classified as a gain on sale of building in the consolidated statement of operations. See "Note 22. Sale of Building" to our consolidated financial statements for additional information.
- (4) On September 30, 2010, the Company sold its ERP division for cash proceeds of \$5.6 million, net of transaction costs of \$0.7 million, and recognized a pre-tax loss on sale of less than \$0.1 million. The Company previously recorded a pre-tax loss on sale of \$1.3 million in fiscal 2009. In completing this sale, the Company elected to retain a single contract that had previously been included within the ERP division. This contract had identifiable cash flows and requires MAXIMUS to provide services which are dissimilar to other projects within the ERP division. The retained contract has been transferred to another business division within continuing operations. The results of this contract have been included in continuing operations for all the periods shown above. See "Note 21. Discontinued Operations" to our consolidated financial statements for additional information.
- (5) Under new accounting guidance effective since October 1, 2007, the Company has accounted for uncertain tax positions by recognizing the financial statement effects of a tax position only when, based upon the technical merits, it is "more-likely-than-not" that the position will be sustained upon examination. See "Note 18. Income Taxes" to our consolidated financial statements.

**ITEM 7. Management’s Discussion and Analysis of Financial Condition and Results of Operation.**

*The following discussion and analysis of financial condition and results of operations is provided to enhance the understanding of, and should be read in conjunction with, our Consolidated Financial Statements and the related Notes.*

**Forward–Looking Statements**

Included in this Annual Report on Form 10–K are forward–looking statements within the meaning of the Private Securities Litigation Reform Act of 1995. These forward–looking statements are based on current expectations, estimates, forecasts and projections about our company, the industry in which we operate and other matters, as well as management’s beliefs and assumptions and other statements that are not historical facts. Words such as “anticipate,” “believe,” “could,” “expect,” “estimate,” “intend,” “may,” “opportunity,” “plan,” “potential,” “project,” “should,” and “will” and similar expressions are intended to identify forward–looking statements and convey uncertainty of future events or outcomes. These statements are not guarantees and involve risks, uncertainties and assumptions that are difficult to predict. Actual outcomes and results may differ materially from such forward–looking statements due to a number of factors, including without limitation, the factors set forth in Exhibit 99.1 of this Annual Report on Form 10–K under the caption “Special Considerations and Risk Factors.” As a result of these and other factors, our past financial performance should not be relied on as an indication of future performance. Additionally, we caution investors not to place undue reliance on any forward–looking statements as these statements speak only as of the date when made. We undertake no obligation to publicly update or revise any forward–looking statements, whether resulting from new information, future events or otherwise.

**Business Overview**

We provide business process outsourcing services to government health and human services agencies under our mission of *Helping Government Serve the People*.<sup>®</sup> Our business is focused almost exclusively on administering government–sponsored programs such as Medicaid, the Children’s Health Insurance Program (CHIP), health care reform, welfare–to–work, Medicare, child support enforcement and other government programs. Founded in 1975, we are one of the largest pure–play health and human services administrative providers to governments in the United States, Australia, Canada and the United Kingdom. We use our expertise, experience and advanced technological solutions to help government agencies run efficient, cost–effective programs and to improve program accountability, while enhancing the quality of services provided to program beneficiaries.

During recent years, the Company has made a number of changes to the business to eliminate unprofitable lines of business, focus on the Company’s core health and human services business, and put into place a risk management structure to enable focus on profitable growth. These steps have included the expansion of the Company’s core business, both domestically and internationally, the divestiture of several non–core businesses during 2008 and 2010, and the exit from an unprofitable contract in 2008, which resulted in a large legal and settlement expense in that year. The growth in 2010 in the welfare–to–work business in Australia and the United Kingdom has increasingly made the company a global competitor. We believe the growth in revenues and net income in these periods reflects the steps taken to improve the focus of this business.

During the fourth quarter, the Company aligned its organization of the business to reflect its focus on the administration of government health and human services programs. As a result of this organizational realignment, the Company has reclassified its segment financial information to reflect the two new operating segments of Health Services and Human Services. All historical results have been recast to reflect the organization in its current form. See “Note 20. Quarterly Information” to our consolidated financial statements for our unaudited quarterly segment income statement data.

[Table of Contents](#)**Results of Operations***Consolidated*

The following table sets forth, for the fiscal year ends indicated, selected statements of operations data:

	Year ended September 30,		
	2008	2009	2010
	(dollars in thousands, except per share data)		
Revenue	\$ 699,552	\$ 720,108	\$ 831,749
Gross profit	190,891	191,346	220,833
Selling, general and administrative expense	110,443	107,028	118,778
Selling, general and administrative expense as a percentage of revenue	15.8%	14.9%	14.3%
Gain on sale of building	3,938	—	—
Legal and settlement expense (recovery), net	38,358	(4,271)	(5,351)
Operating income from continuing operations	46,028	88,589	107,406
Operating margin from continuing operations	6.6%	12.3%	12.9%
Interest and other income, net	2,423	145	916
Provision for income taxes	18,989	34,893	38,925
Income (loss) from discontinued operations, net of income taxes	(17,150)	(5,734)	1,040
Loss on disposal	(5,635)	(1,567)	(28)
Net income	\$ 6,677	\$ 46,540	\$ 70,409
Basic Earnings (loss) per share:			
Income from continuing operations	\$ 1.55	\$ 3.06	\$ 3.99
Income (loss) from discontinued operations	(1.20)	(0.41)	0.05
Basic earnings per share	\$ 0.35	\$ 2.65	\$ 4.04
Diluted Earnings (loss) per share:			
Income from continuing operations	\$ 1.53	\$ 3.01	\$ 3.86
Income (loss) from discontinued operations	(1.18)	(0.41)	0.06
Diluted earnings per share	\$ 0.35	\$ 2.60	\$ 3.92

We discuss constant currency revenue information to provide a framework for assessing how our business performed excluding the effect of foreign currency rate fluctuations. To provide this information, revenue from foreign operations is converted into United States dollars using average exchange rates from the previous fiscal year.

We also discuss organic growth revenue information to provide a framework for assessing how the business performed excluding the effect of business combinations. To provide this information, revenue from recently-acquired entities is removed from the current and prior years with no full-year comparative revenues.

Both constant currency and organic growth revenue information are non-GAAP numbers. We believe that these numbers provide a useful basis for assessing the Company's performance. The presentation of these non-GAAP numbers is not meant to be considered in isolation, or as an alternative to revenue growth as a measure of performance.

Revenue increased 15.5% to \$831.7 million for the year ended September 30, 2010, compared with the prior year. Organic growth was responsible for 14.5% of this growth. On a constant currency basis, the revenue growth would have been 11.2%.

The principal driver of growth was the Human Services Segment. See "Human Services Segment" below.

Revenue increased 2.9% to \$720.1 million for the year ended September 30, 2009, compared with the prior year. Organic growth was responsible for 2.0% of this growth. On a constant currency basis, the revenue increase would have been 6.1%.

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The principal driver of growth for the 2009 fiscal year was strong results in our Health Services Segment. The Human Services Segment was adversely affected by the strong United States Dollar, which was partially offset by the benefit of a full year of operations from the Company's UK subsidiary, which was acquired in the fourth quarter of fiscal 2008.

Selling, general and administrative expense (SG&A) consists of costs related to general management, marketing and administration. These costs include salaries, benefits, bid and proposal efforts, travel, recruiting, continuing education, employee training, non-chargeable labor costs, facilities costs, printing, reproduction, communications, equipment depreciation, intangible amortization, and legal expenses incurred in the ordinary course of business. In fiscal 2008, SG&A includes an additional charge of \$2.2 million related to the under-estimation of stock option charges in 2006 and 2007. Without this adjustment, SG&A expenses in that year as a percentage of revenue would have been 15.5%. In 2010, SG&A included a bad debt charge of \$2.2 million related to a long-term receivable balance. Without this charge, SG&A as a percentage of revenue would have been 14.0%. SG&A as a percentage of revenue has declined year-on-year for each of the last two years. This is the result of improved efficiencies within the business.

Operating income from continuing operations increased 21.2% in fiscal 2010 compared to fiscal 2009, from \$88.6 million to \$107.4 million. The increase of \$18.8 million has been driven by growth in the business, the benefits of favorable exchange rates on foreign-sourced income, and increasing economies of scale in operating the business.

Operating income from continuing operations increased 92% in fiscal 2009, compared to fiscal 2008, from \$46.0 million to \$88.6 million. The increase of \$42.6 million is primarily attributable to a \$4.3 million legal and settlement recovery in 2009 compared with a charge of \$38.4 million in 2008. See the discussion of Legal and Settlement expense below for a breakdown of this balance. In addition, fiscal 2008 benefited from a non-recurring \$3.9 million gain on the sale of a property in McLean, Virginia.

Legal and settlement expense (recovery), net for fiscal years 2008, 2009 and 2010 was \$38.4 million, (\$4.3 million), and (\$5.4 million), respectively. Legal and settlement expense (recovery) consists of costs, net of reimbursed insurance claims, related to significant legal settlements and non-routine legal matters, including future probable legal costs estimated to be incurred in connection with those matters. Legal expenses incurred in the ordinary course of business are included in selling, general and administrative expense.

Following a change in accounting standards, from October 1, 2009 the incremental costs of acquisitions, including legal fees, brokerage fees, and valuation reports, are included in this balance. Under previous accounting guidance, these expenses were included as part of the acquisition consideration of successful acquisitions. The following table sets forth the matters that represent legal and settlement expense (recovery), net:

	Year ended September 30,		
	2008	2009	2010
		(Dollars in thousands)	
Acquisition expenses	\$ —	\$ —	\$ 254
Accenture Arbitration, Related Settlement and Insurance Recoveries, net	38,377	(6,300)	(7,500)
Other	(19)	2,029	1,895
Total	<u>\$ 38,358</u>	<u>\$ (4,271)</u>	<u>\$ 5,351</u>

In December 2008, MAXIMUS, Accenture LLP and the Texas Health and Human Services Commission ("HHSC") entered into an agreement settling all claims among the parties arising from a prime contract between Accenture and HHSC for integrated eligibility services and a subcontract between MAXIMUS and Accenture in support of the prime contract. In connection with that settlement, MAXIMUS paid a total of \$40.0 million and agreed to provide services to HHSC valued at an additional \$10.0 million. The Company's primary insurance carrier paid \$12.5 million of the amount due from MAXIMUS at the time of the settlement. In fiscal 2009, the Company recovered an additional \$6.3 million from one of its excess insurance carriers, and in fiscal 2010 the Company recovered \$7.5 million from another excess insurance carrier.

The decrease in interest and other income between 2008 and 2010 is primarily attributable to declines in market rates. At the beginning of fiscal 2008, the Company held a balance of cash and cash equivalents and marketable securities of \$196.7 million. During the first quarter, \$150 million was used as part of a share buyback, significantly reducing the cash balance and the consequent interest income. At the current time, the Company holds cash and cash equivalents in excess of \$150 million but is generating significantly lower returns on this balance due to the decline of market rates. Approximately half of the interest earned in 2010 relates to interest on the loan note related to the sale of Unison MAXIMUS Inc., discussed below under Discontinued Operations.

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Provisions for income taxes from continuing operations were 39.2%, 39.3%, and 35.9% in 2008, 2009 and 2010, respectively. The principal reason for the decline in the tax rate reflects the increasing amount of profit being recorded in foreign jurisdictions where income tax rates are lower than those within the United States of America. Certain non-recurring items, including adjustments to tax uncertainties and our operations in Israel, were responsible for a decline of 0.8% in the tax rate in 2010.

*Health Services Segment*

	Year ended September 30.		
	2008	2009	2010
	(dollars in thousands)		
Revenue	\$ 465,660	\$ 495,141	\$ 514,258
Gross profit	126,729	131,547	130,276
Operating income	70,176	72,874	64,725
Operating margin percentage	15.1%	14.7%	12.6%

The Health Services Segment provides a variety of business process outsourcing and administrative support services, as well as consulting services for state, provincial and federal programs, such as Medicaid, CHIP, Medicare, and the British Columbia Health Insurance Program.

In fiscal 2010, revenue increased 3.9% compared to fiscal 2009 driven by the acquisition of DeltaWare in 2010, which accounted for 1.4% of this growth, with the rest of the growth attributable to new work. Operating margin in 2010 was lower compared to fiscal 2009, principally due to the timing on contract rebids and the expansion of lower-risk, cost-reimbursable programs, where margins are typically lower.

Revenue increased 6.3% to \$495.1 million in fiscal 2009 compared with fiscal 2008, driven by new work. Operating margin in fiscal 2009 was slightly lower compared to fiscal 2008, driven principally by the timing of contract rebids.

*Human Services Segment*

	Year ended September 30.		
	2008	2009	2010
	(dollars in thousands)		
Revenue	\$ 233,892	\$ 224,967	\$ 317,491
Gross profit	64,162	59,799	90,557
Operating income	12,196	12,353	39,490
Operating margin percentage	5.2%	5.5%	12.4%

The Human Services Segment includes a variety of business process outsourcing, case management, job training, and support services for programs such as welfare-to-work programs, child support enforcement, K-12 special education, and other specialized consulting services.

Revenues increased 41.1% to \$317.5 million in fiscal 2010 compared to fiscal 2009. The increase is primarily driven by program expansion in Australia (which commenced in the fourth quarter of fiscal 2009) and new work in the United Kingdom (which commenced in the first quarter fiscal 2010). Operating margin improvement in fiscal 2010 compared to fiscal 2009 was driven by margin improvement attributed to revenue growth in Australia and the United Kingdom, with the results tempered by cost growth on a fixed price education contract in the United States.

Revenues decreased 3.8% to \$225.0 million in fiscal 2009 compared to 2008. Revenue growth in Australia was offset by declines related to the Company's wind down of its Federal claiming business, which the Company formally exited in fiscal 2009. The Company had approximately \$6.1 million of acquired growth from the United Kingdom business acquired in 2008, offset by \$15.0 million of decline caused by foreign exchange. Operating margin of 5.5% was consistent with an operating margin of 5.2% in fiscal 2008.

[Table of Contents](#)**Discontinued Operations***Enterprise Resource Planning (ERP)*

On September 30, 2010, the Company sold its ERP division for cash proceeds of \$5.6 million, net of transaction costs of \$0.7 million, and recognized a pre-tax loss on sale of less than \$0.1 million. The Company previously recognized a pre-tax loss on sale of \$1.3 million in fiscal 2009. In completing this sale, the Company elected to retain a single contract that had previously been included within the ERP division. This contract had identifiable cash flows and requires MAXIMUS to provide services which are dissimilar to other projects within the ERP division. The retained contract has been transferred to another business division within the Health Services segment.

*Security Solutions*

On April 30, 2008, the Company sold its Security Solutions division for cash proceeds of \$4.6 million, net of transaction costs of \$0.4 million, and recognized a pre-tax gain on the sale of \$2.9 million.

*Unison MAXIMUS, Inc.*

On May 2, 2008, the Company sold Unison MAXIMUS, Inc. for proceeds of \$6.5 million. The sale transaction is structured as a sale of stock to the management team of the subsidiary. The sale price of \$6.5 million consists of \$0.1 million in cash and \$6.4 million in the form of a promissory note secured by (1) a security interest in all of the assets of the former subsidiary; (2) a pledge of shares by the buyer; and (3) a personal guaranty by members of the management team who are shareholders of the buyer. The Company has deferred recognition of a pre-tax gain on the sale of \$3.9 million, and interest income on the promissory note, until realization is more fully assured. The deferred gain and deferred interest of \$4.6 million and \$4.5 million is reflected as a deduction from the note receivable on the consolidated balance sheets as of September 30, 2009 and 2010, respectively.

*Justice Solutions, Education Systems and Asset Solutions*

On September 30, 2008, the Company sold its Justice Solutions, Education Systems, and Asset Solutions divisions, which were previously reported as part of its Systems Segment. At that time, the Company recognized a pre-tax loss of \$12.2 million, subject to adjustment for purchase price adjustments and estimated transaction costs. During fiscal 2009, the Company reached a final settlement with the purchaser, resulting in a pre-tax gain of \$0.7 million.

The following table summarizes the operating results of the discontinued operations included in the Consolidated Statements of Operations (in thousands):

	Year Ended September 30,		
	2008	2009	2010
		(Dollars in thousands)	
<b>Revenue</b>	\$ 131,113	\$ 29,393	\$ 27,054
Income (loss) from operations before income taxes	\$ (28,332)	\$ (9,478)	\$ 1,664
Provision (benefit) for income taxes	(11,182)	(3,744)	624
<b>Income (loss) from discontinued operations</b>	\$ (17,150)	\$ (5,734)	\$ 1,040
Loss on disposal before income taxes	\$ (9,314)	\$ (686)	\$ (45)
Provision (benefit) for income taxes	(3,679)	881	(17)
<b>Loss on disposal</b>	\$ (5,635)	\$ (1,567)	\$ (28)
<b>Income (loss) from discontinued operations</b>	\$ (22,785)	\$ (7,301)	\$ 1,012

**Quarterly Results**

Set forth in "Note 20. Quarterly Information (unaudited)" to our consolidated financial statements (Item 8 of this Annual Report on Form 10-K) is selected income statement data for the eight quarters ended September 30, 2010. We derived this information from unaudited quarterly financial statements that include, in the opinion of our management, all adjustments necessary for a fair presentation of the information for such periods. You should read this information in conjunction with the audited consolidated financial statements and notes thereto. Results of operations for any fiscal quarter are not necessarily indicative of results for any future period.



## Liquidity and Capital Resources

### Current Economic Environment

Within the United States, the current economic environment facing state and local governments is extremely challenging. Not only are they experiencing declining tax revenues, but they are also facing increasing demand for critical services from the most vulnerable members of society. At the same time, states are generally required to balance their budgets each year. Certain states may delay payments to vendors as a result of budgetary constraints. In prior periods, the Company has faced short-term payment delays from state customers, all of which were ultimately recovered. The Company believes its liquidity and capital positions are adequate to weather short-term payment delays. In the event of more protracted delays, the Company may be required to seek additional capital sources, amend payment terms or take other actions. Extended payment delays could adversely affect the Company's cash flows, operations and profitability.

The Federal government has passed economic stimulus legislation to address some of the pressures facing state and local governments. The Company believes that demand for its services in its core areas of health, education and human services will remain strong and that the economic stimulus package could ultimately increase demand for such services. However, any increases in demand resulting from the economic stimulus legislation will depend largely upon the timing, amount and nature of the stimulus targeted at the states as well as the timing and nature of the states' actions in response to such funding.

The situation for international governments is also challenging, with each of the areas in which MAXIMUS operates offering unique local issues in addition to general global economic factors. Both Australia and the United Kingdom have had recent changes in government leadership and both appear set to attempt austerity measures to deal with significant debt and commitments.

	Year ended September 30,		
	2008	2009	2010
	(dollars in thousands)		
Net cash provided by (used in):			
Operating activities—continuing operations	\$ 54,144	\$ 32,534	\$ 140,971
Operating activities—discontinued operations	1,406	(1,901)	(2,530)
Investing activities—continuing operations	151,393	(26,946)	(32,395)
Investing activities—discontinued operations	(2,933)	(90)	—
Financing activities—continuing operations	(154,877)	(35,574)	(42,402)
Financing activities—discontinued operations	—	—	—
Effect of exchange rates on cash and cash equivalents	—	187	3,862
Net increase (decrease) in cash and cash equivalents	<u>\$ 49,133</u>	<u>\$ (31,790)</u>	<u>\$ 67,506</u>

Cash provided by operating activities from continuing operations was \$141.0 million in fiscal 2010, an increase of \$108.4 million compared to fiscal 2009. Principal drivers for this increase were an increase in net income of \$23.9 million, favorable payment terms on certain contracts resulting in significant deferred revenue of \$25.5 million, timing on cash collections of receivables of \$22.2 million, and a non-recurring payment of \$40 million made in conjunction with the legal settlement with TX HHSC and Accenture in December 2008, offset by \$18.8 million of insurance recoveries. The legal settlement was recorded as an expense in fiscal 2008 but not paid until fiscal 2009.

Cash provided by operating activities from continuing operations in 2009 was \$32.5 million, a decline of \$21.6 million compared to fiscal 2008, notwithstanding improved profitability in 2009. The decline was principally driven by the payments of \$40 million offset by recoveries of \$18.8 million related to the legal settlement with TX HHSC and Accenture in December 2008.

Cash used in investing activities from continuing operations was \$32.4 million in fiscal 2010, compared with \$26.9 million in 2009. The increase of \$5.5 million is principally driven by (1) \$12 million of acquisition payments related to DeltaWare and other acquisitions in 2010, compared with \$0.4 million in 2009, offset by (2) declines in overall capital spending of approximately \$4.0 million following significant build out for contract expansions in Australia and the United Kingdom, as well as the completion of an Enterprise Resource Planning system for internal use in 2009, and (3) \$1.7 million of cash received from the sale of the Company's ERP division in 2010, compared with cash payments of \$1.6 million related to other disposals in 2009.

Cash used in investing activities from continuing operations was \$26.9 million in fiscal 2009, compared with cash provided by investing operations of \$151.4 million in fiscal 2008. The difference of \$178.3 million was primarily driven by the sale of \$126.2 million of marketable securities, representing the entire balance held by the Company at the beginning of fiscal 2008, \$37.7 million from the disposition of the Company's Systems businesses in 2008, and \$5.9 million from the sale of a building in 2008, offset by \$3.1 million of cash outflow from the purchase of a business in the United Kingdom. The balance of the difference is driven principally by an increase in acquisitions of capital assets as the result of contract expansions in Australia and new work in the United Kingdom, as well as the installation of an ERP system for internal use in the United States.

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Cash used in financing activities from continuing operations was \$154.9 million, \$35.6 million, and \$42.4 million in fiscal years 2008, 2009, and 2010, respectively. These cash flows were principally driven by repurchases of common stock, including a price adjustment under an accelerated share repurchase agreement in 2008, of \$150.6 million, \$30.0 million, and \$40.2 million in 2008, 2009, and 2010, respectively. Details of the Company's share repurchase activity are set forth in "Note 13. Shareholders' Equity". The Company also paid \$7.8 million, \$8.1 million and \$8.4 million in dividends in 2008, 2009, and 2010, respectively.

The beneficial effect of exchange rates of cash and cash equivalents of \$3.9 million in the current year reflects the weakening of the United States Dollar and increases in our overseas cash balances, notably in Australia.

To supplement our statements of cash flows presented on a GAAP basis, we use the non-GAAP measure of free cash flows from continuing operations to analyze the funds generated from operations. We believe free cash flow from continuing operations is a useful basis for comparing our performance with our competitors. The presentation of non-GAAP free cash flows from continuing operations is not meant to be considered in isolation, or as an alternative to net income as an indicator of performance, or as an alternative to cash flows from operating activities as a measure of liquidity. We calculate free cash flow from continuing operations as follows:

	<u>Year ended September 30.</u>		
	<u>2008</u>	<u>2009</u>	<u>2010</u>
	(dollars in thousands)		
Cash provided by operating activities – continuing operations	\$ 54,144	\$ 32,534	\$ 140,971
Purchases of property and equipment	(10,380)	(19,694)	(13,936)
Capitalized software costs	(5,131)	(6,888)	(8,672)
Free cash flow from continuing operations	<u>\$ 38,633</u>	<u>\$ 5,952</u>	<u>\$ 118,363</u>

*Repurchases of the Company's common stock*

On November 14, 2007, the Company announced that its Board of Directors had authorized the repurchase of up to \$150.0 million of the Company's outstanding common stock under an Accelerated Share Repurchase ("ASR") program. Under the ASR agreement, the Company acquired and retired 3,758,457 shares at an initial price of \$39.91 per share for \$150.0 million plus fees of approximately \$0.4 million. The counter-party purchased an equivalent number of shares in the open market over the nine-month period ended August 15, 2008. Pursuant to the ASR agreement, at its completion the Company's initial price under the ASR agreement was adjusted down based on the volume-weighted average price ("VWAP") of the Company's stock during this period. Such adjustment could be settled in cash or stock at the Company's discretion. On July 11, 2008, the counter-party completed the purchase of shares in the open market, and the Company elected to receive the price adjustment of \$13.9 million in cash. In the fourth quarter of fiscal 2008, this receipt of cash was recorded as a decrease to common stock in the full amount of \$13.9 million.

Under a resolution adopted in July 2008, the Board of Directors authorized the repurchase, at management's discretion, of up to an aggregate of \$75.0 million of the Company's common stock. The resolution also authorized the use of option exercise proceeds for the repurchase of the Company's common stock. In September 2010, a further board resolution increased the authorized repurchases by an additional \$100 million.

Total share purchases under these plans are summarized as follows (in thousands):

	<u>Year ended September 30.</u>		
	<u>2008</u>	<u>2009</u>	<u>2010</u>
Number of share acquired under:			
ASR Agreement	3,758,457	—	—
July 2008 and September 2010 resolutions	386,600	927,690	750,764
Total	<u>4,145,057</u>	<u>927,690</u>	<u>750,764</u>
Total cost of shares (in thousands of dollars) acquired under:			
ASR Agreement	\$ 150,400	\$ —	\$ —
Price adjustment under ASR Agreement	(13,903)	—	—
July 2008 and September 2010 resolutions	14,066	30,046	40,217
Total	<u>\$ 150,563</u>	<u>\$ 30,046</u>	<u>\$ 40,217</u>

As of November 19, 2010, the Company had repurchased an additional 37,500 shares at a cost of \$2.3 million during the first quarter of fiscal 2011.

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### *Credit arrangements*

On January 25, 2008, the Company entered into a Revolving Credit Agreement providing for a senior secured revolving credit facility, with SunTrust Bank as administrative agent, issuing bank and swingline lender, and a syndicate of other lenders (the "Credit Facility"). The Credit Facility provides for a \$35.0 million revolving line of credit commitment, which may be used (i) for revolving loans, (ii) for swingline loans, subject to a sublimit of \$5.0 million, and (iii) to request the issuance of letters of credit on the Company's behalf, subject to a sublimit of \$25.0 million. The Company may request an increase in the commitment under the Credit Facility, such that the aggregate commitments under the Credit Facility shall at no time exceed \$75.0 million. The credit available under the Credit Facility may be used, among other purposes, to refinance the Company's current indebtedness, to repurchase shares of the Company's capital stock and to finance the ongoing working capital, capital expenditure, and general corporate needs of the Company.

Subject to applicable conditions, the Company may elect interest rates on its revolving borrowings calculated by reference to (i) the prime lending rate as announced by SunTrust Bank (or, if higher, the federal funds effective rate plus 0.50%) (a "Base Rate Borrowing"), or (ii) the reserve adjusted rate per annum equal to the offered rate for deposits in U.S. dollars for a one (1), two (2), three (3) or six (6) month period in the London Inter-Bank Market (a "LIBOR Borrowing"), and, in each case, plus an applicable margin that is determined by reference to the Company's then-current leverage ratio. For swingline borrowings, the Company will pay interest at the rate of interest for a one (1) month LIBOR Borrowing, plus the applicable margin, or at a rate to be separately agreed upon by the Company and the administrative agent.

At September 30, 2010, the Company had issued three letters of credit under the credit facility totaling \$10.3 million. A letter of credit for \$10 million may be called by a customer in the event that the Company defaults under the terms of a contract. The letter was renewed in March 2010 and expires in March 2011. Two letters of credit totaling \$0.3 million have been issued in relation to the Company's insurance policies. These letters of credit expire in May 2011 and may be renewed annually thereafter. At September 30, 2010, the Company has capacity to borrow, subject to covenant constraints, of up to \$23.3 million under this agreement.

The Credit Facility matures on January 25, 2013, at which time all outstanding borrowings must be repaid and all outstanding letters of credit must be terminated or cash collateralized.

The Credit Facility, as amended by the Company and its lender on December 12, 2008, provides for the payment of specified fees and expenses, including an up-front fee and commitment and letter of credit fees, and contains customary financial and other covenants that require the maintenance of certain ratios including a maximum leverage ratio and a minimum fixed charge coverage ratio. The Company was in compliance with all covenants in the amended Credit Facility as of September 30, 2010. The Company's obligations under the Credit Facility are guaranteed by certain of the Company's direct and indirect subsidiaries (collectively, the "Guarantors") and are secured by substantially all of MAXIMUS' and the Guarantors' present and future tangible and intangible assets, including the capital stock of subsidiaries and other investment property.

In addition to this credit facility, the Company has a loan agreement with the Atlantic Innovation Fund of Canada, which was acquired as part of the DeltaWare acquisition (see "Note 3. Acquisition"). This provides for a loan of up to 1.7 million Canadian Dollars, which must be used for specific technology-based research and development. The loan has no interest charge and is repayable in installments between 2012 and 2022. At September 30, 2010, \$1.4 million (1.4 million Canadian Dollars) was outstanding under this agreement. The balance will be repayable in forty quarterly installments commencing from July 1, 2012, with the final payment no later than fiscal 2022. Borrowings using this facility reduce the availability of credit under the Revolving Credit Agreement.

### *Other*

Our working capital at September 30, 2009 and 2010 was \$164.6 million and \$191.5 million, respectively. At September 30, 2010, we had cash and cash equivalents of \$155.3 million and debt of \$1.4 million. Management believes this liquidity and financial position, along with the revolving credit facility discussed above, provides sufficient liquidity to continue any contemplated stock repurchase program (depending on the price of the Company's common stock), to pursue selective acquisitions, and to consider the continuation of dividends on a quarterly basis. Restricted cash represents amounts collected on behalf of certain customers and its use is restricted to the purposes specified under our contracts with these customers.

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Under the provisions of certain long-term contracts, we may incur certain reimbursable transition period costs. During the transition period, these expenditures result in the use of our cash and in our entering into lease financing arrangements for a portion of the costs. Reimbursement of these costs may occur in the set-up phase or over the contract operating period. Related revenue may also be deferred during the set-up phase. As of September 30, 2010, \$6.7 million in net costs had been incurred and reported as deferred contract costs on our consolidated balance sheet.

On October 8, 2010, the Company's Board of Directors declared a quarterly cash dividend of \$0.12 for each share of the Company's common stock outstanding. The dividend will be paid on November 30, 2010 to shareholders of record on November 15, 2010. Based on the number of shares outstanding, the payment will be approximately \$2.1 million.

We believe that we will have sufficient resources to meet our currently anticipated capital expenditure and working capital requirements for at least the next twelve months.

### **Off-balance sheet arrangements**

We do not have material off-balance sheet risk or exposure to liabilities that are not recorded or disclosed in our financial statements.

### **Effects of Inflation**

As measured by revenue, approximately 29% of our business is conducted under cost-reimbursable contracts which adjust revenue to cover costs increased by inflation. Approximately 3% of the business is time-and-material contracts where labor rates are often fixed for several years. We generally have been able to price these contracts in a manner that accommodates the rates of inflation experienced in recent years. The remaining portions of our contracts are fixed price and performance based and are typically priced to account for the likely inflation from period to period to mitigate the risk of our business being adversely affected by inflation.

### **Critical Accounting Policies and Estimates**

Our discussion and analysis of financial condition and results of operations are based on our consolidated financial statements, which have been prepared in accordance with accounting principles generally accepted in the United States. The preparation of these financial statements requires us to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent liabilities and the reported amounts of revenue and expenses. On an ongoing basis, we evaluate our estimates including those related to revenue recognition and cost estimation on certain contracts, the realizability of goodwill, and amounts related to income taxes, certain accrued liabilities and contingencies and litigation. We base our estimates on historical experience and on various other assumptions that are believed to be reasonable under the circumstances, the results of which form the basis for making judgments about the carrying values of assets and liabilities. Actual results could differ from those estimates.

We do not have material off-balance sheet risk or exposure to liabilities that are not recorded or disclosed in our financial statements. While we have significant operating lease commitments for office space, those commitments are generally tied to the period of performance under related contracts. Additionally, although on certain contracts we are bound by performance bond commitments and standby letters of credit, we have not had any defaults resulting in draws on performance bonds. Also, we do not speculate in derivative transactions.

We believe the following critical accounting policies affect the significant judgments and estimates used in the preparation of our consolidated financial statements:

*Revenue Recognition.* In fiscal 2010, approximately 59% of our total revenue was derived from state and local government agencies; 27% from foreign customers; 9% from federal government agencies; and 5% from other sources, such as commercial customers. Revenue is generated from contracts with various pricing arrangements, including: (1) fixed-price; (2) performance-based criteria; (3) costs incurred plus a negotiated fee ("cost-plus"); and (4) time and materials. Also, some contracts contain "not-to-exceed" provisions. Of the contracts with "not-to-exceed" provisions, to the extent we estimate we will exceed the contractual limits, we treat these contracts as fixed price. For fiscal 2010, revenue from performance-based contracts was approximately 47% of total revenue; revenue from cost-plus contracts was approximately 29% of total revenue; revenue from fixed-price contracts was approximately 21% of total revenue; and revenue from time and materials contracts was approximately 3% of total revenue. A majority of the contracts with state and local government agencies have been fixed-price and performance-based, and our contracts with the federal government generally have been cost-plus. Fixed-price and performance-based contracts generally offer higher margins but typically involve more risk than cost-plus or time and materials reimbursement contracts.

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We recognize revenue on general service arrangements as work is performed and amounts are earned. We consider amounts to be earned once evidence of an arrangement has been obtained, services are delivered, fees are fixed or determinable, and collectability is reasonably assured.

We recognize revenue on fixed-price contracts when earned, as services are provided. For certain fixed-price contracts, primarily systems design, development and implementation, we recognize revenue based on costs incurred using estimates of total expected contract revenue and costs to be incurred. The cumulative impact of any revisions in estimated revenue and costs is recognized in the period in which the facts that give rise to the revision become known. Provisions for estimated losses on incomplete contracts are provided for in full in the period in which such losses become known.

For other fixed-price contracts, revenue is recognized on a straight-line basis unless evidence suggests that revenue is earned or obligations are fulfilled in a different pattern. Where obligations are fulfilled in a different pattern, revenue is generally recognized as services are provided, based upon outputs provided to the customer. With fixed-price contracts, we are subject to the risk of potential cost overruns. Costs related to contracts may be incurred in periods prior to recognizing revenue. These costs are generally expensed. However, certain direct and incremental set-up costs may be deferred until services are provided and revenue begins to be recognized, when such costs are recoverable from a contractual arrangement. Set-up costs are costs related to activities that enable us to provide contractual services to a client. The timing of expense recognition may result in irregular profit margins.

We recognize revenue on performance-based contracts as such revenue becomes fixed or determinable, which generally occurs when amounts are billable to customers. For certain contracts, this may result in revenue being recognized in irregular increments.

Revenue on cost-plus contracts is recognized based on costs incurred plus an estimate of the negotiated fee earned. Revenue on time and materials contracts is recognized based on hours worked and expenses incurred.

Our most significant expense is cost of revenue, which consists primarily of project-related costs such as employee salaries and benefits, subcontractors, computer equipment and travel expenses. Our management uses its judgment and experience to estimate cost of revenue expected on projects. Our management's ability to accurately predict personnel requirements, salaries and other costs as well as to effectively manage a project or achieve certain levels of performance can have a significant impact on the gross margins related to our fixed-price, performance-based and time and materials contracts. If actual costs are higher than our management's estimates, profitability may be adversely affected. Service cost variability has little impact on cost-plus arrangements because allowable costs are reimbursed by the customer.

We also license software under license agreements. Software license revenue is recognized when a customer enters into a non-cancelable license agreement, the software product has been delivered, there are no uncertainties surrounding product acceptance, there are no significant future performance obligations, the license fees are fixed or determinable and collection of the license fee is considered probable. Amounts received in advance of meeting these criteria are deferred and classified as deferred revenue in the accompanying consolidated balance sheets. The Company determines the value of the software component of its multiple-element arrangements using the residual method as vendor specific objective evidence ("VSOE") of fair value exists for the undelivered elements such as the support and maintenance agreements and related implementation and training services, but not for all delivered elements such as the software itself. The residual method requires revenue to be allocated to the undelivered elements based on the fair value of such elements, as indicated by VSOE. VSOE is based on the price charged when the element is sold separately. Maintenance and post-contract customer support revenue are recognized ratably over the term of the related agreements, which in most cases is one year. Revenue from software-related consulting services under time and material contracts and for training is recognized as services are performed. Revenue from other software-related contract services requiring significant modification or customization of software is recognized under the percentage-of-completion method.

Where contracts have multiple deliverables, we evaluate these deliverables at the inception of each contract and as each item is delivered. As part of this evaluation, we consider whether (i) a delivered item has value to a customer on a stand-alone basis; (ii) there is objective and reliable evidence of the fair market value of the undelivered items; and (iii) whether the delivery of the undelivered items is considered probable and substantially within our control, if a general right of return exists. Where deliverables, or groups of deliverables, have all three of these characteristics, we treat each deliverable item as a separate unit of accounting and apply the relevant revenue recognition guidance to each deliverable. For transactions entered into after September 30, 2010, the Company will adopt updated accounting rules with respect to multiple-element arrangements. See "Note 2. Recent Accounting Pronouncements" in Item 8 of this Form 10-K.

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*Impairment of Goodwill.* Goodwill is typically obtained by the Company as a result of business combinations. Goodwill represents the difference between the consideration paid in acquiring the business and the fair value of the identifiable net assets acquired.

Goodwill is not amortized but is subject to impairment testing on an annual basis, or more frequently if impairment indicators arise. Impairment testing is performed at the reporting unit level. Performing the goodwill impairment test requires judgment, including how we define reporting units and determine their fair value. A reporting unit is the operating segment, or a business one level below that operating segment (the component level) if discrete financial information is prepared and reviewed regularly by segment management. However, components are aggregated if they have similar economic characteristics. We recognize an impairment charge for any amount by which the carrying amount of a reporting unit's goodwill exceeds its fair value. We use discounted cash flows to establish fair values. When available and as appropriate, we use comparative market multiples to corroborate the discounted cash flow results. When a portion of a reporting unit is disposed of, goodwill is allocated using the relative fair value method for purposes of calculating the gain or loss on disposal. In addition, a goodwill impairment test is performed for the remaining portion of the reporting unit.

The Company performs its annual impairment test as of July 1<sup>st</sup> of each year. At July 1, 2010, the Company performed the annual impairment test based upon the reporting units in existence at this time, which were consistent with the Company's operating segments at this time, Consulting and Operations. Based upon this test, management determined that there had been no impairment of goodwill. Upon the reorganization of the business in the fourth quarter, goodwill balances were reallocated to the new reporting units and a further test for goodwill impairment was performed. This also did not demonstrate any evidence of goodwill impairment.

Changes in estimates and assumptions we make in conducting our goodwill impairment assessment could affect the estimated future fair value of one or more of our reporting units and could result in a goodwill impairment in the future. However, a 25% decline in the estimated fair value of any of our reporting units at July 1, 2010 or September 30, 2010 would not have resulted in a goodwill impairment charge.

*Acquisition-related contingent consideration.* For all acquisitions occurring after October 1, 2009, the Company is required to calculate the fair value of any contingent consideration included within the acquisition agreement. Subsequent changes to the fair value of the contingent consideration will be included as an expense or a benefit in the financial statements of the Company. The Company reassesses the most likely value of the consideration payable at each reporting period, based upon the financial performance or sales performance of the acquired entities and adjusts the liability to reflect these revised estimates. Any differences from the Company's expectations of future profitability, both beneficially and adverse, will have an effect on the acquisition-related contingent consideration liability.

*Capitalized Software Development Costs.* All of the software development costs included within continuing operations relate to software which is intended for the Company's internal use. Direct costs of time and material incurred for the development of application software for internal use are capitalized and amortized using the straight-line method over the estimated useful life of the software, ranging from three to eight years.

*Allowance for Doubtful Accounts.* We maintain an allowance for doubtful accounts at an amount we estimate to be sufficient to cover the risk of collecting less than full payment on our receivables. On a regular basis we re-evaluate our client receivables, especially receivables that are past due, and reassess our allowance for doubtful accounts based on specific client collection issues. If our clients were to express dissatisfaction with the services we have provided, additional allowances may be required.

*Deferred Contract Costs.* Deferred contract costs consist of contractually recoverable direct set-up costs relating to long-term service contracts in progress. These costs include direct and incremental costs incurred prior to the commencement of us providing service to enable us to provide the contracted services to our customer. Such costs are expensed over the period services are provided under the long-term service contract. We review deferred contract costs for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. Our review is based on our projection of the undiscounted future operating cash flows of the related customer project. To the extent such projections indicate that future undiscounted cash flows are not sufficient to recover the carrying amount, we recognize a non-cash impairment charge to reduce the carrying amount to equal projected future discounted cash flows. No impairment charges were recorded in the three years ending September 30, 2010.

*Contingencies.* From time to time, we are involved in legal proceedings, including contract and employment claims, in the ordinary course of business. We assess the likelihood of any adverse judgments or outcomes to these contingencies as well as potential ranges of probable losses and establish reserves accordingly. The amount of reserves required may change in future periods due to new developments in each matter or changes in approach to a matter such as a change in settlement strategy.

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*Legal and Settlement Expense (Recovery), Net.* Legal and settlement expense consists of costs, net of reimbursed insurance claims, related to significant legal settlements and non-routine legal matters, including future probable legal costs estimated to be incurred in connection with those matters. Legal expenses incurred in the ordinary course of business are included in selling, general and administrative expense.

*Income taxes.* To record income tax expense, we are required to estimate our income taxes in each of the jurisdictions in which we operate. In addition, income tax expense at interim reporting dates requires us to estimate our expected effective tax rate for the entire year. This process involves estimating our actual current tax liability together with assessing temporary differences that result in deferred tax assets and liabilities and expected future tax rates. Circumstances that could cause our estimates of income tax expense to change include: the impact of information that subsequently becomes available as we prepare our tax returns; revision to tax positions taken as a result of further analysis and consultation; changes in the geographic mix of our business; the actual level of pre-tax income; changes in tax rules, regulations and rates; and changes mandated as a result of audits by taxing authorities.

We may also establish tax reserves when, despite our belief that our tax return positions are fully supportable, we believe that certain positions are subject to challenge and that we may not fully succeed. We adjust these reserves in light of changing facts, such as the progress of a tax audit, new case law, or expiration of a statute of limitations.

The Company accounts for uncertain tax positions by recognizing the financial statement effects of a tax position only when, based upon the technical merits, it is "more-likely-than-not" that the position will be sustained upon examination.

### **ITEM 7A. *Quantitative and Qualitative Disclosures About Market Risk.***

We believe that our exposure to market risk related to the effect of changes in interest rates, commodity prices and other market risks with regard to instruments entered into for trading or for other purposes is immaterial.

The Company is exposed to foreign exchange fluctuations in the Australian Dollar, Canadian Dollar, British Pound and Israeli Shekel. During the year ended September 30, 2010, the Company earned approximately 27% of revenues and 39% of operating income from foreign subsidiaries. At September 30, 2010, approximately 35% of the Company's assets are held by foreign subsidiaries. The Company mitigates its foreign exchange risks through maintaining sufficient capital within its foreign subsidiaries to support the short-term and long-term capital requirements of these businesses. The Company's foreign subsidiaries typically incur costs in the same currency as they earn revenues, thus limiting the Company's exposure to unexpected expenditures. The operations of the U.S. business do not depend upon cash flows from foreign subsidiaries.

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**ITEM 8. *Financial Statements and Supplementary Data.***

The following consolidated financial statements and supplementary data are included as part of this Annual Report on Form 10-K:

<a href="#">Report of Independent Registered Public Accounting Firm</a>	31
<a href="#">Consolidated Balance Sheets at September 30, 2009 and 2010</a>	32
<a href="#">Consolidated Statements of Operations for the years ended September 30, 2008, 2009 and 2010</a>	33
<a href="#">Consolidated Statements of Changes in Shareholders' Equity for the years ended September 30, 2008, 2009 and 2010</a>	34
<a href="#">Consolidated Statements of Cash Flows for the years ended September 30, 2008, 2009 and 2010</a>	35
<a href="#">Notes to Consolidated Financial Statements</a>	36

**REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM**

The Board of Directors and Shareholders of MAXIMUS, Inc.

We have audited the accompanying consolidated balance sheets of MAXIMUS, Inc. as of September 30, 2009 and 2010, and the related consolidated statements of operations, changes in shareholders' equity, and cash flows for each of the three years in the period ended September 30, 2010. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of MAXIMUS, Inc. at September 30, 2009 and 2010, and the consolidated results of its operations and its cash flows for each of the three years in the period ended September 30, 2010, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), MAXIMUS, Inc.'s internal control over financial reporting as of September 30, 2010, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated November 19, 2010 expressed an unqualified opinion thereon.

/s/Ernst & Young LLP

McLean, Virginia  
November 19, 2010

MAXIMUS, Inc.

## CONSOLIDATED BALANCE SHEETS

(Dollars in thousands)

	September 30,	
	2009	2010
<b>ASSETS</b>		
Current assets:		
Cash and cash equivalents	\$ 87,815	\$ 155,321
Restricted cash	3,919	4,182
Accounts receivable—billed, net	133,485	136,260
Accounts receivable—unbilled	19,510	17,245
Current portion of note receivable	736	—
Prepaid income taxes	7,501	4,149
Deferred income taxes	5,389	13,290
Prepaid expenses and other current assets	19,749	25,702
Current assets of discontinued operations	14,007	—
Total current assets	292,111	356,149
Property and equipment, net	45,286	48,873
Capitalized software, net	18,969	24,715
Deferred contract costs, net	8,206	6,708
Goodwill	61,029	71,251
Intangible assets, net	2,455	7,778
Deferred income taxes	1,239	1,844
Deferred compensation plan assets	—	8,317
Other assets	3,939	2,106
Total assets	<u>\$ 433,234</u>	<u>\$ 527,741</u>
<b>LIABILITIES AND SHAREHOLDERS' EQUITY</b>		
Current liabilities:		
Accounts payable	\$ 44,644	\$ 49,200
Accrued compensation and benefits	31,738	40,807
Deferred revenue	22,177	58,070
Acquisition—related contingent consideration	—	923
Income taxes payable	—	7,120
Accrued liabilities	15,083	7,934
Liabilities of discontinued operations	13,823	634
Total current liabilities	127,465	164,688
Deferred revenue, less current portion	6,527	4,083
Long-term debt	—	1,411
Acquisition—related contingent consideration, less current portion	—	2,138
Income taxes payable, less current portion	1,871	1,793
Deferred income taxes	243	4,946
Deferred compensation plan liabilities	—	9,893
Total liabilities	136,106	188,952
Commitments and contingencies (Notes 11 and 12)		
Shareholders' equity:		
Common stock, no par value; 60,000,000 shares authorized; 27,161,849 and 27,487,725 shares issued and 17,599,029 and 17,174,141 outstanding at September 30, 2009 and September 30, 2010, at stated amount, respectively	338,739	352,696
Treasury stock, at cost; 9,562,820 and 10,313,584 shares at September 30, 2009 and September 30, 2010, respectively	(319,149)	(359,366)
Accumulated other comprehensive income	8,268	14,530
Retained earnings	269,270	330,929
Total shareholders' equity	<u>297,128</u>	<u>338,789</u>
Total liabilities and shareholders' equity	<u>\$ 433,234</u>	<u>\$ 527,741</u>

See notes to consolidated financial statements.

## MAXIMUS, Inc.

## CONSOLIDATED STATEMENTS OF OPERATIONS

(In thousands, except per share data)

	Year ended September 30,		
	2008	2009	2010
Revenue	\$ 699,552	\$ 720,108	\$ 831,749
Cost of revenue	508,661	528,762	610,916
Gross profit	190,891	191,346	220,833
Selling, general and administrative expenses	110,443	107,028	118,778
Gain on sale of building	3,938	—	—
Legal and settlement expense (recovery), net (Note 17)	38,358	(4,271)	(5,351)
Operating income from continuing operations	46,028	88,589	107,406
Interest and other income, net	2,423	145	916
Income from continuing operations before income taxes	48,451	88,734	108,322
Provision for income taxes	18,989	34,893	38,925
Income from continuing operations	29,462	53,841	69,397
Discontinued operations, net of income taxes:			
Income (loss) from discontinued operations	(17,150)	(5,734)	1,040
Loss on disposal	(5,635)	(1,567)	(28)
Income (loss) from discontinued operations	(22,785)	(7,301)	1,012
Net income	\$ 6,677	\$ 46,540	\$ 70,409
Basic earnings (loss) per share:			
Income from continuing operations	\$ 1.55	\$ 3.06	\$ 3.99
Income (loss) from discontinued operations	(1.20)	(0.41)	0.05
Basic earnings per share	\$ 0.35	\$ 2.65	\$ 4.04
Diluted earnings (loss) per share:			
Income from continuing operations	\$ 1.53	\$ 3.01	\$ 3.86
Income (loss) from discontinued operations	(1.18)	(0.41)	0.06
Diluted earnings per share	\$ 0.35	\$ 2.60	\$ 3.92
Dividends per share	\$ 0.40	\$ 0.46	\$ 0.48
Weighted average shares outstanding:			
Basic	19,060	17,570	17,413
Diluted	19,305	17,886	17,965

See notes to consolidated financial statements.

MAXIMUS, Inc.

CONSOLIDATED STATEMENTS OF CHANGES IN SHAREHOLDERS' EQUITY

(In thousands)

	Common Shares Outstanding	Common Stock	Accumulated Other Comprehensive Income	Retained Earnings	Treasury Stock	Total Shareholders' Equity
Balance at September 30, 2007	22,194	\$ 299,846	\$ 1,730	\$ 232,071	\$ (124,637)	\$ 409,010
Net income	—	—	—	6,677	—	6,677
Foreign currency translation	—	—	3,806	—	—	3,806
Comprehensive income						10,483
Employee stock transactions	253	4,422	—	—	—	4,422
Cash dividends	—	—	—	(7,798)	—	(7,798)
Repurchases of common stock	(4,145)	—	—	—	(164,466)	(164,466)
Price adjustment under Accelerated Share Repurchase agreement	—	13,903	—	—	—	13,903
Non-cash equity based compensation	—	9,463	—	—	—	9,463
Tax benefit due to option exercises	—	689	—	—	—	689
Balance at September 30, 2008	18,302	328,323	5,536	230,950	(289,103)	275,706
Net income	—	—	—	46,540	—	46,540
Foreign currency translation	—	—	2,732	—	—	2,732
Comprehensive income						49,272
Employee stock transactions	225	2,292	—	—	—	2,292
Cash dividends	—	—	—	(8,054)	—	(8,054)
Repurchases of common stock	(928)	—	—	—	(30,046)	(30,046)
Dividends on RSUs	—	166	—	(166)	—	—
Non-cash equity based compensation	—	7,307	—	—	—	7,307
Tax benefit due to option exercises	—	651	—	—	—	651
Balance at September 30, 2009	17,599	338,739	8,268	269,270	(319,149)	297,128
Net income	—	—	—	70,409	—	70,409
Foreign currency translation	—	—	6,262	—	—	6,262
Comprehensive income						76,671
Employee stock transactions	326	2,763	—	—	—	2,763
Cash dividends	—	—	—	(8,375)	—	(8,375)
Repurchases of common stock	(751)	—	—	—	(40,217)	(40,217)
Dividends on RSUs	—	375	—	(375)	—	—
Non-cash equity based compensation	—	7,918	—	—	—	7,918
Tax benefit due to option exercises	—	2,901	—	—	—	2,901
Balance at September 30, 2010	17,174	\$ 352,696	\$ 14,530	\$ 330,929	\$ (359,366)	\$ 338,789

See notes to consolidated financial statements.

MAXIMUS, Inc.

CONSOLIDATED STATEMENTS OF CASH FLOWS

(Dollars in thousands)

	Year ended September 30,		
	2008	2009	2010
<b>Cash flows from operating activities:</b>			
Net income	\$ 6,677	\$ 46,540	\$ 70,409
Adjustments to reconcile net income to net cash provided by operating activities:			
(Income) loss from discontinued operations	22,785	7,301	(1,012)
Depreciation	8,845	8,882	12,857
Amortization	3,396	3,350	5,483
Deferred income taxes	(28,851)	26,471	(3,172)
Gain on sale of building	(3,938)	—	—
Gain on sale of fixed assets	—	(51)	—
Deferred interest income on note receivable	147	376	263
Non-cash equity based compensation	9,123	7,307	7,918
Changes in assets and liabilities, net of effects from divestitures:			
Accounts receivable—billed	(12,694)	(13,052)	38
Accounts receivable—unbilled	(1,259)	(6,677)	2,415
Due from insurance carrier	(12,500)	12,500	—
Prepaid expenses and other current assets	(1,207)	(11,801)	(1,740)
Deferred contract costs	2,792	(2,882)	1,541
Other assets	(1,250)	(822)	(6,773)
Accounts payable	1,021	993	(407)
Accrued compensation and benefits	2,422	5,497	7,883
Deferred revenue	(90)	5,820	31,294
Income taxes	11,223	(20,503)	6,374
Other liabilities	47,502	(36,715)	7,600
Cash provided by operating activities—continuing operations	54,144	32,534	140,971
Cash provided by (used in) operating activities—discontinued operations	1,406	(1,901)	(2,530)
Cash provided by operating activities	55,550	30,633	138,441
<b>Cash flows from investing activities:</b>			
Proceeds (payments) from sales of discontinued operations, net of transaction costs	37,678	(1,626)	1,700
Proceeds from sale of building, net of transaction costs	5,929	—	—
Acquisition of businesses, net of cash acquired	(3,150)	(406)	(11,960)
Proceeds from note receivable	237	972	473
Purchases of property and equipment	(10,380)	(19,694)	(13,936)
Capitalized software costs	(5,131)	(6,888)	(8,672)
Decrease in marketable securities	126,210	—	—
Proceeds from sale of equipment	—	696	—
Cash provided by (used in) investing activities—continuing operations	151,393	(26,946)	(32,395)
Cash used in investing activities—discontinued operations	(2,933)	(90)	—
Cash provided by (used in) investing activities	148,460	(27,036)	(32,395)
<b>Cash flows from financing activities:</b>			
Employee stock transactions	4,422	2,292	2,763
Repurchases of common stock	(164,466)	(30,046)	(40,217)
Price adjustment under Accelerated Share Repurchase agreement	13,903	—	—
Payments on capital lease obligations	(1,627)	(417)	—
Tax benefit due to option exercises and restricted stock units vesting	689	651	2,901
Repayment of long-term debt	—	—	(7)
Issuance of long-term debt	—	—	533
Cash dividends paid	(7,798)	(8,054)	(8,375)
Cash used in financing activities—continuing operations	(154,877)	(35,574)	(42,402)
Cash provided by financing activities—discontinued operations	—	—	—
Cash used in financing activities	(154,877)	(35,574)	(42,402)
Effect of exchange rate changes on cash	—	187	3,862
Net increase (decrease) in cash and cash equivalents	49,133	(31,790)	67,506
Cash and cash equivalents, beginning of period	70,472	119,605	87,815
Cash and cash equivalents, end of period	<u>\$ 119,605</u>	<u>\$ 87,815</u>	<u>\$ 155,321</u>

See notes to consolidated financial statements.

**MAXIMUS, Inc.**

**Notes to Consolidated Financial Statements**

**For the years ended September 30, 2008, 2009 and 2010**

**1. Business and Summary of Significant Accounting Policies**

*(a) Description of Business*

MAXIMUS, Inc. (the “Company” or “we”) provides business process outsourcing services to government health and human services agencies in the United States and to foreign governments. During the year, management made changes to the manner in which they operated the business. Following this reorganization, the Company conducts its operations through two business segments: Health Services and Human Services. The Health Services Segment provides a variety of business process managed services and administrative support services for state, federal, national and local government programs, including: Medicaid, Medicaid Managed Care, CHIP, Health Care Reform, Medicare and Health Insurance BC (British Columbia). The Human Services Segment provides a variety of administrative support and case management services for federal, national, state and county human services agencies including welfare-to-work programs, child support enforcement, higher education services and K-12 special education services.

Other than disclosed in Note 21, the Notes to Consolidated Financial Statements reflect operating results from continuing operations.

The Company operates predominantly in the United States. Revenue from foreign-based projects and offices was 17%, 17%, and 27% of total revenue for the years ended September 30, 2008, 2009 and 2010, respectively.

*(b) Principles of Consolidation*

The consolidated financial statements include the accounts of MAXIMUS, Inc. and its wholly-owned subsidiaries. All significant intercompany balances and transactions have been eliminated in consolidation.

*(c) Revenue Recognition*

In fiscal 2010, approximately 59% of our total revenue was derived from state and local government agencies; 27% from foreign customers; 9% from federal government agencies; and 5% from other sources, such as commercial customers. Revenue is generated from contracts with various pricing arrangements, including: (1) fixed-price; (2) performance-based criteria; (3) costs incurred plus a negotiated fee (“cost-plus”); and (4) time and materials. Also, some contracts contain “not-to-exceed” provisions. Of the contracts with “not-to-exceed” provisions, to the extent we estimate we will exceed the contractual limits, we treat these contracts as fixed price. For fiscal 2010, revenue from performance-based contracts was approximately 47% of total revenue; revenue from cost-plus contracts was approximately 29% of total revenue; revenue from fixed-price contracts was approximately 21% of total revenue; and revenue from time and materials contracts was approximately 3% of total revenue. A majority of the contracts with state and local government agencies have been fixed-price and performance-based, and our contracts with the federal government generally have been cost-plus. Fixed-price and performance-based contracts generally offer higher margins but typically involve more risk than cost-plus or time and materials reimbursement contracts.

We recognize revenue on general service arrangements as work is performed and amounts are earned. We consider amounts to be earned once evidence of an arrangement has been obtained, services are delivered, fees are fixed or determinable, and collectability is reasonably assured.

We recognize revenue on fixed-priced contracts when earned, as services are provided. For certain fixed-price contracts, primarily systems design, development and implementation, we recognize revenue based on costs incurred using estimates of total expected contract revenue and costs to be incurred. The cumulative impact of any revisions in estimated revenue and costs is recognized in the period in which the facts that give rise to the revision become known. Provisions for estimated losses on incomplete contracts are provided for in full in the period in which such losses become known.

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For other fixed-price contracts, revenue is recognized on a straight-line basis unless evidence suggests that revenue is earned or obligations are fulfilled in a different pattern. Where obligations are fulfilled in a different pattern, revenue is generally recognized as services are provided, based upon outputs provided to the customer. With fixed-price contracts, we are subject to the risk of potential cost overruns. Costs related to contracts may be incurred in periods prior to recognizing revenue. These costs are generally expensed. However, certain direct and incremental set-up costs may be deferred until services are provided and revenue begins to be recognized, when such costs are recoverable from a contractual arrangement. Set-up costs are costs related to activities that enable us to provide contractual services to a client. The timing of expense recognition may result in irregular profit margins.

We recognize revenue on performance-based contracts as such revenue becomes fixed or determinable, which generally occurs when amounts are billable to customers. For certain contracts, this may result in revenue being recognized in irregular increments.

Revenue on cost-plus contracts is recognized based on costs incurred plus an estimate of the negotiated fee earned. Revenue on time and materials contracts is recognized based on hours worked and expenses incurred.

Our most significant expense is cost of revenue, which consists primarily of project-related costs such as employee salaries and benefits, subcontractors, computer equipment and travel expenses. Our management uses its judgment and experience to estimate cost of revenue expected on projects. Our management's ability to accurately predict personnel requirements, salaries and other costs as well as to effectively manage a project or achieve certain levels of performance can have a significant impact on the gross margins related to our fixed-price, performance-based and time and materials contracts. If actual costs are higher than our management's estimates, profitability may be adversely affected. Service cost variability has little impact on cost-plus arrangements because allowable costs are reimbursed by the customer.

We also license software under license agreements. Software license revenue is recognized when a customer enters into a non-cancelable license agreement, the software product has been delivered, there are no uncertainties surrounding product acceptance, there are no significant future performance obligations, the license fees are fixed or determinable and collection of the license fee is considered probable. Amounts received in advance of meeting these criteria are deferred and classified as deferred revenue in the accompanying consolidated balance sheets. The Company determines the value of the software component of its multiple-element arrangements using the residual method as vendor specific objective evidence ("VSOE") of fair value exists for the undelivered elements such as the support and maintenance agreements and related implementation and training services, but not for all delivered elements such as the software itself. The residual method requires revenue to be allocated to the undelivered elements based on the fair value of such elements, as indicated by VSOE. VSOE is based on the price charged when the element is sold separately. Maintenance and post-contract customer support revenue are recognized ratably over the term of the related agreements, which in most cases is one year. Revenue from software-related consulting services under time and material contracts and for training is recognized as services are performed. Revenue from other software-related contract services requiring significant modification or customization of software is recognized under the percentage-of-completion method.

Where contracts have multiple deliverables, we evaluate these deliverables at the inception of each contract and as each item is delivered. As part of this evaluation, we consider whether (i) a delivered item has value to a customer on a stand-alone basis; (ii) there is objective and reliable evidence of the fair market value of the undelivered items; and (iii) whether the delivery of the undelivered items is considered probable and substantially within our control, if a general right of return exists. Where deliverables, or groups of deliverables, have all three of these characteristics, we treat each deliverable item as a separate unit of accounting and apply the relevant revenue recognition guidance to each deliverable. For transactions entered into after September 30, 2010, the Company will adopt updated accounting rules with respect to multiple-element arrangements. See "Note 2. Recent Accounting Pronouncements."

### *(d) Cash Equivalents*

The Company considers all highly liquid investments with an original maturity of three months or less when purchased to be cash equivalents. Cash equivalents are valued at cost, which approximates market.

### *(e) Restricted Cash*

Restricted cash represents amounts collected on behalf of certain customers and its use is restricted to the purposes specified under our contracts with these customers.

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### *(f) Accounts Receivable and Allowance for Doubtful Accounts*

Accounts receivable are recorded at their face amount less an allowance for doubtful accounts. We maintain an allowance for doubtful accounts at an amount we estimate to be sufficient to cover the risk of collecting less than full payment on our receivables. On a regular basis we re-evaluate our client receivables, especially receivables that are past due, and reassess our allowance for doubtful accounts based on specific client collection issues.

### *(g) Property and Equipment*

Property and equipment is stated at cost and depreciated using the straight-line method based on estimated useful lives not to exceed 39.5 years for the Company's buildings and between three and seven years for office furniture and equipment. Leasehold improvements are amortized over their useful life or the remaining term of the lease, whichever is shorter.

### *(h) Software Development Costs*

All of the software development costs included within continuing operations relate to software which is intended for the Company's internal use. Direct costs of time and material incurred for the development of application software for internal use are capitalized and amortized using the straight-line method over the estimated useful life of the software, ranging from three to eight years.

### *(i) Deferred Contract Costs*

Deferred contract costs consist of contractually recoverable direct set-up costs relating to long-term service contracts in progress. These costs include direct and incremental costs incurred prior to the commencement of us providing service to enable us to provide the contracted services to our customer. Such costs are expensed over the period services are provided under the long-term service contract. We review deferred contract costs for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. Our review is based on our projection of the undiscounted future operating cash flows of the related customer project. To the extent such projections indicate that future undiscounted cash flows are not sufficient to recover the carrying amount, we recognize a non-cash impairment charge to reduce the carrying amount to equal projected future discounted cash flows. No impairment charges were recorded in the three years ending September 30, 2010.

### *(j) Goodwill and Intangible Assets*

Goodwill is typically obtained by the Company as a result of business combinations. Goodwill represents the difference between the consideration paid in acquiring the business and the fair value of the identifiable net assets acquired.

Goodwill is not amortized but is subject to impairment testing on an annual basis, or more frequently if impairment indicators arise. Impairment testing is performed at the reporting unit level. A reporting unit is the operating segment, or a business one level below that operating segment (the component level) if discrete financial information is prepared and reviewed regularly by segment management. However, components are aggregated if they have similar economic characteristics. We recognize an impairment charge for any amount by which the carrying amount of a reporting unit's goodwill exceeds its fair value. We use discounted cash flows to establish fair values. When available and as appropriate, we use comparative market multiples to corroborate the discounted cash flow results. When a portion of a reporting unit is disposed of, goodwill is allocated using the relative fair value method for purposes of calculating the gain or loss on disposal. In addition, a goodwill impairment test is performed for the remaining portion of the reporting unit.

The Company performs its annual impairment test as of July 1<sup>st</sup> of each year. At July 1, 2010, the Company performed the annual impairment test based upon the reporting units in existence at this time, which were consistent with the Company's operating segments, Consulting and Operations. Based upon this test, management determined that there had been no impairment of goodwill.

During the fourth quarter, management reorganized the manner in which the Company is operated, which resulted in changes to the operating segments and reporting units. A further assessment was made of goodwill at this time, and no impairment was noted.

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Intangible assets from acquisitions, which consist primarily of customer contracts and relationships, technology-based intangibles and non-competition agreements, are amortized using the straight-line method over one to ten years, based on their estimated useful lives.

### *(k) Long-Lived Assets (excluding Goodwill)*

The Company reviews long-lived assets for impairment whenever events or circumstances indicate that the carrying amount of an asset may not be fully recoverable. An impairment loss is recognized if the sum of the long-term undiscounted cash flows is less than the carrying amount of the long-lived assets being evaluated and a determination is made that the fair value of the asset is less than its book value. Any write-downs are treated as permanent reductions in the carrying amount of the assets. The Company believes that the carrying values of its assets as of September 30, 2010 are fully realizable.

### *(l) Legal and Settlement Expense (Recovery), Net*

Legal and settlement expense consists of costs, net of reimbursed insurance claims, related to significant legal settlements and non-routine legal matters, including future probable legal costs estimated to be incurred in connection with those matters. Legal expenses incurred in the ordinary course of business are included in selling, general and administrative expense.

### *(m) Income Taxes*

Deferred tax liabilities and assets are determined based on the difference between the financial statement and tax basis of assets and liabilities using enacted rates expected to be in effect during the year in which the differences reverse. The effect on deferred tax assets and liabilities due to a change in tax rates is recognized in income tax expense in the period that includes the enactment date. A tax benefit or expense is recognized for the net change in the deferred tax asset or liability during the year and the current tax liability for the year. As of September 30, 2010, the Company had \$4.0 million of net operating loss carryforwards related to a Canadian subsidiary. A full valuation allowance of \$1.1 million has been established against the related deferred tax asset. Evaluating the net operating loss carryforwards requires us to make certain estimates relating to the future operating results and cash flows to assess the valuation of the deferred tax assets.

The Company accounts for uncertain tax positions by recognizing the financial statement effects of a tax position only when, based upon the technical merits, it is "more-likely-than-not" that the position will be sustained upon examination.

### *(n) Comprehensive Income*

Comprehensive income includes changes in the balances of the items that are reported directly as separate components of shareholder's equity. Comprehensive income includes net income plus changes in cumulative foreign currency translation adjustments.

### *(o) Foreign Currency*

The assets and liabilities of foreign operations are translated into U.S. dollars at current exchange rates, and revenue and expenses are translated at average exchange rates for the period. The resulting cumulative translation adjustment is included in accumulated other comprehensive income on the consolidated balance sheet. For the years ended September 30, 2008, 2009, and 2010, accumulated foreign currency gains included in accumulated other comprehensive income (loss) were \$3.8 million, \$2.7 million, and \$6.3 million, respectively. Foreign currency transaction gains (losses), including foreign currency gains (losses) on short-term loans with our foreign subsidiaries, are included in other income and were \$0.2 million, \$0.2 million, and (\$0.1 million) for the years ended September 30, 2008, 2009 and 2010, respectively.

### *(p) Earnings per Share*

The Company presents both basic and diluted earnings per share on the face of the Consolidated Statements of Operations.

Basic earnings per share exclude dilution and are computed by dividing net income by the weighted average number of common shares outstanding for the period.

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Diluted earnings per share reflect potential dilution that could occur if securities or other contracts to issue common stock were exercised or converted into common stock. Diluted earnings per share include the incremental effect of stock options and restricted stock units calculated using the treasury stock method.

### *(q) Fair Value of Financial Instruments*

The Company considers the recorded value of its financial assets and liabilities, which consist primarily of cash and cash equivalents, accounts receivable and accounts payable, acquisition-related contingent consideration and deferred compensation plan liabilities, to approximate the fair value of the respective assets and liabilities at September 30, 2009 and 2010.

### *(r) Use of Estimates*

The preparation of financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities, and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates. Significant estimates used by the Company include estimates of profits or loss on contracts in process, estimates of collectability of receivables, evaluation of asset impairment, accrual of estimated liabilities, and valuation of acquisition-related contingent consideration liabilities.

### *(s) Reclassifications*

Certain financial results have been reclassified to conform to the current year presentation.

In fiscal 2009, we presented our consolidated balance sheet as of September 30, 2009 to show the assets and liabilities of the ERP division as discontinued operations. We also previously reclassified our consolidated statements of operations and statements of cash flows for the years ended September 30, 2008 and 2009 to show the results of this division as discontinued operations. The sale of the ERP division was concluded in 2010 but the company retained a single contract. Accordingly, this contract has been removed from discontinued operations for all comparative periods and shown within continuing operations.

### *(t) Contingencies*

From time to time, we are involved in legal proceedings, including contract and employment claims, in the ordinary course of business. We assess the likelihood of any adverse judgments or outcomes to these contingencies as well as potential ranges of probable losses and establish reserves accordingly. The amount of reserves required may change in future periods due to new developments in each matter or changes in approach to a matter such as a change in settlement strategy.

## **2. Recent Accounting Pronouncements**

In December 2007, the Financial Accounting Standards Board ("FASB") issued a new accounting standard that provides guidance for business combinations. Under this standard, more transactions will be recorded as business combinations, as it changes the definitions of a business, which would no longer be required to be self-sustaining or revenue generating, and a business combination, which would include combinations that occur by contract alone or due to changes in substantive participation rights, such as a lapse in minority veto rights. Certain acquired contingencies will be recorded initially at fair value on the acquisition date. After the acquisition, if new information is available, contingent liabilities will be measured at the higher of the likely amount to be paid and the acquisition-date fair value. Contingent assets will be measured subsequently at the lower of the current estimated future amount to be realized and the acquisition-date fair value. Transaction and restructuring costs generally will be expensed as incurred. The Company adopted this standard in the current fiscal year, and applied the standard to the acquisition of DeltaWare (see "Note 3. Acquisition"). The Company will utilize this standard on all such future transactions.

In December 2007, the FASB issued a new accounting standard that provides guidance on the accounting and reporting requirements for noncontrolling interests in financial statements. The guidance requires ownership interests in subsidiaries other than MAXIMUS, Inc. to be clearly identified, labeled and presented in the consolidated statement of financial position within equity, but separate from MAXIMUS, Inc.'s equity. It also requires the amount of consolidated net income attributable to MAXIMUS, Inc. and to the noncontrolling interest to be clearly identified and presented on the face of the consolidated statement of income. The Company does not have any material noncontrolling interests and, accordingly, there was no material impact on the adoption of this standard.

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In February 2008, the FASB issued revised guidance delaying the effective date for requirements relating to the fair valuation of non-financial assets and liabilities, except for items that are recognized or disclosed at fair value in the financial statements on a recurring basis. For items within its scope, the update deferred the effective date of the fair value measurement to the start of the Company's current fiscal year, or October 1, 2009. The Company has assessed the impact of this guidance for its non-financial assets and liabilities and determined that there was no material impact.

In September 2009, the FASB issued revised guidance for accounting for arrangements that contain more than one contract element. The revised guidance establishes a selling price hierarchy for determining the selling price of each contract element. The guidance also expands the required disclosures. The Company will adopt this standard on a prospective basis on October 1, 2010. We do not believe the adoption of this standard would have materially affected the accounting treatment for our existing contracts.

### 3. Acquisition

#### *DeltaWare*

On February 10, 2010 (the acquisition date), the Company acquired 100% of the share capital of DeltaWare, Inc. (DeltaWare). DeltaWare is a Canadian company specializing in health administration management systems. MAXIMUS acquired DeltaWare, among other reasons, to broaden its core health services offerings and strengthen its position in the administration of public health programs. The acquired assets and business have been integrated into the Company's Health Services segment.

The estimated acquisition date fair value of consideration transferred, assets acquired and liabilities are presented below and represent management's best estimates (in thousands).

Cash, net of cash acquired	\$	10,385
Contingent consideration obligations		<u>3,015</u>
Total fair value of consideration	\$	<u>13,400</u>
Accounts receivable	\$	2,010
Other tangible assets		1,571
Intangible assets		<u>6,060</u>
Total identifiable assets acquired		9,641
Accounts payable and other liabilities		2,125
Loans payable		870
Deferred revenue		<u>723</u>
Total liabilities assumed		<u>3,718</u>
Net identifiable assets acquired		5,923
Goodwill		<u>7,477</u>
Net assets acquired	\$	<u>13,400</u>

On the acquisition date, we paid \$9.1 million to the previous owners of DeltaWare in return for all of the outstanding ownership interests. Additional payments of \$1.3 million were made to the previous owners based upon the final calculation of the tangible net worth of the business acquired.

In addition, we may make future additional payments (contingent consideration) totaling up to seven million Canadian Dollars in cash over the course of the next seven years. The contingent consideration payments are based upon the achievement of profitability and sales targets over the seven year period.

A liability totaling \$3.0 million was recognized for an estimate of the acquisition date fair value of the contingent consideration. We determined the fair value of the liability based on a probability-weighted approach derived from management's own estimates of profitability and sales targets. Any change in the estimated liability subsequent to the acquisition date fair value will be recognized in earnings in the period in which the change of estimate occurs. From the acquisition date through September 30, 2010, there has been no change to the estimated liability except foreign exchange fluctuations.

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The identifiable assets acquired and liabilities assumed were recognized and measured as of the acquisition date based upon their estimated fair values. The excess of the acquisition date fair value of consideration over the estimated fair value of the net assets acquired was recorded as goodwill. The Company considers the goodwill to represent a number of potential strategic and financial benefits that are expected to be realized as a result of the acquisition, including, but not limited to bringing new capabilities to MAXIMUS in the adjacent markets and opportunities to expand its geographic reach

The valuation of the intangible assets acquired is summarized below (in thousands).

	<u>Useful life</u>	<u>Fair value</u>
Technology-based intangibles	8.5 years	\$ 3,733
Customer contracts and relationships	8–10 years	1,474
Non-compete arrangements	4 years	239
Trade name	10 years	614
<b>Total intangible assets</b>		<b>\$ 6,060</b>

The total weighted average amortization period is 8.6 years.

The fair value of the accounts receivable balance comprises gross receivables of \$2.0 million. There is no material valuation allowance against this balance at acquisition.

Of the total fair value of consideration, \$7.5 million was allocated to goodwill. Goodwill is not expected to be deductible for income tax purposes.

DeltaWare contributed \$7.0 million of revenue and \$0.6 million of net income for the year ending September 30, 2010.

#### 4. Goodwill and Intangible Assets

Changes in goodwill for the years ended September 30, 2009 and 2010 are as follows (in thousands):

	<u>Health Services</u>	<u>Human Services</u>	<u>Total</u>
Balance as of September 30, 2008	\$ 35,678	\$ 23,781	\$ 59,459
Goodwill activity during year related to acquisitions	—	724	724
Foreign currency translation	—	846	846
Balance as of September 30, 2009	35,678	25,351	61,029
Goodwill activity during year related to acquisitions	7,477	1,058	8,535
Foreign currency translation	115	1,572	1,687
Balance as of September 30, 2010	<b>\$ 43,270</b>	<b>\$ 27,981</b>	<b>\$ 71,251</b>

During the year ended September 30, 2010, the Company acquired DeltaWare, resulting in additional goodwill of \$7.5 million (see “Note 3. Acquisition”). The Company also had an adjustment to goodwill of approximately \$1.1 million relating to the finalization of amounts related to previous acquisitions.

During the year ended September 30, 2008, the Company acquired 100% of the shares of Westcountry Training and Consultancy Services Limited. The transaction included additional purchase consideration contingent upon the attainment of certain business performance criteria. These criteria were attained during the year ended September 30, 2009.

Included within discontinued operations for 2008 and 2009 were goodwill impairment charges of \$7.6 million and \$1.2 million respectively. Both charges relate to our ERP division which we sold in the current year.

The following table sets forth the components of intangible assets (in thousands):

	<u>As of September 30, 2009</u>			<u>As of September 30, 2010</u>		
	<u>Cost</u>	<u>Accumulated Amortization</u>	<u>Intangible Assets, net</u>	<u>Cost</u>	<u>Accumulated Amortization</u>	<u>Intangible Assets, net</u>
Technology-based intangible assets	\$ 3,370	\$ 3,370	\$ —	\$ 7,160	\$ 3,654	\$ 3,506
Customer contracts and relationships	6,100	3,645	2,455	8,989	5,504	3,485
Non-compete arrangements	—	—	—	243	39	204
Trademark	—	—	—	622	39	583
<b>Total</b>	<b>\$ 9,470</b>	<b>\$ 7,015</b>	<b>\$ 2,455</b>	<b>\$ 17,014</b>	<b>\$ 9,236</b>	<b>\$ 7,778</b>

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The intangible assets include \$3.4 million of fully-amortized technology-based assets still in use by the Company. Excluding these assets, the Company's intangible assets have a weighted average remaining life of 6.4 years, comprising 7.9 years for technology-based intangible assets, 4.5 years for customer contracts and relationships, 3.4 years for non-compete arrangements and 9.4 years for the trademark. Amortization expense for the year ended September 30, 2010 was \$2.1 million. Future amortization expense is estimated as follows (in thousands):

Year ending September 30, 2011	\$ 2,106
Year ending September 30, 2012	1,141
Year ending September 30, 2013	1,063
Year ending September 30, 2014	700
Year ending September 30, 2015	677
Thereafter	2,091
<b>Total</b>	<b>\$ 7,778</b>

**5. Contract Receivables and Deferred Revenue**

Uncompleted contracts consist of the following components (in thousands):

	Accounts receivable— unbilled	Deferred revenue
September 30, 2009:		
Revenue	\$ 507,178	\$ 1,109,228
Billings	487,668	1,137,932
<b>Total</b>	<b>\$ 19,510</b>	<b>\$ (28,704)</b>
September 30, 2010:		
Revenue	\$ 328,505	\$ 1,637,295
Billings	311,260	1,699,448
<b>Total</b>	<b>\$ 17,245</b>	<b>\$ (62,153)</b>

Unbilled accounts receivable and deferred revenue relate primarily to contracts wherein the timing of billings to customers varies based on individual contracts and often differs from the period of revenue recognition. At September 30, 2009 and 2010, there was \$1.5 million and \$3.3 million, respectively, billed but not paid by customers pursuant to contractual retainage provisions. Such balances are included in billed accounts receivable in the accompanying consolidated balance sheets.

At September 30, 2009 and 2010, \$2.2 million and \$3.1 million of billed long-term contract receivables, net of reserves of \$0.6 million and \$3.1 million, are included in other assets.

In evaluating the net realizable value of accounts receivable, the Company considers such factors as current economic trends, customer credit-worthiness, and changes in the customer payment terms and collection trends. Changes in the assumptions used in analyzing a specific account receivable may result in a reserve being recognized in the period in which the change occurs.

Changes in the reserves against current billed accounts receivable were as follows (in thousands):

	Year ended September 30,		
	2008	2009	2010
Balance at beginning of year	\$ 27,993	\$ 4,930	\$ 5,249
Additions to cost and expense	4,158	1,486	1,594
Deductions	(27,221)	(1,167)	(4,998)
<b>Balance at end of year</b>	<b>\$ 4,930</b>	<b>\$ 5,249</b>	<b>\$ 1,845</b>

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Deductions from reserves against billed accounts receivable in fiscal year 2008 of \$27.2 million include \$21.9 million related to the write-off of a fully-reserved account receivable due from Accenture. The write-off of the fully-reserved account receivable due from Accenture arose from the related settlement with Accenture in the fourth quarter of fiscal 2008.

## 6. Property and Equipment

Property and equipment, at cost, consist of the following (in thousands):

	As of September 30,	
	2009	2010
Land	\$ 1,800	\$ 1,800
Building and improvements	11,318	11,393
Office furniture and equipment	79,382	97,714
Leasehold improvements	6,281	4,833
	98,781	115,740
Less: Accumulated depreciation and amortization	(53,495)	(66,867)
Total property and equipment, net	\$ 45,286	\$ 48,873

Fixed asset depreciation expense for the years ended September 30, 2008, 2009 and 2010 was \$8.8 million, \$8.9 million, and \$12.9 million respectively.

## 7. Software Development Costs

Software development costs consist of the following (in thousands):

	As of September 30,	
	2009	2010
Capitalized software development costs	\$ 26,475	\$ 35,648
Less: Accumulated amortization	(7,506)	(10,933)
Total Software development costs, net	\$ 18,969	\$ 24,715

Capitalized software amortization expense for the years ended September 30, 2008, 2009 and 2010 was \$1.8 million, \$2.0 million, and \$3.4 million respectively.

## 8. Deferred Contract Costs

Deferred contract costs consist of contractually recoverable direct set-up costs relating to long-term service contracts in progress. These costs include direct and incremental costs incurred prior to the commencement of us providing contracted services to our customers totaling \$13.0 million and \$9.8 million at September 30, 2009 and 2010, respectively. Deferred contract costs are expensed ratably as services are provided under the contracts. At September 30, 2009 and 2010, accumulated amortization of deferred contract costs was \$4.8 million and \$3.1 million, respectively.

## 9. Fair Value Measurements

The Company is required to disclose the fair value of all assets and liabilities subject to fair value measurement and the nature of the valuation techniques, including their classification within the fair value hierarchy, utilized by the Company in performing these measurements.

The FASB provides a fair value framework which requires the categorization of assets and liabilities into three levels based upon the assumptions (or inputs) used to price the assets or liabilities. Level 1 provides the most reliable measure of fair value, whereas Level 3 generally requires significant management judgment. The three levels are defined as follows:

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- Level 1: Observable inputs such as quoted prices (unadjusted) in active markets for identical assets or liabilities.
- Level 2: Inputs other than quoted prices that are observable for the asset or liability, either directly or indirectly. These include quoted prices for similar assets or liabilities in active markets and quoted prices for identical or similar assets or liabilities in markets that are not active.
- Level 3: Unobservable inputs that reflect the reporting entity's own assumptions.

The Company's financial assets subject to fair value measurements and the necessary disclosures are as follows (in thousands):

Description	Fair Value as of September 30, 2010	Fair Value Measurements as of September 30, 2010 Using Fair Value Hierarchy		
		Level 1	Level 2	Level 3
Current portion of acquisition-related contingent consideration	\$ (923)	\$ —	\$ —	\$ (923)
Acquisition-related contingent consideration, less current portion	(2,138)	—	—	(2,138)
Deferred compensation plan liabilities	(9,893)	—	(9,893)	—

The Company's only acquisition-related contingent consideration liability resulted from the acquisition of DeltaWare in the current fiscal year. The fair value of the acquisition-related contingent consideration liability is based on a probability-weighted approach derived from management's own estimates of profitability and sales targets. There has been no change to management's estimates of profitability and sales targets between the acquisition date and September 30, 2010 and the only change to the value of the liability relates to foreign-exchange adjustments, which have been recorded as a component of other comprehensive income.

### 10. Credit Facilities

On January 25, 2008, the Company entered into a Revolving Credit Agreement providing for a senior secured revolving credit facility, with SunTrust Bank as administrative agent, issuing bank and swingline lender, and a syndicate of other lenders (the "Credit Facility"). The Credit Facility provides for a \$35.0 million revolving line of credit commitment, which may be used (i) for revolving loans, (ii) for swingline loans, subject to a sublimit of \$5.0 million, and (iii) to request the issuance of letters of credit on the Company's behalf, subject to a sublimit of \$25.0 million. The Company may request an increase in the commitment under the Credit Facility, such that the aggregate commitments under the Credit Facility shall at no time exceed \$75.0 million. The credit available under the Credit Facility may be used, among other purposes, to refinance the Company's current indebtedness, to repurchase shares of the Company's capital stock and to finance the ongoing working capital, capital expenditure, and general corporate needs of the Company.

Subject to applicable conditions, the Company may elect interest rates on its revolving borrowings calculated by reference to (i) the prime lending rate as announced by SunTrust Bank (or, if higher, the federal funds effective rate plus 0.50%) (a "Base Rate Borrowing"), or (ii) the reserve adjusted rate per annum equal to the offered rate for deposits in U.S. dollars for a one (1), two (2), three (3) or six (6) month period in the London Inter-Bank Market (a "LIBOR Borrowing"), and, in each case, plus an applicable margin that is determined by reference to the Company's then-current leverage ratio. For swingline borrowings, the Company will pay interest at the rate of interest for a one (1) month LIBOR Borrowing, plus the applicable margin, or at a rate to be separately agreed upon by the Company and the administrative agent.

At September 30, 2010, the Company had issued three letters of credit totaling \$10.3 million. A letter of credit for \$10 million may be called by a customer in the event that the Company defaults under the terms of a contract. The letter was renewed in March 2010 and expires in March 2011. Two letters of credit totaling \$0.3 million have been issued in relation to the Company's insurance policies. These letters of credit expire in May 2011 and may be renewed annually thereafter. At September 30, 2010, the Company has capacity to borrow, subject to covenant constraints, of up to \$23.3 million under this agreement.

The Credit Facility matures on January 25, 2013, at which time all outstanding borrowings must be repaid and all outstanding letters of credit must be terminated or cash collateralized.

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The Credit Facility, as amended by the Company and its lender on December 12, 2008, provides for the payment of specified fees and expenses, including an up-front fee and commitment and letter of credit fees, and contains customary financial and other covenants that require the maintenance of certain ratios including a maximum leverage ratio and a minimum fixed charge coverage ratio. The Company was in compliance with all covenants in the amended Credit Facility as of September 30, 2010. The Company's obligations under the Credit Facility are guaranteed by certain of the Company's direct and indirect subsidiaries (collectively, the "Guarantors") and are secured by substantially all of MAXIMUS' and the Guarantors' present and future tangible and intangible assets, including the capital stock of subsidiaries and other investment property.

In addition to this credit facility, the Company has a loan agreement with the Atlantic Innovation Fund of Canada, which was acquired as part of the DeltaWare acquisition (see "Note 3. Acquisition"). This provides for a loan of up to 1.7 million Canadian Dollars, which must be used for specific technology-based research and development. The loan has no interest charge. At September 30, 2010, \$1.4 million (1.4 million Canadian Dollars) was outstanding under this agreement. The balance will be repayable in forty quarterly installments commencing from July 1, 2012, with the final payment no later than fiscal 2022. Borrowings using this facility reduce the availability of credit under the Revolving Credit Agreement.

Certain contracts require us to provide a surety bond as a guarantee of performance. At September 30, 2009 and September 30, 2010, the Company had performance bond commitments totaling \$71.1 million and \$33.5 million, respectively. These bonds are typically renewed annually and remain in place until the contractual obligations have been satisfied. Although the triggering events vary from contract to contract, in general, we would only be liable for the amount of these guarantees in the event of default in our performance of our obligations under each contract, the probability of which we believe is remote.

## **11. Commitments and Contingencies**

### *Litigation*

The Company is involved in various legal proceedings, including the matters described below, in the ordinary course of its business.

In March 2009, a state Medicaid agency asserted a claim against MAXIMUS in the amount of \$2.3 million in connection with a contract MAXIMUS had through February 1, 2009 to provide Medicaid administrative claiming services to school districts in the state. MAXIMUS entered into separate agreements with the school districts under which MAXIMUS helped the districts prepare and submit claims to the state Medicaid agency which, in turn, submitted claims for reimbursement to the Federal government. No legal action has been initiated. The state has asserted that its agreement with MAXIMUS requires the Company to reimburse the state for the amounts owed to the Federal government. However, the Company's agreements with the school districts require them to reimburse MAXIMUS for such payments and therefore MAXIMUS believes the school districts are responsible for any amounts disallowed by the state Medicaid agency or the Federal government. Accordingly, the Company believes its exposure in this matter is limited to its fees associated with this work and that the school districts will be responsible for the remainder. During the second quarter of fiscal 2009, MAXIMUS recorded a \$0.7 million reduction of revenue reflecting the fees it earned under the contract. MAXIMUS has exited the Federal healthcare claiming business and no longer provides the services at issue in this matter.

In August 2010 the Company received a draft audit report prepared on behalf of one of its former SchoolMAX customers. The SchoolMAX business line was sold as part of the divestiture of the MAXIMUS Education Systems division in 2008. The draft audit report recommends a refund of approximately \$11.6 million primarily arising out of the alleged failure of MAXIMUS and the buyer of the division to observe the most favored customer pricing term of the contract. MAXIMUS believes the audit report is incorrect and that no amounts are owed as a refund. The Company is working with the customer to resolve this matter before the audit report is finalized. To the extent that a resolution is not reached, MAXIMUS will contest the matter through the dispute resolution process set forth in the contract.

### *Employment Agreements*

The Company has an employment agreement with its chief executive officer with a term ending in fiscal 2014.

#### *Collective bargaining agreements*

Approximately 20% of our employees are covered by collective bargaining agreements or similar arrangements. These agreements are typically renewed annually.

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**12. Leases**

The Company leases office space under various operating leases which typically contain clauses permitting cancellation upon certain conditions, including the early termination, non-renewal or material alteration of the related customer contract. The terms of these leases typically provide for certain minimum payments as well as increases in lease payments based upon the operating cost of the facility and the consumer price index. Rent expense for the years ended September 30, 2008, 2009, and 2010 was \$19.5 million, \$24.5 million, and \$30.2 million respectively.

Minimum future payments under leases in effect as of September 30, 2010 are as follows (in thousands):

	Operating Leases
Year ended September 30,	
2011	\$ 28,984
2012	20,661
2013	9,441
2014	6,117
2015	4,585
Thereafter	5,106
Total minimum lease payments	<u>\$ 74,894</u>

**13. Concentrations of Credit Risk and Major Customers**

Financial instruments that potentially subject the Company to significant concentrations of credit risk consist primarily of accounts receivable, billed and unbilled. To date, these financial instruments have been derived from contract revenue earned primarily from federal, state and local government agencies located in the United States.

For the years ended September 30, 2008, 2009, and 2010, the Company derived approximately 16%, 11% and 12% respectively, of its consolidated revenue from contracts with the State of California, principally within our Health Services segment.

For the years ended September 30, 2008, 2009 and 2010, the Company derived approximately 15%, 18% and 16% respectively, of its consolidated revenue from contracts with the State of Texas, principally within our Health Services segment.

For the years ended September 30, 2008, 2009 and 2010, the Company derived approximately 7%, 8% and 16% respectively, of its consolidated revenue from contracts with the Government of Australia, wholly within our Human Services segment.

**14. Earnings Per Share**

The following table sets forth the components of basic and diluted earnings per share (in thousands):

	Year ended September 30,		
	2008	2009	2010
Numerator:			
Income from continuing operations	\$ 29,462	\$ 53,841	\$ 69,397
Income (loss) from discontinued operations	(22,785)	(7,301)	1,012
Net income	<u>\$ 6,677</u>	<u>\$ 46,540</u>	<u>\$ 70,409</u>
Denominator:			
Weighted average shares outstanding	19,060	17,570	17,413
Effect of dilutive securities:			
Employee stock options and unvested restricted stock awards	245	316	552
Denominator for diluted earnings per share	<u>19,305</u>	<u>17,886</u>	<u>17,965</u>

In computing diluted earnings per share for the years ended September 30, 2009, 76,000 employee stock options were excluded from the computation of diluted loss per share as a result of their anti-dilutive effect. No shares were excluded from the computation in computing earnings per share in the years ended September 30, 2008 and 2010.

## 15. Employee Benefit Plans and Deferred Compensation

The Company has 401(k) plans and other defined contribution plans for the benefit of all employees who meet certain eligibility requirements. The plans provide for Company match, specified Company contributions, and/or discretionary Company contributions. During the years ended September 30, 2008, 2009, and 2010, the Company contributed \$3.9 million, \$3.2 million, and \$3.2 million to the 401(k) plans, respectively.

The Company also has a deferred compensation plan, which is a non-qualified plan available to a restricted number of highly-compensated employees. The plan enables participants to defer compensation for tax purposes. These deferred employee contributions are held within a rabbi trust with investments directed by the respective employees. The assets of the rabbi trust are available to satisfy the claims of general creditors in the event of bankruptcy of the Company.

During the current year, the Company determined the assets and liabilities associated with the defined compensation plan should be recorded in the consolidated financial statements. The cumulative effect of the correction during the year resulted in an additional pre-tax charge of \$0.3 million and an after tax charge of \$0.3 million. The impact to both the balance sheet and income statement are not material for the year or any previous periods. The plan assets contain life insurance policies, which are valued at cash surrender value. The balance sheet at September 30, 2010 includes an addition \$0.6 million of cash and cash equivalents, an asset of \$8.3 million related to the other rabbi trust assets, which are held at cash surrender value, and a long-term liability of \$9.9 million related to the deferred compensation plan liabilities.

## 16. Shareholders' Equity

### *Stock-Based Compensation*

The Company's Board of Directors established stock option plans during 1997 pursuant to which the Company may grant non-qualified stock options to officers, employees and directors of the Company. Such plans also provide for stock awards and direct purchases of the Company's common stock. At September 30, 2010, 1.4 million shares remained available for grants under the Company's stock plans. The Company typically issues new shares in satisfying its obligations under its stock plans.

The Company previously granted stock options to certain employees. These were granted at exercise prices equal to the fair market value of the Company's common stock at the date of grant and generally vest ratably over a period of four years. Options issued prior to fiscal 2005 expire ten years after date of grant; those issued since expire after six years. The Company has transitioned towards providing Restricted Stock Units rather than options and, accordingly, no options have been granted since 2008. For the fiscal years ended September 30, 2008, 2009, and 2010, compensation expense related to stock options was \$2.7 million, \$1.4 million, and \$0.8 million, respectively.

The Company issues Restricted Stock Units (RSUs) to officers, employees and directors of the Company under its 1997 Equity Incentive Plan ("Plan"). Generally, RSUs issued before 2009 vest ratably over six years. RSUs issued since then vest ratably over five years. The fair value of the RSUs, based on the Company's stock price at the grant date, is expensed over the vesting period. For the fiscal years ended September 30, 2008, 2009 and 2010, compensation expense recognized related to RSUs was \$6.8 million, \$5.9 million and \$7.1 million, respectively.

In calculating stock-based compensation cost, the Company takes into account the expected fair value of the awards to be granted to employees and recognizes this over the service period. The methodology for calculating fair value of stock options typically utilizes the Black-Scholes method. The valuation of RSUs is based upon the share price on the day of grant. The Company considers the effect of estimated forfeitures and adjusts for changes in these estimates over the life of each grant. Stock-based compensation was \$9.5 million, \$7.3 million and \$7.9 million for the fiscal years ended September 30, 2008, 2009 and 2010, respectively.

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During the first quarter of fiscal 2008, the Company identified an error in prior periods in recorded stock-based compensation expense related to stock options and RSUs. The error was due, in part, to how the software used by the Company applied estimated forfeiture rates to fully vested stock options and RSUs. The impact was to underestimate stock compensation expense by \$1.1 million in each of fiscal 2006 and 2007. The Company corrected this error by recording additional stock compensation expense of \$2.2 million in the first quarter of fiscal 2008.

The total income tax benefit recognized in the income statement for share-based compensation arrangements was \$3.8 million, \$2.9 million and \$3.1 million for the fiscal years ended September 30, 2008, 2009 and 2010, respectively.

The weighted average fair value of stock options was estimated at the date of the grant using the Black-Scholes option pricing method with the following assumptions for the fiscal year ended September 30, 2008:

	<u>2008</u>
Dividend yield	0.9%
Risk-free interest rate	4.1%
Expected volatility	33%
Expected life of option term (in years)	4.3
Weighted average fair value at grant date	\$ 14.12

The dividend yield is based on historical experiences and expected future changes. The risk-free interest rate is derived from the U.S. Treasury yields in effect at the time of grant. Expected volatilities are based on the historical volatility of our common stock. The expected life of the option is derived from historical data pertaining to option exercises and employee terminations.

A summary of the Company's stock option activity for the year ended September 30, 2010, is as follows:

	<u>Options</u>	<u>Weighted Average Exercise Price</u>
Outstanding at September 30, 2009	956,257	\$ 32.27
Exercised	(186,417)	31.91
Forfeited or expired	(441)	27.04
Outstanding at September 30, 2010	769,399	32.36
Exercisable at September 30, 2010	754,399	32.21

The intrinsic value of exercisable stock options at September 30, 2010, was \$22.2 million with a weighted average remaining life of 2.4 years.

The following table summarizes information pertaining to the stock options vested and exercised for the years presented:

	<u>Year ended September 30,</u>		
	<u>2008</u>	<u>2009</u>	<u>2010</u>
Aggregate fair value of all stock options vesting	\$ 3,300	\$ 1,735	\$ 1,233
Aggregate intrinsic value of all stock options exercised	2,000	1,752	4,730

The following table provides certain information with respect to stock options outstanding at September 30, 2010:

<u>Range of Exercise Prices</u>	<u>Stock Options Outstanding</u>	<u>Weighted Average Exercise Price</u>	<u>Weighted Average Remaining Life</u>
\$19.88-\$46.20	769,399	32.36	2.01

The following table provides certain information with respect to stock options exercisable at September 30, 2010:

<u>Range of Exercise Prices</u>	<u>Stock Options Exercisable</u>	<u>Weighted Average Exercise Price</u>
\$19.88-\$46.20	754,399	32.21

A summary of the Company's RSU activity for the year ended September 30, 2010, is as follows:

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	Shares	Weighted-Average Grant-Date Fair Value
Non-vested shares outstanding at September 30, 2009	639,465	\$ 33.38
Granted	262,884	47.16
Vested	(158,950)	36.48
Forfeited	(16,400)	35.28
Non-vested shares outstanding at September 30, 2010	726,999	37.64

As of September 30, 2010, the total remaining unrecognized compensation cost related to unvested stock options and RSUs was \$0.1 million and \$22.0 million, respectively. This charge is expected to be realized over one year for stock options and 4.5 years for RSUs.

Cash flows resulting from the tax benefits generated from tax deductions in excess of the compensation costs recognized for those options and RSUs (excess tax benefits) are classified as financing cash flows.

*Stock Repurchase Programs*

On November 14, 2007, the Company announced that its Board of Directors had authorized the repurchase of up to \$150.0 million of the Company's outstanding common stock under an Accelerated Share Repurchase ("ASR") program. Under the ASR agreement, the Company acquired and retired 3,758,457 shares at an initial price of \$39.91 per share for \$150.0 million plus fees of approximately \$0.4 million. The counter-party purchased an equivalent number of shares in the open market over the nine-month period ended August 15, 2008. Pursuant to the ASR agreement, at its completion the Company's initial price under the ASR agreement was adjusted down based on the volume-weighted average price ("VWAP") of the Company's stock during this period. Such adjustment could be settled in cash or stock at the Company's discretion. On July 11, 2008, the counter-party completed the purchase of shares in the open market, and the Company elected to receive the price adjustment of \$13.9 million in cash. In the fourth quarter of fiscal 2008, this receipt of cash was recorded as a decrease to common stock in the full amount of \$13.9 million.

Under a resolution adopted in July 2008, the Board of Directors authorized the repurchase, at management's discretion, of up to an aggregate of \$75.0 million of the Company's common stock. The resolution also authorized the use of option exercise proceeds for the repurchase of the Company's common stock. In September 2010, a further board resolution increased the authorized repurchases by an additional \$100 million.

Total share purchases under these plans are summarized as follows (in thousands):

	Year ended September 30,		
	2008	2009	2010
Number of share acquired under:			
ASR Agreement	3,758,457	—	—
July 2008 and September 2010 resolutions	386,600	927,690	750,764
Total	4,145,057	927,690	750,764
Total cost of shares (in thousands of dollars) acquired under:			
ASR Agreement	\$ 150,400	\$ —	\$ —
Price adjustment under ASR Agreement	(13,903)	—	—
July 2008 and September 2010 resolutions	14,066	30,046	40,217
Total	\$ 150,563	\$ 30,046	\$ 40,217

As of November 19, 2010, the Company had repurchased an additional 37,500 shares at a cost of \$2.3 million during the first quarter of fiscal 2011.

**17. Legal and Settlement Expense (Recovery), Net**

Legal and settlement expense (recovery), net consists of costs, net of reimbursed insurance claims, related to significant legal settlements and non-routine legal matters, including future probable legal costs estimated to be incurred in connection with those matters. Legal expenses incurred in the ordinary course of business are included in selling, general and administrative expense.

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Following a change in accounting standards, from October 1, 2009 the incremental costs of acquisitions, including legal fees, brokerage fees, and valuation reports, are included in this balance. Under previous accounting guidance, these expenses were included as part of the acquisition consideration of successful acquisitions. The following table sets forth the matters that represent legal and settlement expense (recovery), net (in thousands):

	Year ended September 30,		
	2008	2009	2010
Acquisition expenses	\$ —	\$ —	\$ 254
Accenture Arbitration, Related Settlement and Insurance Recoveries, net	38,377	(6,300)	(7,500)
Other	(19)	2,029	1,895
<b>Total</b>	<b>\$ 38,358</b>	<b>\$ (4,271)</b>	<b>\$ 5,351</b>

In December 2008, MAXIMUS, Accenture LLP and the Texas Health and Human Services Commission (“HHSC”) entered into an agreement settling all claims among the parties arising from a prime contract between Accenture and HHSC for integrated eligibility services and a subcontract between MAXIMUS and Accenture in support of the prime contract. In connection with that settlement, MAXIMUS paid a total of \$40.0 million and agreed to provide services to HHSC valued at an additional \$10.0 million. The Company’s primary insurance carrier paid \$12.5 million of the amount due from MAXIMUS at the time of the settlement. In fiscal 2009, the Company recovered an additional \$6.3 million from one of its excess insurance carriers, and in fiscal 2010 the Company recovered \$7.5 million from another excess insurance carrier.

**18. Income Taxes**

The Company’s provision for income taxes is as follows (in thousands):

	Year ended September 30,		
	2008	2009	2010
Current provision:			
Federal	\$ 39,410	\$ 5,013	\$ 23,712
State and local	5,611	1,143	5,197
Foreign	2,819	2,266	13,188
<b>Total current provision</b>	<b>47,840</b>	<b>8,422</b>	<b>42,097</b>
Deferred tax expense (benefit):			
Federal	\$ (25,573)	\$ 21,203	\$ (1,678)
State and local	(4,633)	4,534	(278)
Foreign	1,355	734	(1,216)
<b>Total deferred tax expense (benefit)</b>	<b>(28,851)</b>	<b>26,471</b>	<b>(3,172)</b>
<b>Income tax expense</b>	<b>\$ 18,989</b>	<b>\$ 34,893</b>	<b>\$ 38,925</b>

The provision for income taxes differs from that which would have resulted from the use of the federal statutory income tax rate as follows (in thousands):

	Year ended September 30,		
	2008	2009	2010
Federal income tax provision at statutory rate of 35%	\$ 16,958	\$ 31,057	\$ 37,913
Valuation allowance on net operating loss carryforwards	—	(330)	(33)
Permanent items	886	512	1,263
Municipal interest	(264)	—	—
State income taxes, net of federal benefit	2,217	3,811	3,153
Foreign taxes	(595)	(518)	(2,177)
Other	(213)	361	(1,194)
<b>Income tax expense</b>	<b>\$ 18,989</b>	<b>\$ 34,893</b>	<b>\$ 38,925</b>

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The significant items comprising the Company's deferred tax assets and liabilities as of September 30, 2009 and 2010 are as follows (in thousands):

	<u>As of September 30,</u>	
	<u>2009</u>	<u>2010</u>
Deferred tax assets—current:		
Costs deductible in future periods	\$ 6,823	\$ 8,060
Deferred revenue	8,043	13,177
	<u>14,866</u>	<u>21,237</u>
Total deferred tax assets—current		
Deferred tax liabilities—current:		
Accounts receivable—unbilled	9,035	6,701
Other	442	1,246
Total deferred tax liabilities—current:	<u>9,477</u>	<u>7,947</u>
Net deferred tax asset —current	<u>\$ 5,389</u>	<u>\$ 13,290</u>
Deferred tax assets (liabilities)—non-current:		
Non-cash equity compensation	\$ 4,432	\$ 4,852
Costs deductible in future periods	3,512	5,093
Net operating loss carryforwards	1,853	1,079
Valuation allowance on net operating loss carryforwards	(1,773)	(1,079)
Amortization of intangible assets	(243)	(2,064)
Amortization of goodwill	1,591	(164)
Depreciation	(5,909)	(6,723)
Capitalized software	(3,779)	(4,332)
Deferred contract costs	177	464
Other	1,135	(228)
Net deferred tax asset (liability) — non-current	<u>\$ 996</u>	<u>\$ (3,102)</u>

Due to deferred tax assets and liabilities in different tax jurisdictions, the net long-term assets and liabilities are reflected on the accompanying consolidated balance sheet as follows (in thousands):

	<u>As of September 30,</u>	
	<u>2009</u>	<u>2010</u>
Long-term assets	\$ 1,239	\$ 1,844
Long-term liabilities	243	4,946
Net deferred tax asset (liability)—non-current	<u>\$ 996</u>	<u>\$ (3,102)</u>

We do not provide for U.S. income taxes on the undistributed earnings of our foreign subsidiaries, as we consider these to be permanently reinvested in the operations of such subsidiaries. If some of these earnings were distributed, some countries may impose withholding taxes; in addition, as foreign taxes have been previously paid on these earnings, we would expect to be entitled to a U.S. foreign tax credit that would reduce the U.S. taxes owed on such distributions. As at September 30, 2010, the approximate amount of cumulative earnings from foreign subsidiaries is \$44.3 million. The amount of taxes that may be applicable on earnings planned to be reinvested indefinitely outside the United States is not readily determinable given the various tax planning alternatives the Company could employ should it decide to repatriate these earnings.

As of September 30, 2010, the Company had \$4.0 million of net operating loss carryforwards related to a Canadian subsidiary. A full valuation allowance of \$1.1 million has been established against the related deferred tax asset. These net operating loss carryforwards begin to expire at the end of fiscal 2013 through fiscal 2017.

Cash paid for income taxes during the years ended September 30, 2008, 2009, and 2010 was \$23.8 million, \$24.1 million, and \$33.3 million, respectively.

Approximately 60% of the Company's total goodwill is expected to be deductible for income tax purposes.

The Company accounts for uncertain tax positions by recognizing the financial statement effects of a tax position only when, based upon the technical merits, it is "more-likely-than-not" that the position will be sustained upon examination. The Company's net unrecognized tax benefits totaled \$2.0 million, \$1.9 million, and \$1.5 million at September 30, 2008, 2009, and 2010, respectively. The total amount of unrecognized tax benefits that, if recognized, would affect the annual effective income tax rate is \$1.5 million at September 30, 2010.

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The Company has elected to report interest and penalties as a component of income tax expense. In the fiscal years ending September 30, 2008, 2009, and 2010, the Company recognized interest expense relating to unrecognized tax benefits of less than \$0.1 million in each year. The net liability balance at September 30, 2008, 2009 and 2010 includes approximately \$0.2 million, \$0.3 million, and \$0.3 million, respectively, of interest and penalties.

It is reasonably possible that the total amount of unrecognized tax benefits could decrease by as much as \$0.1 million within the next twelve months as a result of settlement of expiration of statute of limitations, which could have an impact on the effective tax rate. The anticipated reversals are related to state tax items, none of which individually are significant.

The Company recognizes and presents uncertain tax positions on a gross basis (i.e., without regard to likely offsets for deferred tax assets, deductions, and/or credits that would result from payment of uncertain tax amounts). The reconciliation of the beginning and ending amount of gross unrecognized tax benefits is as follows (in thousands):

	Year Ended September 30		
	2008	2009	2010
Balance at beginning of year	\$ 2,439	\$ 2,291	\$ 2,045
Additions based on tax positions related to the current year	79	—	45
Reductions for tax positions of prior years	(85)	—	(196)
Lapse of statute of limitations	(142)	(68)	—
Settlements	—	(178)	(341)
Balance at end of year	<u>\$ 2,291</u>	<u>\$ 2,045</u>	<u>\$ 1,553</u>

The Company files income tax returns in the United States Federal jurisdiction and in various state and foreign jurisdictions. The Company is no longer subject to U.S. Federal income tax examinations for years before 2006 and is no longer subject to state and local, or foreign income tax examinations by tax authorities for years before 2004.

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**19. Business Segments**

During the fourth quarter, the Company aligned its organization of the business to reflect its focus on the administration of government health and human services programs. As a result of this organizational realignment, the Company has reclassified its segment financial information to reflect the two new operating segments of Health Services and Human services. The results of the segments for the three years ended September 30, 2010, as well as information related to their asset base, are shown below (in thousands):

	<b>Year ended September 30.</b>		
	<b>2008</b>	<b>2009</b>	<b>2010</b>
Revenue:			
Health Services	\$ 465,660	\$ 495,141	\$ 514,258
Human Services	233,892	224,967	317,491
Total	<u>\$ 699,552</u>	<u>\$ 720,108</u>	<u>\$ 831,749</u>
Gross Profit:			
Health services	\$ 126,729	\$ 131,547	\$ 130,276
Human Services	64,162	59,799	90,557
Total	<u>\$ 190,891</u>	<u>\$ 191,346</u>	<u>\$ 220,833</u>
Selling, General and Administrative expense:			
Health Services	\$ 56,553	\$ 58,673	\$ 65,551
Human Services	51,966	47,442	51,067
Corporate / Other	1,924	913	2,160
Total	<u>\$ 110,443</u>	<u>\$ 107,028</u>	<u>\$ 118,778</u>
Operating income from continuing operations (before income taxes):			
Health Services	\$ 70,176	\$ 72,874	\$ 64,725
Human Services	12,196	12,357	39,490
Consolidating adjustments	(1,924)	(913)	(2,160)
Gain on sale of building	3,938	—	—
Legal and settlement expense (recovery), net	38,358	(4,271)	(5,351)
Total	<u>\$ 46,028</u>	<u>\$ 88,589</u>	<u>\$ 107,406</u>
Identifiable assets:			
Health Services	\$ 169,705	\$ 192,121	\$ 202,339
Human Services	95,394	93,881	190,695
Corporate / Other	189,855	147,232	134,707
Total	<u>\$ 454,954</u>	<u>\$ 433,234</u>	<u>\$ 527,741</u>
Depreciation and amortization:			
Health Services	\$ 5,504	\$ 6,545	\$ 9,055
Human Services	4,481	4,006	6,623
Corporate / Other	2,256	1,681	2,662
Total	<u>\$ 12,241</u>	<u>\$ 12,232</u>	<u>\$ 18,340</u>

The Company operates in the United States, Australia, Canada, the United Kingdom and Israel.

Revenues for the Company were distributed as follows (in thousands):

	<b>Year ended September 30.</b>		
	<b>2008</b>	<b>2009</b>	<b>2010</b>
United States	\$ 578,346	\$ 601,060	\$ 606,396
Australia	51,570	54,487	135,635
Rest of World	69,636	64,561	89,718
Total	<u>\$ 699,552</u>	<u>\$ 720,108</u>	<u>\$ 831,749</u>

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Total assets of the Company were distributed as follows (in thousands):

	Year Ended September 30	
	2009	2010
United States	\$ 348,545	\$ 349,795
Australia	41,105	84,777
Rest of World	43,584	93,169
Total	<u>\$ 433,234</u>	<u>\$ 527,741</u>

**20. Quarterly Information (Unaudited)**

Set forth below are selected quarterly income statement data for the fiscal years ended September 30, 2009 and 2010. The Company derived this information from unaudited quarterly financial statements that include, in the opinion of Company's management, all adjustments necessary for a fair presentation of the information for such periods. Results of operations for any fiscal quarter are not necessarily indicative of results for any future period.

The information below differs from information previously reported by the Company on Forms 10-K and 10-Q. As discussed in "Note 19. Business Segments", the Company has reclassified its segment financial information to reflect the two new operating segments of Health Services and Human services. As discussed in "Note 21. Discontinued Operations", in completing this sale of the ERP business, the Company retained a single contract that was previously reported in discontinued operations. The results of this contract have been reclassified as continuing operations for all periods presented.

Earnings per share amounts are computed independently each quarter. As a result, the sum of each quarter's earnings per share amount may not equal the total earnings per share amount for the respective year.

	Quarter Ended			
	Dec. 31, 2008	March 31, 2009	June 30, 2009	Sept. 30, 2009
	(In thousands, except per share data)			
<b>Fiscal Year 2009</b>				
Revenue:				
Health Services	\$ 121,995	\$ 121,228	\$ 122,415	\$ 129,503
Human Services	47,715	55,930	56,019	65,303
Total revenue	169,710	177,158	178,434	194,806
Gross profit	46,904	46,534	47,370	50,538
Selling, general and administrative expenses	26,414	26,714	27,255	26,645
Operating income from continuing operations:				
Health Services	20,625	18,429	14,804	19,016
Human Services	100	1,746	5,355	5,156
Consolidating adjustments	(235)	(355)	(44)	(279)
Legal and settlement expense (recovery)	—	368	(4,829)	190
Operating income from continuing operations	20,490	19,452	24,944	23,703
Discontinued operations, net of income taxes				
Loss from discontinued operations	(485)	(763)	(186)	(4,300)
Loss on disposal	(5)	—	—	(1,562)
Loss from discontinued operations	(490)	(763)	(186)	(5,862)
Net income	\$ 11,963	\$ 11,027	\$ 14,983	\$ 8,567
Basic earnings (loss) per share:				
Income from continuing operations	\$ 0.70	\$ 0.68	\$ 0.87	\$ 0.82
Loss from discontinued operations	(0.03)	(0.05)	(0.01)	(0.33)
Basic earnings per share	<u>\$ 0.67</u>	<u>\$ 0.63</u>	<u>\$ 0.86</u>	<u>\$ 0.49</u>
Diluted earnings (loss) per share:				
Income from continuing operations	\$ 0.69	\$ 0.66	\$ 0.85	\$ 0.80
Loss from discontinued operations	(0.02)	(0.04)	(0.01)	(0.32)
Diluted earnings (loss) per share	<u>\$ 0.67</u>	<u>\$ 0.62</u>	<u>\$ 0.84</u>	<u>\$ 0.48</u>

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	Quarter Ended			
	Dec. 31, 2009	March 31, 2010	June 30, 2010	Sept. 30, 2010
	(In thousands, except per share data)			
<b>Fiscal Year 2010</b>				
Revenue:				
Health Services	\$ 130,640	\$ 127,279	\$ 127,307	\$ 129,032
Human Services	72,680	77,107	84,220	83,484
Total revenue	203,320	204,386	211,527	212,516
Gross profit	52,175	50,551	57,013	61,094
Selling, general and administrative expenses	27,429	28,787	31,658	30,904
Operating income from continuing operations:				
Health Services	17,508	12,723	14,509	19,985
Human Services	7,379	9,037	10,684	12,390
Consolidating adjustments	(141)	4	162	(2,185)
Legal and settlement expense (recovery), net	686	(6,037)	—	—
Operating income from continuing operations	24,060	27,801	25,355	30,190
Discontinued operations, net of income taxes				
Income (loss) from discontinued operations	(1,972)	752	1,200	1,060
Loss on disposal	—	—	—	(28)
Income (loss) from discontinued operations	(1,972)	752	1,200	1,032
Net income	\$ 12,628	\$ 18,743	\$ 17,325	\$ 21,713
Basic earnings per share:				
Income from continuing operations	\$ 0.83	\$ 1.03	\$ 0.93	\$ 1.20
Income (loss) from discontinued operations	(0.11)	0.05	0.06	0.06
Basic earnings per share	<u>\$ 0.72</u>	<u>\$ 1.08</u>	<u>\$ 0.99</u>	<u>\$ 1.26</u>
Diluted earnings per share:				
Income from continuing operations	\$ 0.81	\$ 1.00	\$ 0.90	\$ 1.16
Loss from discontinued operations	(0.11)	0.04	0.06	0.06
Diluted earnings per share	<u>\$ 0.70</u>	<u>\$ 1.04</u>	<u>\$ 0.96</u>	<u>\$ 1.22</u>

[Table of Contents](#)**21. Discontinued Operations**

The Company has classified the results of the following divisions within discontinued operations: Enterprise Resource Planning (ERP), Security Solutions, Justice Solutions, Education Systems and Asset Solutions. In completing the sale of the ERP division, a single contract was not transferred to the buyer. The remaining contract has been included within the Human Services segment.

The Company has also classified the results of its Unison MAXIMUS, Inc. subsidiary (Unison) within discontinued operations.

The results of these entities had previously been recorded within operating segments which no longer correspond to the operating segments disclosed in these financial statements. The associated financial position, results of operations, and cash flows of these businesses are reported as discontinued operations for all periods presented.

*Enterprise Resource Planning (ERP)*

On September 30, 2010, the Company sold its ERP division for cash proceeds of \$5.6 million, net of transaction costs of \$0.7 million, and recognized a pre-tax loss on sale of less than \$0.1 million. The Company previously recorded a pre-tax loss on sale of \$1.3 million in fiscal 2009. In completing this sale, the Company elected to retain a single contract that had previously been included within the ERP division. This contract had identifiable cash flows and requires MAXIMUS to provide services which are dissimilar to other projects within the ERP division.

*Security Solutions*

On April 30, 2008, the Company sold its Security Solutions division for cash proceeds of \$4.6 million, net of transaction costs of \$0.4 million, and recognized a pre-tax gain on the sale of \$2.9 million.

*Unison MAXIMUS, Inc.*

On May 2, 2008, the Company sold Unison for proceeds of \$6.5 million. The sale transaction was structured as a sale of stock to the management team of the subsidiary. The sale price of \$6.5 million consists of \$0.1 million in cash and \$6.4 million in the form of a promissory note secured by (1) a security interest in all of the assets of the former subsidiary; (2) a pledge of shares by the buyer; and (3) a personal guaranty by members of the management team who are shareholders of the buyer. The Company has deferred recognition of a pre-tax gain on the sale of \$3.9 million, and interest income on the promissory note, until realization is more fully assured. The deferred gain and deferred interest of \$4.6 million and \$4.5 million is reflected as a deduction from the note receivable on the consolidated balance sheets as of September 30, 2009 and 2010, respectively.

*Justice Solutions, Education Systems and Asset Solutions*

On September 30, 2008, the Company sold its Justice Solutions, Education Systems, and Asset Solutions divisions, which were previously reported as part of its Systems Segment. At that time, the Company recognized a pre-tax loss of \$12.2 million, subject to adjustment for purchase price adjustments and estimated transaction costs. During fiscal 2009, the Company reached a final settlement with the purchaser, resulting in a pre-tax gain of \$0.7 million.

The following table summarizes the operating results of the discontinued operations included in the Consolidated Statements of Operations (in thousands):

	Year Ended September 30,		
	2008	2009	2010
<b>Revenue</b>	\$ 131,113	\$ 29,393	\$ 27,054
Income (loss) from operations before income taxes	\$ (28,332)	\$ (9,478)	\$ 1,664
Provision (benefit) for income taxes	(11,182)	(3,744)	624
<b>Income (loss) from discontinued operations</b>	\$ (17,150)	\$ (5,734)	\$ 1,040
Loss on disposal before income taxes	\$ (9,314)	\$ (686)	\$ (45)
Provision (benefit) for income taxes	(3,679)	881	(17)
<b>Loss on disposal</b>	\$ (5,635)	\$ (1,567)	\$ (28)
<b>Income (loss) from discontinued operations</b>	\$ (22,785)	\$ (7,301)	\$ 1,012

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The following table summarizes the carrying values of the assets and liabilities associated with discontinued operations included in the Consolidated Balance Sheets (in thousands):

	As of September 30, 2009	As of September 30, 2010
Accounts receivable—billed	\$ 5,250	\$ —
Accounts receivable—unbilled	8,704	—
Prepaid expenses and other current assets	53	—
<b>Current assets of discontinued operations</b>	<b>\$ 14,007</b>	<b>\$ —</b>
Accounts payable	\$ 5,919	\$ 95
Accrued compensation and benefits	909	539
Other accrued liabilities	6,995	—
<b>Current liabilities of discontinued operations</b>	<b>\$ 13,823</b>	<b>\$ 634</b>

## 22. Sale of Building

During the year ended September 30, 2008, the Company sold a 21,000 square foot administrative office building in McLean, Virginia for proceeds of \$5.9 million, net of transactions costs of \$0.2 million, and recognized a pre-tax gain on the sale of \$3.9 million. This gain has been classified as gain on sale of building in the consolidated statement of operations.

## 23. Related Party Transactions

Governor James R. Thompson, one of our outside directors who the Company's Board of Directors has determined to be independent, is Senior Chairman of the law firm of Winston & Strawn in Chicago. Winston & Strawn has provided certain legal services to the Company. These services were provided in the normal course of business on terms and conditions consistent with the standard practices of Winston & Strawn and MAXIMUS. Governor Thompson had no personal involvement in the services provided. In 2008, 2009, and 2010, the Company paid Winston & Strawn \$620,800, \$934,391 and \$150,609, respectively. These transactions do not represent a significant portion of Winston & Strawn's annual revenues.

## 24. Subsequent Events

### *Dividend*

On October 8, 2010, the Company's Board of Directors declared a quarterly cash dividend of \$0.12 for each share of the Company's common stock outstanding. The dividend will be paid on November 30, 2010 to shareholders of record on November 15, 2010. Based on the number of shares outstanding, the payment will be approximately \$2.1 million.

### *Share Repurchases*

As of November 19, 2010, the Company had repurchased an additional 37,500 shares at a cost of \$2.3 million during the first quarter of fiscal 2011.

**ITEM 9. Changes in and Disagreements with Accountants on Accounting and Financial Disclosure.**

None.

**ITEM 9A. Controls and Procedures.**

*Evaluation of Disclosure Controls and Procedures.* Our management, with the participation of our principal executive officer and principal financial officer, has evaluated the effectiveness of the design and operation of our disclosure controls and procedures (as defined in Rule 13a-15(e) under the Securities Exchange Act of 1934 (the “Exchange Act”)) as of the end of the period covered by this Annual Report on Form 10-K. Based on this evaluation, our principal executive officer and principal financial officer concluded that our disclosure controls and procedures are effective and designed to ensure that the information required to be disclosed in our reports filed or submitted under the Exchange Act is recorded, processed, summarized and reported within the requisite time periods.

*Management’s Report on Internal Control Over Financial Reporting.* Our management is responsible for establishing and maintaining adequate internal control over financial reporting (as defined in Rule 13a-15(f) under the Exchange Act). Our internal control over financial reporting is designed to provide reasonable assurance regarding the reliability of our financial reporting and the preparation of published financial statements in accordance with generally accepted accounting principles.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Therefore, even those systems determined to be effective can provide only reasonable assurance with respect to financial statement preparation and presentation. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Management assessed the effectiveness of our internal control over financial reporting as of September 30, 2010. In making this assessment, management used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in *Internal Control—Integrated Framework*. Based on our assessment, we believe that as of September 30, 2010, our internal control over financial reporting was effective based on criteria set forth by COSO in *Internal Control—Integrated Framework*.

The attestation report concerning the effectiveness of our internal control over financial reporting as of September 30, 2010, issued by Ernst & Young LLP, the independent registered public accounting firm who also audited our consolidated financial statements, is included following this Item 9A.

*Changes in Internal Control Over Financial Reporting.* During the fourth quarter of fiscal 2010, the Company completed the phased implementation of an enterprise resource planning system and completed installation of core financial modules for all US based divisions. We have updated the Company’s internal controls over financial reporting as necessary to accommodate modifications to business processes and accounting procedures. However, the internal control design remained substantially unchanged for the implementation.

Other than the matter noted above, there was no change in our internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) identified in connection with the evaluation of our internal control that occurred during our fourth fiscal quarter of 2010 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

**REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM**

The Board of Directors and Shareholders of MAXIMUS, Inc.

We have audited MAXIMUS, Inc.'s internal control over financial reporting as of September 30, 2010, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (the COSO criteria). MAXIMUS, Inc.'s management is responsible for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, MAXIMUS, Inc. maintained, in all material respects, effective internal control over financial reporting as of September 30, 2010, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the 2010 consolidated financial statements of MAXIMUS, Inc. and our report dated November 19, 2010 expressed an unqualified opinion thereon.

/s/ Ernst & Young LLP

McLean, Virginia  
November 19, 2010

**PART III**

The information required by Items 10, 11, 12, 13 and 14 of Part III of Form 10-K has been omitted in reliance on General Instruction G(3) to Form 10-K and is incorporated herein by reference to the Company's Proxy Statement relating to its Annual Meeting of Shareholders scheduled for March 18, 2011 (the "Proxy Statement") to be filed with the SEC, except as otherwise indicated below:

**ITEM 10. Directors, Executive Officers and Corporate Governance.**

The information required by this Item is incorporated by reference to the Proxy Statement.

**ITEM 11. Executive Compensation.**

The information required by this Item is incorporated by reference to the Proxy Statement.

**ITEM 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters.**

Except for the information disclosed in this Item below, the information required by this Item is incorporated by reference to the Proxy Statement.

**Securities Authorized for Issuance Under Equity Compensation Plans**

The following table provides information as of September 30, 2010 with respect to shares of our common stock that may be issued under our existing equity compensation plans:

	<b>Number of securities to be issued upon exercise of outstanding options, warrants and rights</b>	<b>Weighted average exercise price of outstanding options, warrants and rights</b>	<b>Number of securities remaining available for future issuance under equity compensation plans(1)</b>
Equity compensation plans/arrangements approved by the shareholders(2)	1,496,398	\$ 16.56	1,406,442
Equity compensation plans/arrangements not approved by the shareholders	—	—	—
<b>Total</b>	<b>1,496,398</b>	<b>\$ 16.56</b>	<b>1,406,442</b>

(1) In addition to being available for future issuance upon exercise of options that may be granted after September 30, 2010, all shares under the 1997 Equity Incentive Plan may be issued in the form of restricted stock, performance shares, stock appreciation rights, stock units, or other stock-based awards.

(2) Includes the 1997 Equity Incentive Plan, the 1997 Employee Stock Purchase Plan and the 1997 Director Stock Option Plan.

**ITEM 13. Certain Relationships and Related Transactions, and Director Independence.**

The information required by this Item is incorporated by reference to the Proxy Statement.

**ITEM 14. Principal Accounting Fees and Services.**

The information required by this Item is incorporated by reference to the Proxy Statement.

**PART IV**

**ITEM 15. Exhibits, Financial Statement Schedules.**

- (a) 1. Financial Statements.  
The consolidated financial statements are listed under Item 8 of this Annual Report on Form 10-K.
- 2. Financial Statement Schedules.  
None. Financial statement schedules are either not required under the related instructions or are inapplicable and therefore have been omitted.
- 3. Exhibits.  
The Exhibits filed as part of this Annual Report on Form 10-K are listed on the Exhibit Index immediately preceding such Exhibits, which Exhibit Index is incorporated herein by reference.
- (b) Exhibits—see Item 15(a)(3) above.
- (c) Financial Statement Schedules—see Item 15(a)(2) above.

**SIGNATURES**

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, as amended, the registrant has duly caused this Annual Report on Form 10-K to be signed on its behalf by the undersigned, thereunto duly authorized on the 19<sup>th</sup> day of November 2010.

MAXIMUS, INC.  
By: /s/ RICHARD A. MONTONI  
Richard A. Montoni  
*Chief Executive Officer*

Pursuant to the requirements of the Securities Exchange Act of 1934, as amended, this Annual Report on Form 10-K has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

<u>Signature</u>	<u>Title</u>	<u>Date</u>
<u>/s/ RICHARD A. MONTONI</u> Richard A. Montoni	President, Chief Executive Officer and Director (principal executive officer)	November 19, 2010
<u>/s/ DAVID N. WALKER</u> David N. Walker	Chief Financial Officer and Treasurer (principal financial and accounting officer)	November 19, 2010
<u>/s/ PETER B. POND</u> Peter B. Pond	Chairman of the Board of Directors	November 19, 2010
<u>/s/ RUSSELL A. BELIVEAU</u> Russell A. Beliveau	Director	November 19, 2010
<u>/s/ JOHN J. HALEY</u> John J. Haley	Director	November 19, 2010
<u>/s/ PAUL R. LEDERER</u> Paul R. Lederer	Director	November 19, 2010
<u>/s/ RAYMOND B. RUDDY</u> Raymond B. Ruddy	Director	November 19, 2010
<u>/s/ MARILYN R. SEYMANN</u> Marilyn R. Seymann	Director	November 19, 2010
<u>/s/ JAMES R. THOMPSON, JR.</u> James R. Thompson, Jr.	Director	November 19, 2010
<u>/s/ WELLINGTON E. WEBB</u> Wellington E. Webb	Director	November 19, 2010

**EXHIBIT INDEX**

<b>Exhibit Number</b>	
3.1	Amended and Restated Articles of Incorporation of the Company, as amended.(1)
3.2	Amended and Restated Bylaws of the Company.(2)
4.1	Specimen Common Stock Certificate.(3)
10.1	1997 Equity Incentive Plan, as amended.(4)*
10.2	First Amendment to the 1997 Equity Incentive Plan, as amended.(5)*
10.3	1997 Director Stock Option Plan, as amended.(6)*
10.4	1997 Employee Stock Purchase Plan, as amended.(7)*
10.5	Executive Employment, Non-Compete and Confidentiality Agreement by and between the Company and Richard A. Montoni.(8)*
10.6	First Amendment to the Executive Employment, Non-Compete and Confidentiality Agreement by and between the Company and Richard A. Montoni.(5)*
10.7	Executive Employment, Non-Compete and Confidentiality Agreement by and between the Company and Bruce Caswell.(5)*
10.8	First Amendment to the Executive Employment, Non-Compete and Confidentiality Agreement by and between the Company and Bruce Caswell.(5)*
10.9	Form of Indemnification Agreement by and between the Company and each of the directors of the Company.(9)*
10.10	Amended and Restated Income Continuity Program.(5)*
10.11	Deferred Compensation Plan, as amended.(5)*
10.12	1997 Equity Incentive Plan—Restricted Stock Units—Terms and Conditions.(10)
10.13	1997 Equity Incentive Plan—Non-Qualified Stock Option—Terms and Conditions.(10)
10.14	Purchase Agreement between MAXIMUS, Inc. and UBS AG, London Branch, dated November 15, 2007.(11)
10.15	Revolving Credit Agreement, dated January 25, 2008, by and among MAXIMUS, Inc., as borrower, SunTrust Bank as administrative agent, issuing bank and swingline lender and the other lender parties thereto.(12)
10.16	Security Agreement, dated January 25, 2008, among MAXIMUS, Inc. and certain subsidiaries of MAXIMUS, Inc., in favor of SunTrust Bank.(12)
10.17	Pledge Agreement, dated January 25, 2008, by and among MAXIMUS, Inc. and certain subsidiaries of MAXIMUS, Inc., in favor of SunTrust Bank.(12)
10.18	Extension of Employment Agreement of Richard A. Montoni, dated December 22, 2009 (13)*
21.1	Subsidiaries of the Company. Filed herewith.
23.1	Consent of Independent Registered Public Accounting Firm. Filed herewith.
31.1	Certification Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002. Filed herewith.
31.2	Certification Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002. Filed herewith.
32.1	Section 906 Principal Executive Officer Certification. Furnished herewith.
32.2	Section 906 Principal Financial Officer Certification. Furnished herewith.
99.1	Special Considerations and Risk Factors. Filed herewith.

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\* Denotes management contract or compensation plan.

(1) Filed as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2000 (File No. 1-12997) on August 14, 2000 and incorporated herein by reference.

(2) Filed as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended December 31, 2007, (File No. 1-12997) on February 8, 2008 and incorporated herein by reference.

(3) Filed as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 1997 (File No. 1-12997) on August 14, 1997 and incorporated herein by reference.

(4) Filed as an exhibit to the Company's Registration Statement on Form S-8 (File No. 333-136400) on August 8, 2006 and incorporated herein by reference.

(5) Filed as an exhibit to the Company's Current Report on Form 8-K (File No. 1-12997) on November 27, 2007 and incorporated herein by reference.

(6) Filed as an exhibit to the Company's Annual Report on Form 10-K for the year ended September 30, 1997 (File No. 1-12997) on December 22, 1997 and incorporated herein by reference.

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- (7) Filed as an exhibit to the Company's Registration Statement on Form S-8 (File No. 333-122711) on February 10, 2005 and incorporated herein by reference.
- (8) Filed as an exhibit to the Company's Current Report on Form 8-K (File No. 1-12997) on April 26, 2006 and incorporated herein by reference.
- (9) Filed as an exhibit to the Company's Registration Statement on Form S-1 (File No. 333-21611) on February 12, 1997 and incorporated herein by reference.
- (10) Filed as an exhibit to the Company's Current Report on Form 8-K (File No. 1-12997) on June 23, 2006 and incorporated herein by reference.
- (11) Filed as an exhibit to the Company's Current Report on Form 8-K (File No. 1-12997) on November 20, 2007 and incorporated herein by reference.
- (12) Filed as an exhibit to the Company's Current Report on Form 8-K (File No. 1-12997) on January 29, 2008 and incorporated herein by reference.
- (13) Filed as an exhibit to the Company's Quarterly Report on Form 10-Q for the Quarter ended December 31, 2009 (File No. 1-12997) on February 4, 2010 and incorporated herein by reference.

**MAXIMUS, Inc.**  
**List of Subsidiaries**  
**As of September 30, 2010**

<b>Name*</b>	<b>Jurisdiction of Incorporation/Organization</b>
MAXNetwork Pty Limited	Australia
ACN 083 406 795 Pty Limited	Australia
MAXIMUS Canada, Inc.	Canada
MAXIMUS Canada II, Inc.	Canada
Israel Workforce Solutions Ltd(1)	Israel
MAXIMUS Properties LLC	Virginia
MAXIMUS International, LLC	Virginia
MAXIMUS Federal Services, Inc.	Virginia
MAXIMUS Consulting Services, Inc.	Virginia
MAXIMUS Health Services, Inc.	Indiana
MAXIMUS Human Services, Inc.	Virginia
MAXIMUS ERP Solutions, LLC	Virginia
MAXIMUS Education Services, LLC	Virginia

All subsidiaries are 100% owned by MAXIMUS, unless otherwise noted

(1)—Owned 55% by MAXIMUS

\* This list identifies all subsidiaries that are directly owned by MAXIMUS at the “first tier” of its corporate structure. The names of all of the subsidiaries of these “first tier” subsidiaries have been omitted from this list because, considered in the aggregate, they would not constitute a significant subsidiary under Securities and Exchange Commission Regulation S-X, Rule 1-02(w).

**CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM**

We consent to the incorporation by reference in the following Registration Statements:

(1)  
Registration Statements (Form S-8, Nos. 333-88012, 333-41871, 333-62380, 333-75263 and 333-136400) pertaining to the 1997 Equity Incentive Plan of MAXIMUS, Inc.

(2)  
Registration Statement (Form S-8, Nos. 333-41867 and 333-122711) pertaining to the 1997 Employee Stock Purchase Plan of MAXIMUS, Inc. and

(3)  
Registration Statement (Form S-8, No. 333-41869) pertaining to the 1997 Director Stock Option Plan of MAXIMUS, Inc.

of our report dated November 19, 2010 with respect to the consolidated financial statements of MAXIMUS, Inc., and our report dated November 19, 2010 with respect to the effectiveness of internal control over financial reporting of MAXIMUS, Inc., included in the Annual Report (Form 10-K) for the year ended September 30, 2010.

/s/Ernst & Young LLP

McLean, Virginia  
November 19, 2010

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## Certification Pursuant to Section 302 of the Sarbanes–Oxley Act of 2002

I, Richard A. Montoni, certify that:

1. I have reviewed this Annual Report on Form 10–K of MAXIMUS, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant’s other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a–15(e) and 15d–15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a–15(f) and 15d–15(f)) for the registrant and have:

a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

c) Evaluated the effectiveness of the registrant’s disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

d) Disclosed in this report any change in the registrant’s internal control over financial reporting that occurred during the registrant’s most recent fiscal quarter (the registrant’s fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant’s internal control over financial reporting.

5. The registrant’s other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant’s auditors and the audit committee of the registrant’s board of directors (or persons performing the equivalent functions):

a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant’s ability to record, process, summarize and report financial information; and

b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant’s internal control over financial reporting.

Dated: November 19, 2010

/s/ RICHARD A. MONTONI

Richard A. Montoni  
Chief Executive Officer

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## Certification Pursuant to Section 302 of the Sarbanes–Oxley Act of 2002

I, David N. Walker, certify that:

1. I have reviewed this Annual Report on Form 10–K of MAXIMUS, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant’s other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a–15(e) and 15d–15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a–15(f) and 15d–15(f)) for the registrant and have:

a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

c) Evaluated the effectiveness of the registrant’s disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

d) Disclosed in this report any change in the registrant’s internal control over financial reporting that occurred during the registrant’s most recent fiscal quarter (the registrant’s fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant’s internal control over financial reporting.

5. The registrant’s other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant’s auditors and the audit committee of the registrant’s board of directors (or persons performing the equivalent functions):

a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant’s ability to record, process, summarize and report financial information; and

b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant’s internal control over financial reporting.

Dated: November 19, 2010

/s/ DAVID N. WALKER

David N. Walker  
Chief Financial Officer

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**Section 906 CEO Certification**

I, Richard A. Montoni, Chief Executive Officer of MAXIMUS, Inc. ("the Company"), do hereby certify, under the standards set forth in and solely for the purposes of 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that, to my knowledge:

1. The Annual Report on Form 10-K of the Company for the fiscal year ended September 30, 2010 (the "Annual Report") fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. Section 78m or 78o(d)) and

2. The information contained in the Annual Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: November 19, 2010

/s/ RICHARD A. MONTONI

Richard A. Montoni  
*Chief Executive Officer*

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**Section 906 CFO Certification**

I, David N. Walker, Chief Financial Officer of MAXIMUS, Inc. ("the Company"), do hereby certify, under the standards set forth in and solely for the purposes of 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that, to my knowledge:

1. The Annual Report on Form 10-K of the Company for the fiscal year ended September 30, 2010 (the "Annual Report") fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. Section 78m or 78o(d)) and

2. The information contained in the Annual Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: November 19, 2010

/s/ DAVID N. WALKER

David N. Walker  
*Chief Financial Officer*

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### Special Considerations and Risk Factors

From time to time, we may make forward-looking public statements, such as statements concerning our then-expected future revenue or earnings or concerning projected plans, performance or contract procurement, as well as other estimates relating to future operations. Forward-looking statements may be in reports filed under the Securities Exchange Act of 1934, as amended (the "Exchange Act"), in press releases or in informal statements made with the approval of an authorized executive officer. The words or phrases "will likely result," "are expected to," "will continue," "is anticipated," "estimate," "project," "believe," "could," "intend," "may," "opportunity," "plan," "potential" or similar terms and expressions are intended to identify "forward-looking statements" within the meaning of Section 21E of the Exchange Act and Section 27A of the Securities Act of 1933, as amended, as enacted by the Private Securities Litigation Reform Act of 1995.

We wish to caution you not to place undue reliance on these forward-looking statements that speak only as of the date on which they are made. In addition, we wish to advise you that the factors listed below, as well as other factors we have not currently identified, could affect our financial or other performance and could cause our actual results for future periods to differ materially from any opinions or statements expressed with respect to future periods or events in any current statement.

We will not undertake and we specifically decline any obligation to publicly release revisions to these forward-looking statements to reflect either a circumstance after the date of the statements or the occurrence of events that may cause us to re-evaluate our forward-looking statements.

In connection with the "safe harbor" provisions of the Private Securities Litigation Reform Act, we are hereby filing the following cautionary statements identifying important factors that could cause our actual results to differ materially from those projected in forward-looking statements made by us or on our behalf:

**We may be subject to fines, penalties and other sanctions if we fail to comply with federal, state and local laws governing our business.**

Our business lines operate within a variety of complex regulatory schemes, including but not limited to the Federal Acquisition Regulation ("FAR"), Cost Accounting Standards, the Truth in Negotiations Act, the Fair Debt Collection Practices Act (and analogous state laws), as well as the regulations governing Medicaid and Medicare. If a government audit uncovers improper or illegal activities by us or we otherwise determine that these activities have occurred, we may be subject to civil and criminal penalties and administrative sanctions, including termination of contracts, forfeitures of profits, suspension of payments, fines and suspension or disqualification from doing business with the government. Any adverse determination could adversely impact our ability to bid in response to requests for proposals ("RFPs") in one or more jurisdictions. Further, as a government contractor subject to the types of regulatory schemes described above, we are subject to an increased risk of investigations, criminal prosecution, civil fraud, whistleblower lawsuits and other legal actions and liabilities to which private sector companies are not, the result of which could have a material adverse effect on our operations.

**If we fail to satisfy our contractual obligations or meet performance standards, our contracts may be terminated and we may incur significant costs or liabilities, including liquidated damages and penalties, which could adversely impact our operating results, financial condition and our ability to compete for future contracts.**

Our contracts may be terminated for our failure to satisfy our contractual obligations or to meet performance standards and often require us to indemnify customers. In addition, some of our contracts contain substantial liquidated damages provisions and financial penalties related to performance failures. Although we have liability insurance, the policy coverage and limits may not be adequate to provide protection against all potential liabilities. Further, for certain contracts, we have posted significant performance bonds or issued letters of credit to secure our indemnification and other obligations. If a claim is made against a performance bond or letter of credit, we would be required to reimburse the issuer for the amount of the claim. Consequently, as a result of the above matters, we may incur significant costs or liabilities, including penalties, which could adversely impact our operating results, financial condition and our ability to compete for future contracts.

**We are subject to review and audit by federal, state and local governments at their sole discretion and, if any improprieties are found, we may be required to refund revenue we have received, or forego anticipated revenue, which could have a material adverse impact on our revenues and our ability to bid in response to RFPs.**

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As a provider of services to government agencies, we are subject to periodic audits and other reviews by Federal, state and local governments of our costs and performance, accounting and general business practices relating to our contracts with those government agencies. As part of that process, the government agency reviews our performance on the contract, our pricing practices, our cost structure and our compliance with applicable laws, regulations and standards. Based on the results of these audits, government agencies may demand refunds or adjust our contract-related costs and fees, including internal costs and expense allocation. Although adjustments arising from government audits and reviews have not had a material adverse effect on our results of operations in the past, there can be no assurance that future audits and reviews would not have such effects.

**We may face liabilities arising from divested or discontinued businesses.**

During 2008 we divested our Security Solutions, Unison, Education Systems, Justice Solutions and Asset Solutions businesses. During fiscal 2010, we divested our ERP Solutions business. The transaction documents for those divestitures contain a variety of representations, warranties and indemnification obligations. We could face indemnification claims and liabilities from alleged breaches of representations or warranties. In addition, the majority of our customer contracts require customer consent to assign those contracts to a third party. Although we are cooperating with the buyers of those businesses to obtain all customer consents, a customer could refuse to consent to an assignment and seek to hold us liable for performance problems or other contractual obligations.

During 2009 we exited the revenue maximization business. Although we no longer provide those services, former projects that we performed for state clients remain subject to Federal audits. Our contracts for that business generally provide that the company will refund the portion of its fee associated with any Federal disallowance. Accordingly, we may be obligated to refund amounts paid for such revenue maximization services depending on the outcome of future Federal audits.

**If we fail to accurately estimate the factors upon which we base our contract pricing, we may generate less profit than expected or incur losses on those contracts.**

We derived approximately 21% of our fiscal 2010 revenue from fixed-price contracts and approximately 47% of our fiscal 2010 revenue from performance-based contracts. For fixed-price contracts, we receive our fee based on services provided. Those services might include operating a Medicaid enrollment center pursuant to specified standards, designing and implementing computer systems or applications, or delivering a planning document under a consulting arrangement. For performance-based contracts, we receive our fee on a per-transaction basis. These contracts include, for example, child support enforcement contracts, in which we often receive a fee based on the amount of child support collected. To earn a profit on these contracts, we must accurately estimate costs involved and assess the probability of completing individual transactions within the contracted time period. If our estimates prove to be inaccurate, we may not achieve the level of profit we expected or we may incur a net loss on a contract. Although we believe that we have recorded adequate provisions in our financial statements for losses on our fixed-price and cost-plus contracts, as required under U.S. generally accepted accounting principles, we cannot assure you that our contract loss provisions will be adequate to cover all actual future losses.

**Adverse judgments or settlements in legal disputes could harm our financial condition and operating results.**

We are subject to a variety of lawsuits and other claims that arise from time to time in the ordinary course of our business. These may include lawsuits and claims related to contracts, subcontracts and employment claims and compliance with Medicaid and Medicare regulations as well as laws governing debt collections and child support enforcement. Adverse judgments or settlements in some or all of these legal disputes may result in significant monetary damages or injunctive relief against us. In addition, litigation and other legal claims are subject to inherent uncertainties and management's view of these matters may change in the future. Those uncertainties include, but are not limited to, costs of litigation, unpredictable court or jury decisions, and the differing laws and attitudes regarding damage awards among the states and countries in which we operate.

**We may incur significant costs before receiving related contract payments that could result in increasing the use of cash and accounts receivable.**

When we are awarded a contract, we may incur significant expenses before we receive contract payments, if any. These expenses may include leasing office space, purchasing office equipment and hiring personnel. In other situations, contract terms provide for billing upon achievement of specified project milestones. As a result, in these situations, we are required to expend significant sums of money before receiving related contract payments. In addition, payments due to us from government agencies may be delayed due to billing cycles or as a result of failures to approve governmental budgets in a timely manner. These factors could impact us by increasing the use of cash and accounts receivable. Moreover, these impacts could be exacerbated if we fail to either invoice the government agency or collect our fee in a timely manner.

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**We obtain most of our business through competitive bidding in response to government RFPs. We may not be awarded contracts through this process on the same level in the future as in the past, and contracts we are awarded may not be profitable.**

Substantially all of our customers are government agencies. To market our services to government customers, we are often required to respond to government RFPs which may result in contract awards on a competitive basis. To do so effectively, we must estimate accurately our cost structure for servicing a proposed contract, the time required to establish operations and likely terms of the proposals submitted by competitors. We must also assemble and submit a large volume of information within an RFP's rigid timetable. Our ability to respond successfully to RFPs will greatly impact our business. There is no assurance that we will continue to obtain contracts in response to government RFPs and our proposals may not result in profitable contracts. In addition, competitors may protest contracts awarded to us through the RFP process which may cause the award to be delayed or overturned or may require the customer to reinitiate the RFP process.

**Government entities have in the past and may in the future terminate their contracts with us earlier than we expect, which may result in revenue shortfalls.**

Many of our government contracts contain base periods of one or more years, as well as option periods covering more than half of the contract's potential duration. Government agencies do not have to exercise these option periods, and they may elect not to exercise them for budgetary, performance, or any other reason. Our contracts also typically contain provisions permitting a government customer to terminate the contract on short notice, with or without cause. Termination without cause provisions generally allow the government to terminate a contract at any time, and enable us to recover only our costs incurred or committed, and settlement expenses and profit, if any, on the work completed prior to termination. The unexpected termination of significant contracts could result in significant revenue shortfalls. If revenue shortfalls occur and are not offset by corresponding reductions in expenses, our business could be adversely affected. We cannot anticipate if, when or to what extent a customer might terminate its contracts with us.

**If we are unable to manage our growth, our profitability will be adversely affected.**

Sustaining our growth places significant demands on our management as well as on our administrative, operational and financial resources. For us to continue to manage our growth, we must continue to improve our operational, financial and management information systems and expand, motivate and manage our workforce. If our growth comes at the expense of providing quality service and generating reasonable profits, our ability to successfully bid for contracts and our profitability will be adversely affected.

**We rely on key contracts with state and local governments for a significant portion of our revenue. A substantial reduction in those contracts would materially adversely affect our operating results.**

In fiscal 2010, approximately 59% of our total revenue was derived from contracts with state and local government agencies. Any significant disruption or deterioration in our relationship with state and local governments and a corresponding reduction in these contracts would significantly reduce our revenues and could substantially harm our business.

**Government unions may oppose outsourcing of government programs to outside vendors such as us, which could limit our market opportunities and could impact us adversely. In addition, our unionized workers could disrupt our operations.**

Our success depends in part on our ability to win profitable contracts to administer and manage health and human services programs traditionally administered by government employees. Many government employees, however, belong to labor unions with considerable financial resources and lobbying networks. Unions have in the past applied, and are likely to continue to apply, political pressure on legislators and other officials seeking to outsource government programs. Union opposition to these programs may result in fewer opportunities for us to service government agencies and/or longer and more complex procurements.

We do operate outsourcing programs using unionized employees in Canada. We have experienced opposition from the union which does not favor the outsourcing of government programs. As a result, we have received negative press coverage as the union continues to oppose our program operations. Such press coverage and union opposition may have an adverse affect on the willingness of government agencies to outsource such projects as well as certain contracts that are operated within a unionized environment. Our unionized workers could also declare a strike which could adversely affect our performance and financial results.

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**We may be precluded from bidding and performing certain work due to other work we currently perform.**

Various laws and regulations prohibit companies from performing work for government agencies that might be viewed as an actual or apparent conflict of interest. These laws may limit our ability to pursue and perform certain types of work. For example, some of our businesses assist government agencies in developing RFPs for various government programs. In those situations, the divisions involved in operating such programs would likely be precluded from bidding on those RFPs. Similarly, regulations governing the independence of Medicaid enrollment brokers and Medicare appeal providers could prevent us from providing services to other organizations such as health plans.

**We may lose executive officers and senior managers on whom we rely to generate business and execute projects successfully.**

The ability of our executive officers and our senior managers to generate business and execute projects successfully is important to our success. While we have employment agreements with some of our executive officers, those agreements do not prevent them from terminating their employment with us. The loss of an executive officer or senior manager could impair our ability to secure and manage engagements, which could harm our business, prospects, financial condition and results of operations.

**Inaccurate, misleading or negative media coverage could adversely affect our reputation and our ability to bid for government contracts.**

Because of the public nature of many of our business lines, the media frequently focus their attention on our contracts with government agencies. If the media coverage is negative, it could influence government officials to slow the pace of outsourcing government services, which could reduce the number of RFPs. The media also focus their attention on the activities of political consultants engaged by us, and we may be tainted by adverse media coverage about their activities, even when those activities are unrelated to our business. Moreover, inaccurate, misleading or negative media coverage about us could harm our reputation and, accordingly, our ability to bid for and win government contracts.

**We may be unable to attract and retain sufficient qualified personnel to sustain our business.**

Our delivery of services is labor-intensive. When we are awarded a government contract, we must quickly hire project leaders and case management personnel. The additional staff also creates a concurrent demand for increased administrative personnel. Our success requires that we attract, develop, motivate and retain:

- experienced and innovative executive officers;
- senior managers who have successfully managed or designed government services programs; and
- information technology professionals who have designed or implemented complex information technology projects.

Innovative, experienced and technically proficient individuals are in great demand and are likely to remain a limited resource. There can be no assurance that we will be able to continue to attract and retain desirable executive officers and senior managers. Our inability to hire sufficient personnel on a timely basis or the loss of significant numbers of executive officers and senior managers could adversely affect our business.

**If we fail to establish and maintain important relationships with government entities and agencies, our ability to successfully bid for RFPs may be adversely affected.**

To facilitate our ability to prepare bids in response to RFPs, we rely in part on establishing and maintaining relationships with officials of various government entities and agencies. These relationships enable us to provide informal input and advice to the government entities and agencies prior to the development of an RFP. We also engage marketing consultants, including lobbyists, to establish and maintain relationships with elected officials and appointed members of government agencies. The effectiveness of these consultants may be reduced or eliminated if a significant political change occurs. In that circumstance, we may be unable to successfully manage our relationships with government entities and agencies and with elected officials and appointees. Any failure to maintain positive relationships with government entities and agencies may adversely affect our ability to bid successfully in response to RFPs.

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**The federal government may limit or prohibit the outsourcing of certain programs or may refuse to grant consents and/or waivers necessary to permit private entities, such as us, to perform certain elements of government programs.**

The federal government could limit or prohibit private contractors like MAXIMUS from operating or performing elements of certain government programs. State or local governments could be required to operate such programs with government employees as a condition of receiving federal funding. Moreover, under current law, in order to privatize certain functions of government programs, the federal government must grant a consent and/or waiver to the petitioning state or local agency. If the federal government does not grant a necessary consent or waiver, the state or local agency will be unable to outsource that function to a private entity, such as us. This situation could eliminate a contracting opportunity or reduce the value of an existing contract.

**Our business could be adversely affected by future legislative or government budgetary and spending changes.**

The market for our services depends largely on federal and state legislative programs and the budgetary capability to support programs, including the continuance of existing programs. These programs can be modified or amended at any time by acts of federal and state governments.

Moreover, part of our growth strategy includes aggressively pursuing new opportunities and continuing to serve existing programs scheduled for re-bid, which are or may be created by federal and state initiatives, principally in the area of health and human services.

State budgets have been adversely impacted by the recent financial and credit crisis and worldwide economic slowdown, resulting in state budget deficits. There are a number of alternatives to states in managing a possible budget deficit, including:

- Accessing previously set aside or “rainy day” funds;
- Increasing taxes;
- Elimination or reduction in services;
- Cost containment and savings;
- Pursuit of additional federal assistance; and
- Developing additional sources of revenue, such as the legalization of gaming.

While we believe that the demand for our services remains substantial, state budget deficits could adversely impact our existing and anticipated business as well as our future financial performance.

Also, changes in federal initiatives or in the level of federal spending due to budgetary or deficit considerations may have a significant impact on our future financial performance. For example, increased or changed spending on defense, security or anti-terrorism threats may impact the level of demand for our services. Many state programs, such as Medicaid, are federally mandated and fully or partially funded by the federal government. Changes, such as program eligibility, benefits, or the level of federal funding may impact the demand for our services. Certain changes may present new opportunities to us and other changes may reduce the level of demand for services provided by us, which could materially adversely impact our future financial performance.

**If we do not successfully integrate the businesses that we acquire, our results of operations could be adversely affected.**

Business combinations involve a number of factors that affect operations, including:

- diversion of management’s attention;
  - loss of key personnel;
  - entry into unfamiliar markets;
  - assumption of unanticipated legal or financial liabilities;
  - becoming significantly leveraged as a result of incurring debt to finance an acquisition;
-

- unanticipated operating, accounting or management difficulties in connection with the acquired entities;
- impairment of acquired intangible assets, including goodwill; and
- dilution to our earnings per share.

Businesses we acquire may not achieve the revenue and earnings we anticipated. Customer dissatisfaction or performance problems with an acquired firm could materially and adversely affect our reputation as a whole. As a result, we may be unable to profitably manage businesses that we have acquired or that we may acquire or we may fail to integrate them successfully without incurring substantial expenses, delays or other problems that could materially negatively impact our business and results of operations.

**We may rely on subcontractors and partners to provide clients with a single-source solution.**

From time to time, we may engage subcontractors, teaming partners or other third parties to provide our customers with a single-source solution. While we believe that we perform appropriate due diligence on our subcontractors and teaming partners, we cannot guarantee that those parties will comply with the terms set forth in their agreements. We may have disputes with our subcontractors, teaming partners or other third parties arising from the quality and timeliness of the subcontractor's work, customer concerns about the subcontractor or other matters. Subcontractor performance deficiencies could result in a customer terminating our contract for default. We may be exposed to liability, and we and our clients may be adversely affected if a subcontractor or teaming partner failed to meet its contractual obligations.

**We face competition from a variety of organizations, many of which have substantially greater financial resources than we do; we may be unable to compete successfully with these organizations.**

Our consulting businesses typically compete for consulting contracts with large global consulting firms, as well as smaller niche players.

Our BPO businesses compete for program management contracts with the following:

- government services divisions of large organizations such as Affiliated Computer Services, Inc. (acquired by Xerox Corporation), Electronic Data Systems Corporation (acquired by Hewlett-Packard Company), and International Business Machines Corporation;
- specialized service providers; and
- local non-profit organizations such as the United Way of America, Goodwill Industries and Catholic Charities, USA.

Many of these companies are national and international in scope, are larger than us and have greater financial resources, name recognition and larger technical staffs. Substantial resources could enable certain competitors to initiate severe price cuts or take other measures in an effort to gain market share. In addition, we may be unable to compete for the limited number of large contracts because we may not be able to meet an RFP's requirement to obtain and post a large cash performance bond. Also, in some geographic areas, we face competition from smaller consulting firms with established reputations and political relationships. There can be no assurance that we will be able to compete successfully against our existing or any new competitors.

**A number of factors may cause our cash flows and results of operations to vary from quarter to quarter.**

Factors which may cause our cash flows and results of operations to vary from quarter to quarter include:

- the terms and progress of contracts;
  - Caseloads and other volume where revenue is derived on transactional volume on contracts;
-

- the levels of revenue earned and profitability of fixed-price and performance-based contracts;
- expenses related to certain contracts which may be incurred in periods prior to revenue being recognized;
- the commencement, completion or termination of contracts during any particular quarter;
- the schedules of government agencies for awarding contracts;
- the term of awarded contracts; and
- potential acquisitions.

Changes in the volume of activity and the number of contracts commenced, completed or terminated during any quarter may cause significant variations in our cash flows and results of operations because a large amount of our expenses are fixed.

**Our Articles of Incorporation and bylaws include provisions that may have anti-takeover effects.**

Our Articles of Incorporation and bylaws include provisions that may delay, deter or prevent a takeover attempt that shareholders might consider desirable. For example, our Articles of Incorporation provide that our directors are to be divided into three classes and elected to serve staggered three-year terms. This structure could impede or discourage an attempt to obtain control of us by preventing stockholders from replacing the entire board in a single proxy contest, making it more difficult for a third party to take control of us without the consent of our Board of Directors. Our Articles of Incorporation further provide that our shareholders may not take any action in writing without a meeting. This prohibition could impede or discourage an attempt to obtain control of us by requiring that any corporate actions initiated by shareholders be adopted only at properly called shareholder meetings.

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# Weekly Reports



Helping Government Serve the People.®



## VHAMS Weekly Reports

August 2011

To: Bill Clark, Director of Provider and Member Relations

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# Week: August 1<sup>st</sup> – August 5<sup>th</sup> 2011

MAXIMUS is pleased to submit this weekly report to the Department of Vermont Health Access (DVHA) for your review. This report documents our call statistics, as well as beneficiary complaints and feedback, for the week of August 1, 2011 through August 5, 2011. Upon your review, please let us know if you have any comments or questions.

## Call Statistics

The Vermont Health Access Member Services (VHAMS) Project was operational for five business days last week. Call volume this week remained consistent with previous weeks. VHAMS was able to far exceed all call performance standards this week. MAXIMUS staff handled a total of 6,649 calls during this reporting period. The project answered a total of 5,927 incoming Help Line calls and placed 722 outgoing calls. This means that on average MAXIMUS staff handled 1,330 calls per day.

Abandon Percentage	Percent Answered < 2 min	Percent Answered < 4 min
0.8%	100%	100%

IVR Calls In (24 hrs.)	MSU Calls In	MSU Calls Answered	MSU Calls Out
7,476	5,977	5,927	722

Total Calls Handled	Average Calls Daily	Average TTA Seconds	Average Call Length	Longest Wait
6,649	1,330	11	04:02	02:19

## Call Topic Statistics

MAXIMUS documented 1,026 calls relating specifically to premiums during the reporting period. Of the 5,927 phone calls answered last week, 1,668 (28%) were calls noted with a call topic of Client Status. VHAMS fielded many calls from beneficiary's who paid their premium after the due date, but before the closure date. These beneficiaries had not yet had their auto application processed by their eligibility worker. In general, MSRs send CATNs on these cases requesting the auto application. There were several instances of GOVet outages this week and VHAMS assisted DVHA work units in resolving beneficiary issues without state system applications. This week saw a sharp increase of instances in which providers were unwilling to bill for durable medical equipment and inpatient mental health services for VHAP beneficiaries. Despite the change in covered services, many providers were unwilling to bill for VHAP MC services without proof in writing that VHAP FFS and MC now covered the same benefits. VHAMS outreached to DVHA for guidance on handling these calls and situations.

*More VHAP beneficiaries call than any other program. On average, 30% of callers are on VHAP.*

Client Status		Premium		Eligibility		No Update: Change to Member Info		Change to Member Info	
1,668	28%	1,026	17%	583	10%	591	10%	501	8%

## Complaints and Compliments

MAXIMUS documented five complaints and four compliments this week. Please note, some of these complaints may not be reflected in the monthly Help Line call log reports, as the complaint was not the primary topic of the call. Complaints and compliments are written as reported by the caller and not researched or validated by MAXIMUS except where required and necessary.

Program	Issue	Complaint	Resolution
ESIA	Review Process	Jenny complains it is a "waste of the taxpayer's dollars" to insist she fill out an annual review. She feels that she should not be "penalized" just because other people don't report changes to their situation.	The MSR advised her that everyone must fill out a review application to ensure they are still eligible for benefits. MSR offered to forward her concerns to the state.
CHAP	Eligibility Process	Parent of beneficiary complains the CHAP eligibility and enrollment process is too lengthy and complicated. She feels her daughter's coverage should just begin on August 1 <sup>st</sup> and if it did, a lot of time and money would be saved.	The MSR Supervisor apologized for her inconvenience and frustration. The MSR Supervisor explained the Catamount plan start date rules and offered a fair hearing, which the parent refused. The MSR Supervisor offered to document her complaint.
Multiple Programs	Catamount Plan Slicks	Matt complains the Catamount Slicks mailed to him by VHAMS were out of date. He feels we should only be giving out current information.	The MSR apologized for the misinformation and directed him to the plan websites and phone numbers for in-depth help. After researching it was determined that VHAMS had mailed the old versions prior to receiving the new versions, stock is now current.
CHAP	CHAP Enrollment	Kim complains she should have been able to enroll in her Catamount plan when she sent in the premium payment and should not have had to wait for a CPS.	The MSR explained Catamount enrollments cannot be entered into the system without a paid premium and offered to forward her concerns.
CHAP	Morrisville DCF Office	Jacqueline complains she was told at the Morrisville DCF office her husband only had to pay his premium for his CHAP coverage to start immediately. She feels she should have been told CHAP is a multi-step process and he is required to pay his premium and enroll in a Catamount plan.	The MSR apologized for the misinformation and offered to forward her concerns.

Date	Type	Client Info	Compliments/Comments
08/03/11	VHAMS	Hilde	"Therese was so pleasant. It was really nice to speak with someone who cares."
08/02/11	VHAMS	Sandra	"Molly was very calm and gave me clear cut answers without talking down to me."

08/02/11	VHAMS	Robert	"You are all very helpful. I enjoy talking to you all because you always give such helpful answers."
08/01/11	DCF – Pamela Doyle	William	"My wife and I have lived in Vermont for 40 years and we're very grateful for the help you have given us."

## Month to Date Totals/Averages

Abandon Percentage	Percent Answered < 2 min	Percent Answered < 4 min
0.8%	100%	100%

IVR Calls In (24 hrs.)	MSU Calls In	MSU Calls Answered	MSU Calls Out
7,476	5,977	5,927	722

Total Calls Handled	Average Calls Daily	Average TTA Seconds	Average Call Length	Longest Wait
6,649	1,330	11	04:02	02:19

## Conclusion

Operations for the Vermont Health Access Member Services Project continue to run smoothly as MAXIMUS strives to meet the needs of the Department of Vermont Health Access, the Department for Children and Families, Agency of Human Services, and our beneficiaries.

Sincerely,

Sonia Tagliento

Project Manager



# Monthly Report



Helping Government Serve the People.®



## VHAMS Monthly Report

June 15, 2011

To: Mr. Bill Clark

Director of Provider and Member Relations,  
Department of Vermont Health Access

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## Introduction and Performance

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MAXIMUS is pleased to submit this monthly report to the Department of Vermont Health Access (DVHA) for your review. Upon your review, please let us know whether you have any questions. The following narrative and accompanying exhibits detail our member services, enrollment, mail, and TPL activities performed through the Help Line for the month of June 2011. We define this reporting period as having five full weeks, May 30, 2011 through July 1 2011. VHAMS was closed on May 30<sup>th</sup> for Memorial Day during this reporting period.

While VHAMS continues to experience moments of high call volumes and call durations, which can be attributed to pharmacy review decision and review reminder notices, VHAMS was successful in exceeding our contractual obligations and goals.

	Did not meet standard	Met standard	Exceeded standard	Far exceeded standard
Operate a 'live' toll-free line				✓
Maintain a toll-free TDD/TTY line				✓
Provide translation via the Language Line				✓
Answer calls w.in 25 sec			✓	
Abandonment rate < 10 %				✓
Answer 95% of calls within 2 min			✓	
Answer 100% of calls within 4 min		✓		
Mail monthly enrollment forms within 5 business days			✓	
Mail daily enrollment forms within 1 business day			✓	
Enter enrollment forms within 2 business days			✓	
Return incomplete forms within 2 business days			✓	
Mail confirmation letters within 2 business days			✓	
Maintain an auto-assignment rate of < 25%				✓

## Call Statistics

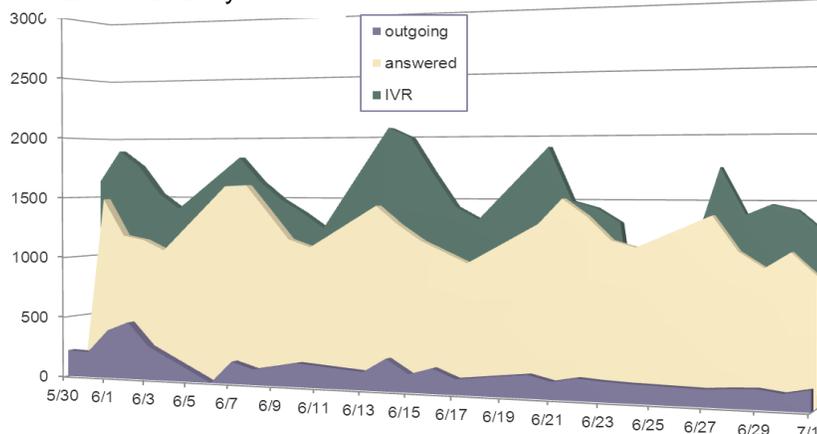
The information in Exhibit 1: Help Line Statistics and Exhibit 2: Daily Calls reflects the information gathered by the IVR May 30, 2011 through July 1 2011. Because of increased call volumes and an extra week in the reporting month, we answered 29,917 incoming calls, an increase of 7,737 calls over last month. We placed 4,622 outgoing calls, an increase of 416 calls from last month. On average, MAXIMUS staff handled 6,907 calls per week in June compared to 6,597 calls per week in May. Exhibit 1 shows that the average time to answer a call for the month was 23 seconds. Of the incoming calls, 100% were answered within four minutes, and 97% were answered within two minutes. Abandoned calls amounted to 1.2% of incoming calls for the month.

Exhibit 1: Helpline Statistics					
	IVR In (24 hrs.)	MSU In	MSU Answered	MSU Out	Total Handled
Week 1	6,164	4,895	4,867	661	5,528
Week 2	8,548	7,009	6,871	1,573	8,444
Week 3	7,595	6,048	6,004	873	6,877
Week 4	8,228	6,684	6,551	795	7,346
Week 5	7,332	5,735	5,624	720	6,344
<b>Total/Average</b>	<b>37,867</b>	<b>30,371</b>	<b>29,917</b>	<b>4,622</b>	<b>34,539</b>

	Calls Daily	TTA Seconds	Call Length	Longest Wait
Week 1	1,382	10	04:01	02:56
Week 2	1,689	17	03:57	04:03
Week 3	1,375	12	04:05	02:43
Week 4	1,469	29	04:08	03:55
Week 5	1,269	32	04:12	04:55
<b>Total/Average</b>	<b>1,439</b>	<b>23</b>	<b>04:04</b>	<b>03:51</b>

	Abandonment Percentage	Percent Answered < 2 minutes	Percent Answered < 4 minutes
Week 1	0.5%	100%	100%
Week 2	0.7%	99%	100%
Week 3	0.7%	99%	100%
Week 4	1.9%	95%	100%
Week 5	1.9%	93%	99%
<b>Total/Average</b>	<b>1.2%</b>	<b>97%</b>	<b>100%</b>

Exhibit 2: Daily Calls

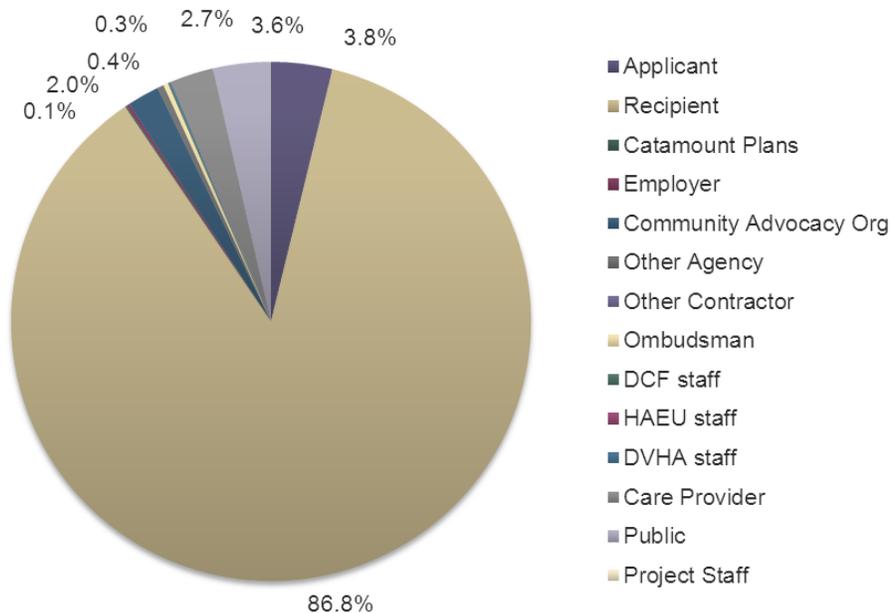


## Caller Type

In Exhibit 3: Caller Type Summary, we report on the category a caller to the Helpline falls into. As you can see, the vast majority (86.8%) of callers continue to be recipients of state funded health care benefits. Individuals wishing to apply for state funded health care benefits accounted for 3.8% of total calls received. Provider calls to the Helpline numbered 702 this month, and accounted for 2.7% of total calls received.

Exhibit 3: Caller Type Summary		
	Total	Percentage
Applicant	1,005	3.8%
Recipient	22,960	86.8%
Catamount Plans	21	0.1%
Employer	44	0.2%
Community Advocacy Org	525	2.0%
Other Agency	114	0.4%
Other Contractor	6	0.0%
Ombudsman	74	0.3%
DCF staff	27	0.1%
HAEU staff	4	0.0%
DVHA staff	23	0.1%
Care Provider	702	2.7%
Public	948	3.6%
Project Staff	10	0.0%
<b>TOTAL</b>	<b>26,463</b>	<b>100.0%</b>

Exhibit 4: Caller Type



## Program Type

Exhibit 5: Percent of Calls by Program

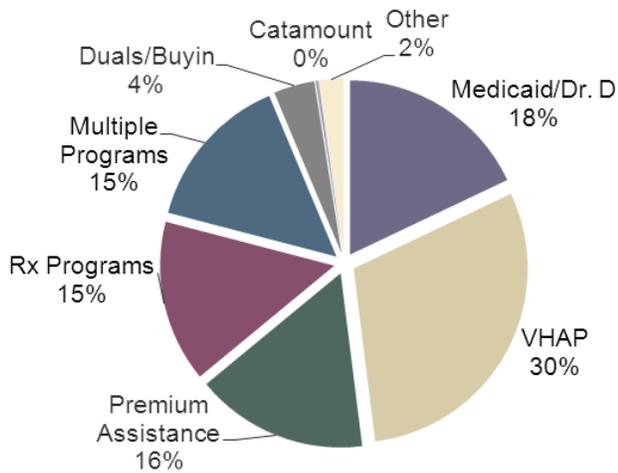


Exhibit 5: Percent of Calls by Program graphically displays the percent of Helpline calls received by program. In Exhibit 6: Incoming Calls by Program, we report the number of calls received by DVHA programs. Medicaid and Dr. Dynasaur calls made up 18% of calls received for a combined total of 4,750 calls. VHAP managed care and VHAP-Limited calls accounted for a combined total of 30% of total call volume. Premium Assistance calls accounted for 16% of total calls. Calls regarding pharmacy programs numbered 3,978 this month, compared to 3,811 last month, and accounted for 15% of all calls. Of the pharmacy calls, 913 were in regards to the Healthy Vermonters Program.

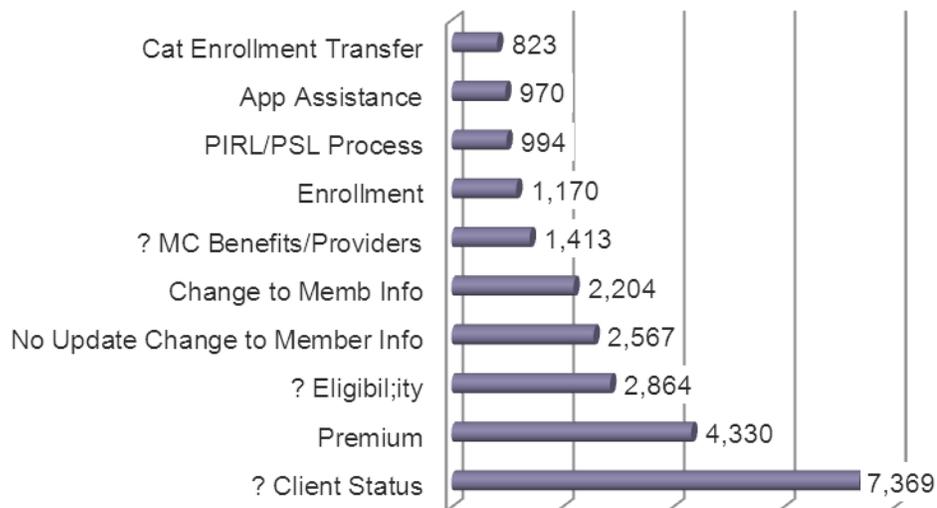
Exhibit 6: Incoming Calls By Program

	Total	Percentage
Medicaid/DrD Managed Care	3,583	13.5%
Medicaid FFS	923	3.5%
Dr. Dynasaur FFS	244	0.9%
VHAP Managed Care	6,957	26.3%
VHAP Limited	999	3.8%
Multiple Programs	3,868	14.6%
Vpharm-1	1,682	6.4%
Vpharm-2	634	2.4%
Vpharm-3	746	2.8%
VHAP Rx, VScript, VScript-Ex	3	0.0%
Medicare/Medicaid (duals)	732	2.8%
Healthy Vermonters	913	3.5%
Citizenship/Identity	16	0.1%
Non-Program Related	575	2.2%
Catamount	75	0.3%
ESIA	272	1.0%
VHAP-ESIA	169	0.6%
CHAP	3,795	14.3%
BUYIN	275	1.0%
<b>TOTAL</b>	<b>26,461</b>	<b>100%</b>

## Call Topics

Exhibit 7: Top 10 Call Topics and Exhibit 8: Other Call Topics, reports on the "business process" the customer conducts during the call. Questions regarding client status ranked first, accounting for 26.1% of the calls received. Callers with questions about their premium bills accounted for 15.3% of the total call volume. Beneficiaries reporting changes to their information totaled 4,771 and accounted for 16.7% of call volume. This topic includes changes to HAEU and District office cases.

Exhibit 7: Top 10 Call Topics



In June, there was an increase in questions regarding the PIRL/PSL process and a decrease in the number of Billing Issues. There were 22 complaints filed this month. Many of these complaints are documented in detail as they occur in the weekly report submitted to DVHA. Other complaints may have been resolved via various Grievance, Appeals, and Complaint resolutions.

Exhibit 8: Other Call Topics

	Total	Percentage
Fraud	7	0.0%
Complaints	22	0.0%
CI Specialist	23	0.1%
MediD/Vpharm/Buyin	63	0.2%
Replacement Card	284	1.0%
Change PCP	397	1.4%
Question	566	2.0%

## Call Resolution

Exhibit 9: Top 10 Call Resolutions and Exhibit 10: Other Call Resolutions reports on the "business processes" the MSR conducted to resolve the call. MSRs provided an overview for 12,533 callers (47.4%) this month. MAXIMUS enrolled 1,124 households into managed care via the Helpline, mailed applications or information to 1,485 households, and resolved billing issues for 40 callers this month. In addition, MAXIMUS staff helped file a complaint resolution on behalf of 16 beneficiaries. MSRs also entered changes to cases or forwarded the information to district office workers on the behalf of 5,767 beneficiaries and MSRs processed 367 PCP changes requested via the Helpline.

Exhibit 9: Top 10 Call Resolutions

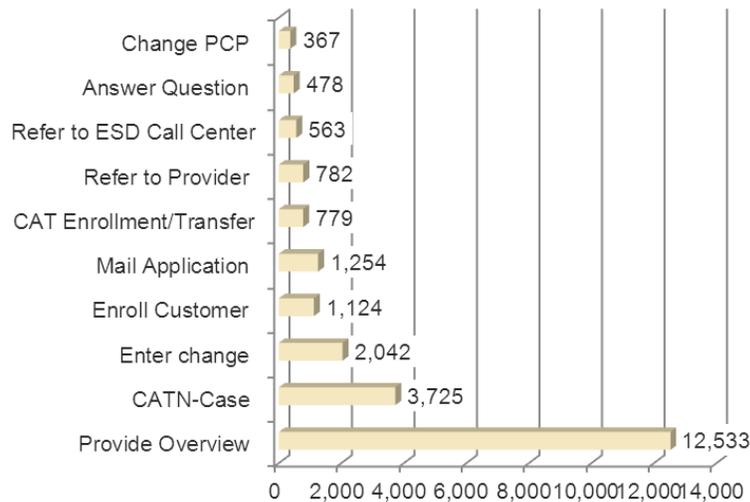
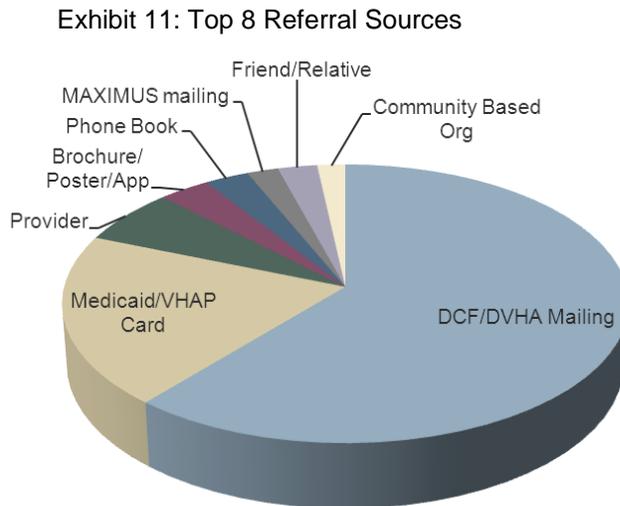


Exhibit 10: Other Call Resolutions

	Total	Percentage
Mail Information	231	0.9%
File GAC	16	0.1%
Reorder Premium Hierarchy	27	0.1%
File incident report	15	0.1%
Submit TPL	144	0.5%
Resolve Billing/System Issue	40	0.2%
Issue card	191	0.7%
Refer to Medicare/SHIP/PDP	149	0.6%
Refer to DVHA	219	0.8%
Refer to Eligibility Worker	431	1.6%
Transfer to supervisor	93	0.4%
Refer to HP/Medmetrics	375	1.4%
Refer to Catamount plans	242	0.9%
Refer to website	413	1.6%
Refer to other resource/agency	228	0.9%

## Referral Source

Exhibit 11: Top 8 Referral Sources is a graphical representation of some of the sources of calls received. Exhibit 12: Other Referral Sources reflects all other referral sources generating calls to the Helpline not represented in the graph. DCF and DVHA mailings generated 56% of the calls this month. The back of the Green Mountain Care card prompted 22% of calls. 621 calls were in response to MAXIMUS outreach efforts via mail and phone.



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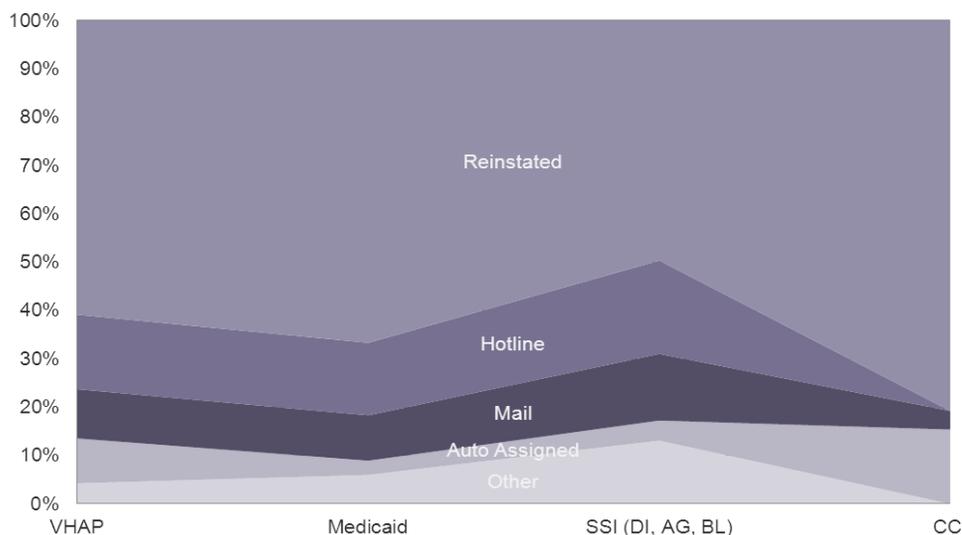
**Exhibit 12: Other Referral Sources**

	Total	Percentage
MAXIMUS Outreach	119	0.5%
Eligibility Worker	50	0.2%
Catamount Plans	157	0.6%
HPE/Medmetrics	14	0.1%
Other Agency	295	1.1%
Ombudsman	56	0.2%
Media	102	0.4%
Internet	263	1.0%
Special Mailing/Initiative	340	1.3%

## PC+ Enrollment

Confirmed enrollments represent individuals who enrolled via the Helpline, email, in-person, or mailed in an enrollment form and remained program eligible through the effective date of the enrollment. Confirmed enrollments also include individuals in a mandatory enrollment groups who did not respond to MAXIMUS outreach efforts and were subsequently manually or auto-assigned. MAXIMUS enrolled 1,218 Medicaid individuals, 1425 VHAP individuals, 62 SSI individuals, and 4 SRS individuals for a total of 2,709 confirmed enrollments for a July 1, 2011 effective date. Exhibit 13 displays the PC Plus enrollments by program and method.

Exhibit 13: PC Plus Enrollments by Program and by Method Effective July 2011



There were also 6,630 beneficiaries reinstated to PC Plus for a July 1, 2011 effective date. Exhibit 14: Confirmed Enrollments displays confirmed PC Plus enrollments by method and aid category. Due to restrictions on outreach and discrepancies for VHAP and SRS enrollment reporting, the SRS and VHAP auto-assignment rate is omitted from the overall project auto-assignment rate. The overall auto-assignment rate for July 1, 2011 enrollments is 10%.

Exhibit 14: Confirmed Enrollments					
	VHAP (1)	Medicaid (2)	SSI (3)	SRS (4)	Month Totals
Helpline	781	584	32	3	1,400
Mail/Email	443	390	14	1	848
Manually Assigned	201	244	16	0	461
*Reinstated	3,286	3,253	87	4	6,630
Auto Assigned	477	122	13	2	614
<b>TOTALS</b>	<b>1,902</b>	<b>1,340</b>	<b>75</b>	<b>6</b>	<b>3,323</b>
AA Rates	25%	9%	17%	33%	<b>Project AA Rate: 10%</b>

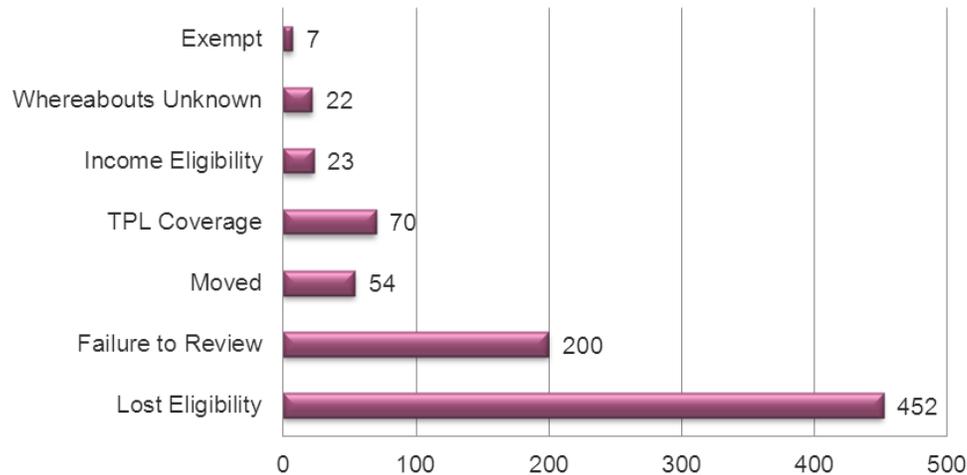
\* Reinstatement is not included in Month Total or AA Rate above.

## Other PC+ Activities

### Disenrollments

Exhibit 15: Reasons for PC + Disenrollment displays disenrollment activity for the month by reason. A total of 828 individuals were disenrolled by the DVHA this month, compared to 795 disenrollments last month.

Exhibit 15: Reasons for PC+ Disenrollments



### PC Plus Outreach

As the designated member services unit for the PC Plus program, MAXIMUS staff outreaches new program members by phone to welcome them into the program and explain benefits. Each month, the DVHA provides MAXIMUS with a list of new members of PC Plus who have not previously been educated regarding managed care. We also outreach members if their designated PCP becomes unavailable or a beneficiary is discharged from the practice to facilitate a PCP transfer. The three exhibits below summarize these activities.

#### Exhibit 16: Welcome Calls

New PC Plus Households	203
Successful Welcome calls	185
Success Rate	91%

#### Exhibit 18: PCP Transfers

Total number of bfys for PCP outreach	278
Time devoted to PCP transfer outreach	11 hrs.

#### Exhibit 19: PCP Outreach

Total number of bfys for PCP outreach	870
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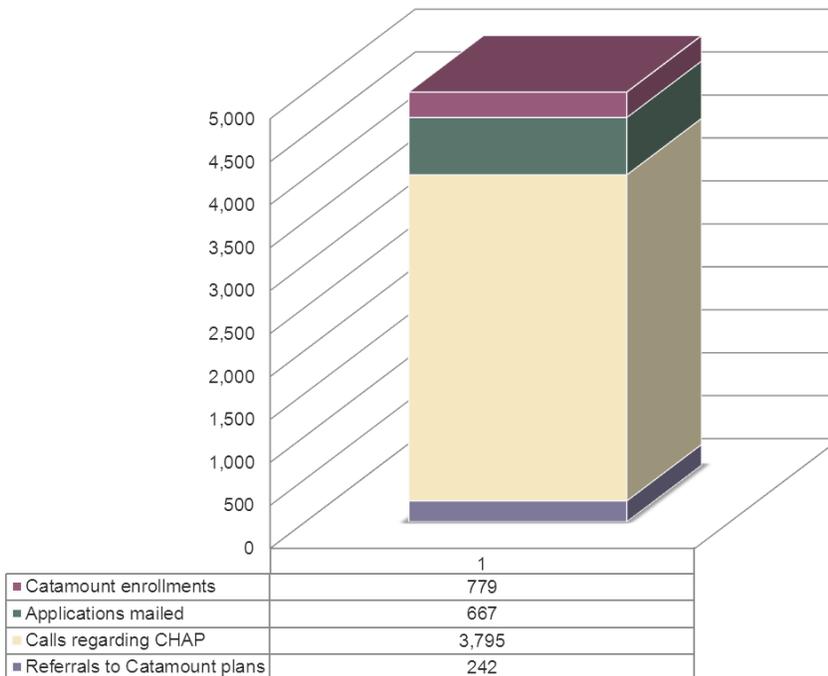
## Dental Home Initiative

MAXIMUS also solicits and records choice of dental providers during the managed care enrollment process for children age one to seventeen years old. Members failing to respond with a dental provider choice are enrolled with an available dentist in their area by MAXIMUS staff and sent a confirmation letter informing them of the available dentist. Exhibit 20: Dental Home Enrollments shows dental enrollment activity this month.

Exhibit 20: Dental Home Enrollments	
Method	Enrollees
Helpline	860
Mail	373
Tooth Tutor	0
Decline	245
Assigned	1
<b>Total</b>	<b>1,234</b>

## Catamount

Exhibit 21: Catamount and CHAP Activity

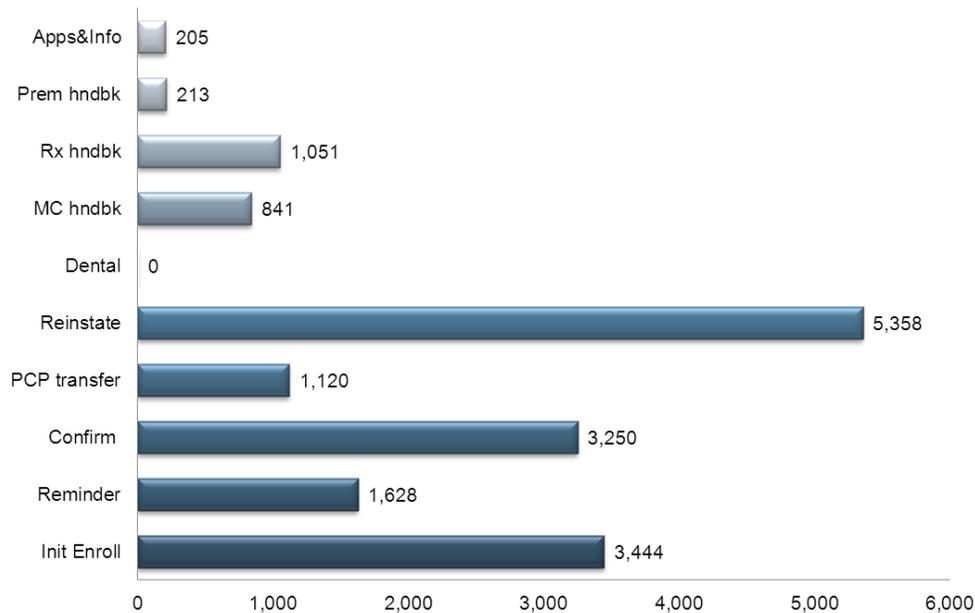


MAXIMUS provides many services to support the Catamount health plans and the related premium assistance program, Catamount Health Access Program (CHAP). These include eligibility pre-screening, guidance through a multi-step eligibility process, and Catamount plan enrollment. Exhibit 21: Catamount & CHAP Activity illustrates these functions performed last month.

## Mailings

Every month, MAXIMUS mails initial enrollment packages, notices related to PC Plus enrollment, program handbooks, applications, forms and various other documents. Callers are also given the option of accessing applications and other documents via the GMC website or email. MAXIMUS mailed a total of 17,110 pieces of mail this month. Exhibit 22: Mailhouse Activity shows the various mailings.

Exhibit 22: Mailhouse Activity



MAXIMUS also receives and processes enrollment forms on a daily basis. These forms are entered into the ACCESS system the same day. Incomplete enrollment forms are handled within one business day; we outreach by telephone or mail incomplete forms back to the beneficiary. MAXIMUS processed 1,131 enrollment forms last month.

## Other Activities

### TPL Activities

TPL information is gathered by representatives and verified and entered into the ACCESS system by a designated TPL Coordinator. In addition, the TPL Coordinator makes corrections on insurance panels entered incorrectly by other parties. Actions included closing, correcting, and creating INSU panels. The chart below summarizes TPL related activity last month. MAXIMUS staff allocated over 63 work hours to this activity in June and created or edited 379 TPL panels.

Exhibit 23: TPL Activity



### Grievances, Appeals, Complaints and Fair Hearings

MAXIMUS processes complaints, grievances, appeals, and fair hearings on behalf of DVHA on a daily basis. Complaints and compliments are logged on the weekly report supplied to the DVHA; these reports document trends in beneficiary issues. Formal complaint resolution requests are handled by the VHAMS Fair Hearing Coordinator, and often require multiple phone calls, emails, and documentation. Exhibit 24: Complaint Resolution Activity summarizes these functions last month.

Exhibit 24: Complaint Resolution Activity		
	Quantity	Minutes spent
Complaints	33	825
Grievances	0	0
Appeals	2	50
Expedited Appeals	5	125
Fair Hearings	4	100
<b>Total</b>	<b>44</b>	<b>1,100</b>

## Post-Call Problem Resolution

Given the complex structure of state health care programs, many issues require research and outreach beyond the initial call made by the beneficiary. MAXIMUS staff works with numerous units within the DVHA and the DCF, as well as other state vendors and community organizations, to resolve these issues and keep callers apprised of the outcomes. This time and effort is not captured within our automated reports. Exhibit 25: Post-Call Problem Resolution Emails summarizes post-call resolution emails last month.

Exhibit 25: Post-Call Problem Resolution Emails						
COPS	AOPS	HAEU	ESD	HP Enterprise	DVHA	COB
420	218	13	8	10	56	3

PDP Team	Lockbox	Catamount Plans	MedMetrics	DVHA RX Team	ADPC	Other
60	28	13	1	0	8	3

## Green Mountain Care (GMC) Website

MAXIMUS responds to emails captured on the GMC website. These emails provide another venue for customer service and topics span the entire array of customer service issues that we address via the Helpline. During the month of June, MAXIMUS received and responded to 154 emails.

## Issues for June 2011

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The following summarizes various issues, activity or projects identified via the weekly complaint report or project management observations during this reporting period.

June 2011 Issues
Callers responded to an ESD non-staggered mailing to 11,500 households regarding a premium credit refund notice.
Callers responded letters dictating the new \$59 surcharge for CHAP beneficiaries enrolled with MVP
Continued inquiries regarding 2 <sup>nd</sup> review reminder notices mailed when an application was on file
Calls from those whose eligibility review had been “bumped” out also received review reminder notices and contacted VHAMS to ensure their eligibility worker had received all requested information.
Continued complaints regarding the premium payment methods. Callers expressing wish to have online or over the phone payment options.
Increased calls from beneficiaries with questions about Health Care Reform and the affect upon the Green Mountain Care programs.
A number of calls were received from those signed up with ACH. In June, the premium bills were updated to show credit on file, but the ACH withdrawal continues to take the full premium amount.
VHAMS received calls from MVP members who were concerned about their deductible resetting as of July 1st.
Complaints were received about the clarity and number of notices beneficiaries receive. Many beneficiaries expressed frustration with the content and amount of letters they received.
Complaints and issues resulting from incorrect healthcare-related information given out by the ESD Call Center.

## Conclusion

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Operations for Vermont Health Access Member Services continue to run smoothly. MAXIMUS remains committed to modifying procedures on an ongoing basis to better meet the needs of the Agency of Human Services, Department of Vermont Health Access, and our clients.

Sincerely,

Sonia Tagliento, Project Manager