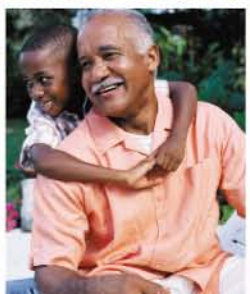
The State of West Virginia

Bureau for Medical Services

A New Decade of Amazing

Medicaid Management Information System (MMIS) Re-procurement • Request for Proposal MED11014 • May 6, 2011 • 1:30 P.M. • Technical Proposal



4.1.1 Title Page

RFP Reference: 4.1.1 Title Page

Title Page	
RFP SUBJECT	The State of West Virginia Bureau for Medical Services Medicaid Management Information System (MMIS) Re-procurement
RFP NUMBER	MED11014
VENDOR	HP Enterprise Services, LLC
BUSINESS ADDRESS	5400 Legacy Drive Plano, TX 75024
TELEPHONE NUMBER	+1 609 714 8931
AUTHORIZED CONTACT PERSON **AUTHORIZED TO COMMIT VENDOR**	Susan D. Arthur Vice President, Americas Healthcare Industry
SIGNATURE	Susan D. Arthur
DATE	4-22-11

OFFICER'S CERTIFICATE

I, John H. Vestal, Assistant Secretary of HP Enterprise Services, LLC, a limited liability company organized under the laws of the State of Delaware (the "Company"), do hereby certify that the Company, effective as of March 18, 2008, has granted signature authority to Susan Arthur on behalf of the Company and its subsidiaries for contracts, agreements and other documents and instruments and the same remains in full force and effect as of this date.

IN WITNESS WHEREOF, I have signed this Officer's Certificate of behalf of the Company this 22nd day of February, 2011.

John H. Vestal, Assistant Secretary
HP Enterprise Services, LLC

STATE OF TEXAS
COUNTY OF COLLIN

BEFORE ME, the undersigned authority, on this day personally appeared John H. Vestal, known to me to be the person whose name is subscribed to the foregoing instrument and known to me to be an Assistant Secretary of HP Enterprise Services, LLC and acknowledged to me that he executed said instrument for the purposes and consideration therein expressed and as the act of said limited liability company.

Given under my hand and seal of office this 22nd day of February, 2011.

Cindy Bunyan

NOTARY PUBLIC STATE OF TEXAS
CINDY BUNYAN
Notary Public
State of Texas
My Comm. Expires 01-13-2014

HP Enterprise Services
5400 Legacy Drive
Plano, TX 75024

April 29, 2011

Bryan Rosen
WV Department of Health and Human Resources
Office of Purchasing
One Davis Square, Suite 100
Charleston, WV 25301

Mr. Rosen:

Susan D Arthur
Vice President, Americas
Healthcare Industry
Tel. 609-714-8931
Fax. 302-607-0896
susan.arthur@hp.com

HP Enterprise Services, LLC (HPES) is pleased to submit our proposal for Medicaid Management Information System (MMIS) Re-procurement to the State of West Virginia Bureau for Medical Services (BMS), request for proposal (RFP) MED11014.

HPES is the leader in MMIS implementations, and has MMIS solutions deployed in 22 states. After careful evaluation of the requirements for West Virginia, we selected the Wisconsin MMIS, an installation of our interChange MMIS, as the transfer solution to best enable BMS to successfully navigate the healthcare transformation journey. This system was recently certified back to day one using the new Centers for Medicare & Medicaid Services (CMS) certification process. Additionally, the system was recognized by CMS as demonstrating several best practices. The value of the Wisconsin interChange MMIS may be best demonstrated by a series of 41 systems changes that were successfully implemented in 2010. These changes are tied to a projected savings of $350 million in benefit expenditures.

BMS will benefit from HPES' MMIS Design, Development, and Implementation (DDI) track record that is characterized by best practice project management and systems life cycle methodologies tested and fine-tuned through 12 successful implementations of the HPES MMIS—interChange—during the past nine years. Our 13th interChange implementation will occur this year.

The quality of our leadership team during the DDI and ongoing operations is paramount to our shared goal to minimize risk, deliver industry best practice methodologies, and validate that BMS receives the highest value from its investment in HP technology. The HPES leadership team offers a combination of extensive experience leading the DDI and operation of MMISs—in particular, our proposed interChange solution.

Supporting our superior leadership team is a technical implementation team that has benefited from multiple implementations of interChange. Consequently, our HPES DDI team can draw from more than 7,000 staff members who have successfully completed

anywhere from one to five interChange MMIS implementations during the past five years.

HPES is willing, able, and committed to perform the services and accepts the terms as defined in the RFP MED11014—including addenda 1 through 6. We look forward to finalizing a contract with BMS in accordance with our proposal response as permitted by section 4.1.12. We also certify that the price was arrived at without any conflict of interest. Together, we can do amazing for the next decade and beyond.

As requested, we have included one original technical and one original cost proposal, plus 12 convenience copies of each, including one copy of each on CD. Signed copies of the addenda are included in tab "4.1.13 Signed Forms." As Vice President, Americas Healthcare Industry, I am authorized by HPES to contractually obligate HPES to this contract, as reflected by the Officer's Certificate behind the title page.

Name: Susan D. Arthur
Title: Vice President, Americas Healthcare Industry
Address: 248 Chapman Road, Suite 100
City, State, ZIP: Newark, Delaware 19702
Telephone Number: 609-714-8931 (office)/609-280-5889 (cell)
Facsimile Number: 302-607-0896
Email Address: susan.arthur@hp.com

The following individual will serve as our point of contact for technical and contractual clarifications through the evaluation period.

Name: Kent Durso
Address: 9038 Old Harding Pike
City, State, ZIP: Franklin, TN 37064
Telephone Number: 615-456-5852
Facsimile Number: N/A
Email Address: kent.durso@hp.com

I thank you for this opportunity to begin a successful long-term relationship as West Virginia's fiscal agent and MMIS contractor. HPES looks forward to serving BMS—plus the members and providers you serve—for years to come.

Sincerely,

Susan D. Arthur
Vice President, Americas Healthcare Industry
HPES

Business Organization

RFP Reference: 4.1.5 Vendor's Organization

The West Virginia Bureau for Medical Services (BMS) needs a Medicaid Management Information System (MMIS) vendor that is well established in the state Medicaid industry, highly reputable, and financially sound. In this section, HP Enterprise Services (HPES) describes our organization and shows why we are the best choice to meet BMS' MMIS Re-procurement Project needs and support its future endeavors.

Business Name

In response to the West Virginia Request for Proposal (RFP) MED11014, the bidding entity is HP Enterprise Services, LLC (HPES).

Address

HPES is headquartered in Plano, Texas, and the address is as follows:

5400 Legacy Drive
Plano, TX 75024-3105

Parent company Hewlett-Packard (HP) is headquartered in Palo Alto, Calif., and the address is as follows:

3000 Hanover St.
Palo Alto, CA 94304-1112

Organization Structure

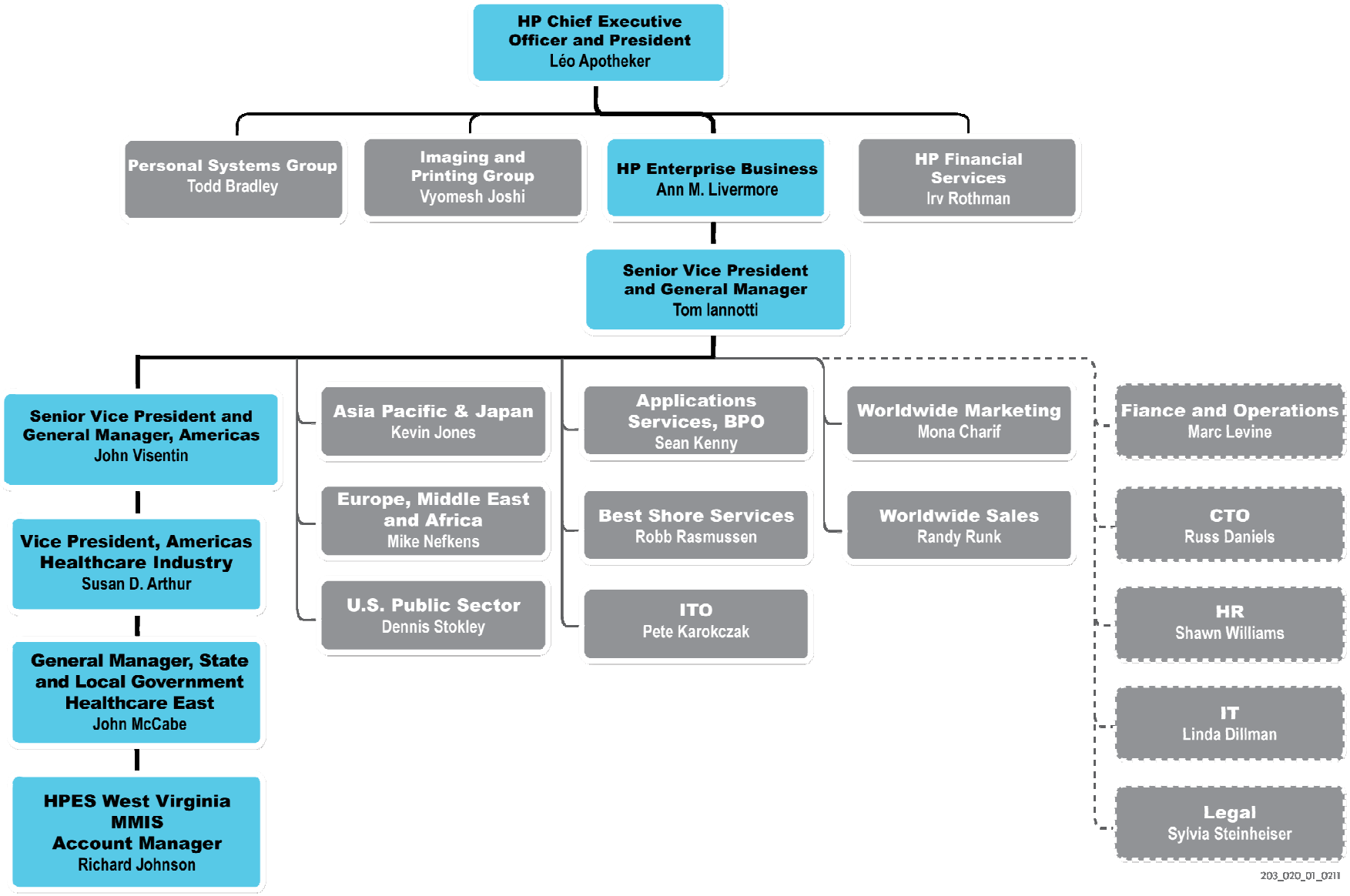
To best focus on and serve our customers, HP comprises four business groups:

- HP Enterprise Business (EB)
- HP Financial Services (HPFS)
- Imaging and Printing Group (IPG)
- Personal Systems Group (PSG)

HPES is part of the EB business group. As shown in the following HP Corporate Organization Chart, HPES Senior Vice President and General Manager Tom Iannotti leads HPES—under Executive Vice President HP EB Ann Livermore. This chart shows the reporting structure for HPES, which includes the West Virginia MMIS Re-procurement Project. HPES West Virginia MMIS Account Manager Richard Johnson will oversee each aspect of our support for the West Virginia MMIS Re-procurement Project and report directly to General Manager, State and Local Government Healthcare East John McCabe.

Because of the specific and critical nature of statewide healthcare programs, HPES aligns an entire division to support our state and local healthcare customers. The chart that follows shows the specific area of the HP organization with responsibility for the West Virginia MMIS Re-procurement Project, reflecting the reporting chain between the HPES West Virginia MMIS Account Manager Richard Johnson and HP Chief Executive Officer (CEO) and President Léo Apotheker.

HP Corporate Organization Chart



Advantages of the HPES Organization

We have carefully structured the HPES organization to serve our healthcare customers. For example, Vice President Susan Arthur, General Manager John McCabe, and MMIS Account Manager Richard Johnson will constantly monitor our performance on every aspect of our work. These leaders will collaborate to mobilize the necessary resources to successfully implement the new WV-iC MMIS and continuously monitor ongoing operations to verify that HPES meets BMS' requirements. Additionally, our organization brings the following advantages to West Virginia:

- Our business practice is to systematically share ideas across HPES' commercial and government healthcare teams. We will bring best practices and lessons learned from previously delivered solutions—including extensive experience with successful MMIS DDIs—to West Virginia. The result for BMS is an MMIS implementation solution built on the best proven architecture and delivery methods available and customized for the State's business environment.
- With more than 7,000 professionals dedicated to supporting healthcare customers worldwide and 22 current state Medicaid customers, HPES offers BMS a deep knowledge base and unequalled Medicaid experience.
- We offer the feet-on-the-ground dedication of MMIS Account Manager Richard Johnson that includes 25 years of leadership in healthcare and healthcare-related positions. He will provide an immediate response to issues, brings great insight into Medicaid business challenges, and will demonstrate a strong, collaborative relationship with BMS.

Date Established

HPES is the bidding entity for the West Virginia MMIS Re-procurement Project. HPES—a Delaware corporation—is a wholly owned subsidiary of HP. HPES' history of establishment is as follows:

- Electronic Data Systems Leasing Corporation was incorporated in Texas on June 27, 1962.
- Electronic Data Systems Leasing Corporation changed its name to Electronic Data Systems Corporation on August 12, 1964.
- Electronic Data Systems Corporation merged into Electronic Data Systems Holding Corporation (Delaware)—which was incorporated as RGR Holdings, Inc. on March 25, 1994—on June 6, 1996, with the name changed to Electronic Data Systems Corporation (EDS). A Restated Certificate of Incorporation was filed June 7, 1996.
- On August 29, 2008, EDS was acquired by Hewlett-Packard Company (HP) and became a wholly owned limited liability corporation, changing its name to Electronic Data Systems, LLC.
- On December 28, 2009, Electronic Data Systems, LLC was changed to HP Enterprise Services, LLC. This change became effective December 1, 2009.

Ownership

HPES is a wholly owned subsidiary of HP, a publically traded company under the New York Stock Exchange (NYSE) symbol HPQ.

State of Incorporation

HPES is incorporated in the State of Delaware.

Licenses

At the end of this section, we have included copies of the following licenses:

- West Virginia Certificate of Authorization
- Certificate of Authorization Name Change
- Certificate of Good Standing with Workers' Compensation programs

HPES will furnish BMS additional required licenses on contract award.

Financial Information

- Fortune 10 United States—the highest-ranking MMIS vendor on the list
- Fortune 32 Global
- 304,000 employees
- $126 billion in revenue FY 2010
- Operates in about 170 countries

HP is a financially strong company, with extensive resources to continue providing services to implement and operate the West Virginia MMIS.

With annual revenue of $126 billion, we rank 10th on the Fortune 500 and 15th on Business Week's Top 50 Most Innovative Companies list, and we are the world's largest technology company. We are investing aggressively in the future, with an annual research and development budget of approximately $2.8 billion. We remain strong moving into 2011 with first quarter net revenue of $32.3 billion.

HP consistently receives positive credit and investment risk ratings from leading independent business research and ratings services. The following table includes the credit information provider and the credit rating.

Key Ratings

Credit Information Provider	Credit Rating
Standard & Poor's	A
Dun & Bradstreet	5A2
Moody's Investors Service	A2
Fitch	A+

Long acknowledged as an industry leader in innovation, quality, and customer satisfaction, HPES has the demonstrated corporate strength and resources to deliver leading-edge technology and unsurpassed services to support BMS' business initiatives.

To view or download our annual reports from the last three years, please use the following link http://www.hp.com/hpinfo/investor/financials/annual/. We also have provided electronic copies on the CD-ROM per Addendum 3.

Subcontractors

More than a year ago, HPES began evaluating the right mix of subcontractors to support the complexities of the West Virginia MMIS Re-procurement Project. HPES and the following two subcontractors—proven leaders in their respective fields—joined HPES to create the HPES team for West Virginia:

- Fenwick Technologies, Inc.
- Arkansas Foundation for Medical Care (AFMC)

Additional information on our subcontractors may be found in the following sections of this proposal:

- 4.1.10 Solution Alignment with BMS' Business and Technical Needs
- 4.1.11 Subcontracting

State of West Virginia

Certificate

I, Natalie E. Tennant, Secretary of State of the State of West Virginia, herby certify that

HP ENTERPRISE SERVICES, LLC

was duly authorized under the laws of this state to transact business in West Virginia as a foreign limited liability company on April 04, 1996.

The company is filed as an at-will company, for an indefinite period.

I further certify that the LLC (PLLC) has not been revoked by the State of West Virginia nor has a Certificate of Cancellation been issued.

Therefore, I hereby issue this

CERTIFICATE OF AUTHORIZATION

Validation ID:0WV49_H55BP

Given under my hand and the Great Seal of the State of West Virginia on this day of March 08, 2011

Natalie E Tennant

Secretary of State

Notice: A certificate issued electronically from the West Virginia Secretary of State's Web site is fully and immediately valid and effective. However, as an option, the issuance and validity of a certificate obtained electronically may be established by visiting the Certificate Validation Page of the Secretary of State's Web site, https://apps.wv.gov/sos/businessentitysearch/validate.aspx entering the validation ID displayed on the certificate, and following the instructions displayed. Confirming the issuance of a certificate is merely optional and is not necessary to the valid and effective issuance of a certificate.

State of West Virginia

Certificate

I, Natalie E. Tennant, Secretary of State of the State of West Virginia, hereby certify that

the attached true and exact copy of the Articles of Amendment to the Articles of Organization of

ELECTRONIC DATA SYSTEMS, LLC

are filed in my office, signed and verified, as required by the provisions of West Virginia Code §31B-2-204 and conform to law. Therefore, I issue this

CERTIFICATE OF AMENDMENT TO THE CERTIFICATE OF AUTHORITY

changing the name of the limited liability company to

HP ENTERPRISE SERVICES, LLC

Given under my hand and the Great Seal of the State of West Virginia on this day of January 6, 2010

Natalie E Tennant

Secretary of State

FILED

JAN 06 2010

IN THE OFFICE OF SECRETARY OF STATE

Natalie E. Tennant
Secretary of State
1900 Kanawha Blvd E.
Bldg 1, Suite 157-K
Charleston, WV 25305

Penney Barker, Manager
Corporations Division
Tel: (304)558-8000
Fax: (304)558-8381
www.wvsos.com
Hrs: 8:30 a.m. – 5:00 p.m. ET

FILE ONE ORIGINAL
(Two if you want a filed stamped copy returned to you)
FEE: $25.00

WV APPLICATION FOR AMENDED CERTIFICATE OF AUTHORITY OF A LIMITED LIABILITY COMPANY

In accordance with the provisions of the West Virginia Code, the undersigned limited liability company hereby applies for an Amended Certificate of Authority and submits the following statement:

1. Name under which the organization was authorized to transact business in WV: Electronic Data Systems, LLC

2. Date Certificate of Authority was issued in West Virginia: 4/4/96

3. Change of Name Information or Text of Amendment: (Attach one certified copy of the name change as filed in the home state)

   Change of name from: Electronic Data Systems, LLC

   To: HP Enterprise Services, LLC

   Name the organization elects to use in WV: HP Enterprise Services, LLC
   (Due to home state name not being available)

   Other amendment (use additional pages if necessary)

4. Contact name and number to reach in case of a problem with filing: (optional, however, listing one may help to avoid a return or rejection of filing if there is a problem with the document)

   Contact Name _____ Phone Number _____

   Business e-mail address, if any: lester.ezrati@hp.com

5. Signature of person executing document:

   Signature Lester D. Ezrati

   Manager
   Title/Capacity
   (Example: member, manager, etc.)

Form LLF-4 Issued by the Office of the Secretary of State Revised 10/09

WV033 - 11/06/2009 C T Filing Manager Online

Delaware

PAGE 1

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY THE ATTACHED IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF AMENDMENT OF "ELECTRONIC DATA SYSTEMS, LLC", CHANGING ITS NAME FROM "ELECTRONIC DATA SYSTEMS, LLC" TO "HP ENTERPRISE SERVICES, LLC", FILED IN THIS OFFICE ON THE TWENTY-EIGHTH DAY OF DECEMBER, A.D. 2009, AT 4:32 O'CLOCK P.M.

AND I DO HEREBY FURTHER CERTIFY THAT THE EFFECTIVE DATE OF THE AFORESAID CERTIFICATE OF AMENDMENT IS THE FIRST DAY OF JANUARY, A.D. 2010.

2387022 8100

100010070

You may verify this certificate online at corp.delaware.gov/authver.shtml

Jeffrey W. Bullock, Secretary of State

AUTHENTICATION: 7738748

DATE: 01-05-10

State of Delaware
Secretary of State
Division of Corporations
Delivered 04:35 PM 12/28/2009
FILED 04:32 PM 12/28/2009
SRV 091141233 - 2387022 FILE

CERTIFICATE OF AMENDMENT
TO THE
CERTIFICATE OF FORMATION
OF
ELECTRONIC DATA SYSTEMS, LLC

Electronic Data Systems, LLC, a Delaware limited liability company (hereinafter called the "Limited Liability Company"), does hereby certify as follows:

FIRST: The Certificate of Formation of the Limited Liability Company is hereby amended as follows:

1. The name of the Limited Liability Company is HP Enterprise Services, LLC.

SECOND: The foregoing amendment was duly adopted in accordance with Section 18-202 of the Delaware Limited Liability Company Act.

THIRD: The effective date will be January 1, 2010.

IN WITNESS WHEREOF, the undersigned has executed this Certificate of Amendment on December 28, 2009.

ELECTRONIC DATA SYSTEMS, LLC

By: /s/ Lester D. Ezrati
Lester D. Ezrati, Manager

04/12/2011 10:38 WV BEF 304 558 6532 → 9129:5827288 NO.416 002

WORK FORCE West Virginia

Earl Ray Tomblin, Governor
Russell L. Fry, Acting Executive Director
Keith Burdette, Cabinet Secretary

April 12, 2011

HP Enterprise Services LLC
5400 Legacy Drive
Plano TX 75024

Account Number: 43755-7

Dear Employer:

Workforce West Virginia has, at your request, researched their records and has found this account is in compliance with the West Virginia Unemployment Compensation Law.

Very truly yours,

Beverly Morris
Assistant Director

ds

Audit and Compliance Section, Unemployment Compensation Division
112 California Avenue, Charleston, WV 25305-0112
304-558-2451
An agency of the Department of Commerce
An equal opportunity employer/program and auxiliary aids are available upon request to individuals with disabilities.
www.workforcewv.org

4.1.3 Table of Contents

Volume I

Volume II

Page Count Matrix

Proposal Section	Pages Included in Limit	Pages Excluded From Limit	Page Range
4.1.1 Title Page	2		Inserts
4.1.2 Transmittal Letter		12	Inserts
4.1.3 Table of Contents	4		
4.1.4 Executive Summary	3		1-3
4.1.5 Vendor's Organization	1		1
4.1.6 Location	1		1
4.1.7 Vendor Capacity, Qualifications, References and Experience	6		1-6
4.1.8 Staff Capacity, Qualifications and Experience	1		1
4.1.9 Project Approach and Solution	3		1-3
4.1.10 Solution Alignment with BMS' Business and Technical Needs			1-408
3.2.1 Proposed West Virginia MMIS	33		1-33
3.2.2 Project Management	28		33-72
Work Breakdown Structure		1	46
Deliverable Dictionary		11	47-57
Project Schedule		136	Insert
3.2.3 Project Staffing	21		72-146
Organization Charts	6		Inserts
Req. 2 Roles and Responsibilities		54	75-128
Resumes		23	insert
3.2.4 Project Facilities	3		147-149
3.2.5 Project Phase Overview	2		149-150
3.2.6 Phase 1: MMIS Replacement DDI & CMS Certification Planning	65		150-214
3.2.7 Phase 2: Fiscal Agent Operations	99		214-312
3.2.8 Phase 3: Turnover and Close-Out	5		312-316
3.2.9 Drug Rebate Solution	9		316-324
3.2.10 Vendor Proposed Services		15	325-339
3.2.11 BMS Optional Services		69	340-408
Appendix E: Business and Technical Requirements		134	Insert
4.1.11 Subcontracting	2		1-2
4.1.12 Special Terms and Conditions	1		1
4.1.13 Signed Forms	3	16	Insert
Ownership & Control Interest Disclosure Form		1	Insert
4.1.14 RFP Requirements Checklist		4	1-4
Sample Deliverable Formats		399	Inserts
Sample Form Templates		18	Inserts
Totals	**298**	**893**	

4.1.4 Executive Summary

RFP Reference: 4.1.4 Executive Summary

Through the Medicaid Management Information System (MMIS) Re-procurement Request for Proposal (RFP) MED 11014, the State of West Virginia Bureau for Medical Services (BMS) documents the requirements for the procurement of a replacement MMIS with fiscal agent operations. As with states nationwide, West Virginia is experiencing significant budgetary pressures brought about by the national economic recession and growing Medicaid program expenditures. HP Enterprise Services (HPES) understands how critical this procurement is to BMS.

We are proud to respond to the RFP. Our thorough response to the RFP requirements and this executive summary affirm our ability to provide experienced personnel, a comprehensive solution, industry best practices, and implementation execution unmatched in the industry. HPES demonstrates that "there is no substitute for *successful* experience."

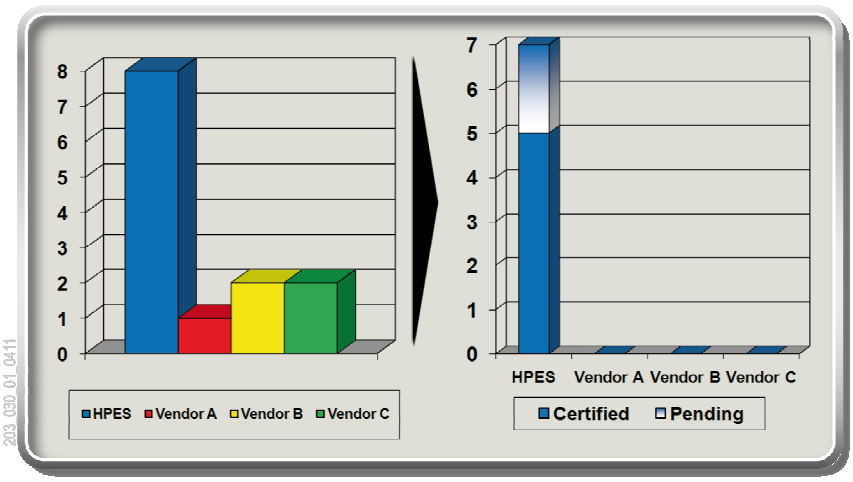
Understanding West Virginia's Medicaid Program

During the last two years and before the MMIS Re-procurement RFP, HPES dedicated time and resources to better understand the State of West Virginia by using one of our core best practices—immersion—that is designed to increase the exposure of HPES healthcare staff members to the issues affecting the Medicaid program in a given jurisdiction. Our effort included periodic meetings in the State with individuals and organizations involved with the West Virginia Medicaid Program. Some of those with whom we have met include the West Virginia Hospital Association, the West Virginia State Medical Association, the West Virginia Primary Care Association, the Community Health Network, the West Virginia Pharmacists Association, the West Virginia Dental Association, the West Virginia Behavioral Health Association, the West Virginia Health Care Association, individual hospitals, State legislators, and the West Virginia Governor's Office. We listened to these important stakeholders. Two major issues repeatedly surfaced—implementation fears and criticism of provider training and outreach.

Implementation fears stemmed from difficulties several years ago when the current system was installed and began operations, and West Virginians do not want a repeat performance. The second issue—that of sufficient training and provider outreach—was nearly as critical. We came to understand directly from those involved with providing services today that communication is of utmost importance. Relying on the system to automatically inform providers and members of important information has been insufficient; the human aspect in the process of communicating important information cannot be overstated. These two crucial aspects of a successful MMIS are addressed in detail throughout our proposal—particularly in our responses to RFP sections 4.1.9 and 4.1.10—and they are the fundamental basis for much of our approach to this bid opportunity.

Proposing a Proven Solution

As with other states, West Virginia's Medicaid Program is one the largest expenditures in the State budget. As such, it affects many people and requires the absolute best effort of everyone concerned. Our dedication to work with government for such critical programs is reflected in the extraordinary success rate of our MMIS implementations. Our MMIS solution, interChange, has never failed, never been canceled, and never been replaced. As the following figure indicates, since 2006 HPES has more successful MMIS implementations and certifications than all other vendors combined.



Our selection of the Wisconsin interChange MMIS—certified by the Centers for Medicare & Medicaid Services (CMS)—as the base transfer system is the best fit for West Virginia. Our offer is fundamentally represented by the Wisconsin transfer of interChange, customized to meet West Virginia's unique requirements, and built to address the realities of the challenges presented by the Mountain State. The interChange MMIS is a browser-based, healthcare administration platform and integrated system that supports payers more efficiently, reimburses providers more quickly, and adjudicates patient claims swiftly and fairly. Aligned with Medicaid Information Technology Architecture (MITA) principles, interChange provides a single platform that multiple payers

can use for program administration. Processing rules are easily configured to match specific plan criteria. Using an n-tier framework, interChange MMIS takes advantage of industry standards to promote interoperability.

The Wisconsin interChange MMIS has demonstrated its adaptability and capability to support changes in the healthcare program through the implementation of 49 complex work items in one summer. These business-driven changes account for savings approaching $400 million in benefit expenditures. West Virginia can use interChange as a tool to achieve similar results.

In August 2010, the Wisconsin Medicaid program was highlighted in a *Newsweek* article for its creative and advanced ways of reducing the cost of administering benefits ("Last year Gov. Jim Doyle proposed to slash $400 million from the state's health-care system, one of the country's most comprehensive. But rather than oversee the cuts, he and the state legislature left them up to Medicaid officials, who not only found the savings but expanded enrollment." — *Wisconsin Makes Nice on Medicaid Cuts, by Ryan Tracy,* Newsweek *Magazine)*

These successes are made possible in part by an industry-best system, architecture, and network. The Wisconsin MMIS was the first MMIS in the country to be certified back to day one using the new CMS certification checklist. The Wisconsin MMIS and its corresponding business processes were noted by CMS for several industry best practices.

HPES brings the least risk and the greatest capability for success based on the broadest experience from any vendor in the MMIS market. More states representing more citizens have depended longer on HPES' MMISs and services than any other company. HPES brings a comprehensive set of Medicaid best practices that can support BMS, providing a new decade of service excellence—and a new decade of amazing.

Providing Experienced Personnel

BMS has wisely stressed the industry experience and capabilities of the key personnel specified by the RFP. Besides a world-class solution, HPES presents a world-class, seasoned, and experienced team with expertise in managing fiscal agent relationships, implementing new Medicaid systems, and managing West Virginia-specific Medicaid programs and policies. HPES offers a unique blend of our corporate healthcare business unit experience, augmented by the infusion of industry talent from two key subcontractors, Fenwick Technologies of Charleston and the Arkansas Foundation for Medical Care. These combined skills cover decades of experience in the MMIS field, and offer BMS the biggest, deepest book of technical and service expertise that can be referenced to support the next decade of dependability for the West Virginia Medicaid Program. The HPES team is led by MMIS Account Manager Rich Johnson. With more than 18 years of Medicaid experience, Rich brings deep knowledge gained in the development, implementation, operation, and certification of Wisconsin MMIS—the proposed transfer system.

This team of executives—combined with our project management methodology and governance approach—provides a well-managed initiative that is continuously aligned to BMS' business objectives and goals. After going live, this key leadership team will be responsible for ongoing operations and support for the West Virginia Medicaid Program. HPES is the largest provider of healthcare IT services in the world, and it is our experienced personnel who deliver these services. Our teams handle 35 percent of Medicaid and Medicare claims in the United States and process 2.4 billion healthcare transactions annually. Our experience at the federal and state levels makes us uniquely qualified to help the agencies we serve lower their administrative costs to better use benefit dollars; achieve certification to maximize federal funding; reduce medication errors; decrease claims processing time; improve the quality of healthcare; improve visibility into program operations; provide the backbone for future program development; and enable connection to the electronic infrastructure that will define healthcare in the next decade.

It is easy for a vendor to cite statistics of claims and transactions processed, but why should that matter to BMS? What does it mean to West Virginians who want the best, once and for all? It means security, the lowest possible risk, and confidence in the delivery of services. It also means freedom—the freedom to rise above frustration with the basic service levels and entertain new ideas, new requirements, and new cost-saving measures. It means expanded access to a network of peers across the state government landscape, a ready resource of ideas and intelligence. For example, as new and expanding Health Information Exchange and Health Insurance Exchange systems become established realities in West Virginia, more than simple interfaces will be required to intelligently take advantage of the strengths of these essentially related programs. A current example of collaboration is the Medicaid Assistance Provider Incentive Repository (MAPIR) system. This system is being developed by 12 HPES interChange customers to implement incentive payments to providers for electronic medical record (EMR) adoption. Having the same or strongly similar responsibilities across our installed MMIS base will enable HPES to give BMS access to the largest inventory of real-world experience. On an ongoing basis, this experience will be brought directly to BMS by our West Virginia HPES leadership team, which will constantly collaborate with our other accounts to share and develop innovative and practical solutions to the unique challenges of Medicaid. Tapping into this knowledge base will help BMS achieve success more rapidly from proven solutions in the industry.

Meeting Mandatory Requirements

Our team has spent a great deal of time in reviewing, understanding, and determining how best HPES will meet the 49 mandatory requirements presented in RFP section "3.1 Mandatory Requirements." Additionally, our proposal response follows the format detailed in RFP section "4.1 Proposal Format." These requirements give us insight into BMS' holistic view toward its Medicaid program—in looking for more than just a system to process claims. With the diversity of requirements, this RFP demands a vendor that can combine people, business processes, and a technical solution that addresses each objective and removes the barriers to enable BMS' move toward its Medicaid enterprise. Throughout our proposal, we highlight our responses to these specific requirements with the placement of this "Mandatory Requirement" icon in our text. This icon affirms our agreement to meet BMS' mandatory requirements.

Positioning BMS for the Future

With the architecture of the proposed West Virginia interChange (WV-iC) MMIS, BMS has a solution that aligns with MITA, employs a service-oriented architecture (SOA), and will meet BMS' integration needs. Additionally, the MITA framework is intended to foster the crucial integrated business and IT transformation across the Medicaid enterprise to improve the expanding administration of healthcare to Medicaid members. HPES understands what needs to be done and is the most capable vendor to support and implement the direction provided by CMS. The MITA transformation strategy requires a member-centric solution capable of exchanging member clinical and administrative healthcare data from an increasing variety of sources, such as healthcare institutions, public agencies, home health, employers, and health plans.

Connecting the healthcare community and working to automate operational tasks to allow more time for plan management in turn lowers Medicaid costs and aligns with MITA's vision for the future. It is the ability to quickly operationalize this vision with MITA principles that has led state healthcare agencies to choose HPES more than any other company. MITA is playing a growing role in defining the set of performance requirements for certification of information systems that are developed with enhanced federal financial participation (FFP). Certification of the MMIS will focus more on the business architecture's business needs and functions, as defined by MITA. HPES is the only contractor that brings to West Virginia a fully functioning, CMS-certified MMIS meeting—and often exceeding—the requirements in 42 CFR 433, Subpart C, Part 11 of the State Medicaid Manual (SMM), and the MITA guidelines.

Few enterprise applications are more complex than those that support Medicaid programs. Federal regulations continue to change and often complicate services delivery. The new Affordable Care Act will mandate changes to West Virginia's Medicaid Program, adding tracking and reporting complexities and tens of thousands of new members to the rolls. This means nearly a quarter of the Mountain State's residents will need to be served by Medicaid, so agencies are faced with the dual challenge of expanding programs while trying to control costs.

HPES has taken MITA's guidance to heart when building the WV-iC MMIS solution to meet today's needs and be flexible in meeting tomorrow's challenges. We have aligned the functional areas around the MITA-defined business areas. We have built the processing platform on a true SOA, supported by web and business services. Through data translation adaptors, we can readily transform data from one format to another, allowing a more interoperable data exchange. We use the MITA Maturity icon to identify in our response where and how our solution supports MITA maturity for those processes, and at other points where our experience with MITA will provide unparalleled support for BMS' MITA maturity plans.

Sharing a New Decade of Amazing

We put ourselves in your shoes and walked a few miles through cities and towns, and the beautiful rural areas of the Mountain State. The people we have met—healthcare professionals, government officials, and West Virginia residents alike—have been welcoming and candid. Because of this, we understand that the next 10 years are a chance to improve dramatically on the problems of the past and establish a new and exhilarating level of service to providers and members, to officials and administrators, to agency staff members who rely on the system, and their vendor-partner every day to help meet the challenges of Medicaid complexity. HPES has a vision for West Virginia Medicaid; it is clear and bright. It is one of confidence based on experience, of pride based on capability, and of satisfaction in knowing the job gets done right the first time, every time.

We look forward to the opportunity to earn your business and your trust every day for the next amazing decade and beyond.

4.1.5 Vendor's Organization

RFP Reference: 4.1.5 Vendor's Organization

HPES has responded to this requirement in our "Business Organization" document that immediately follows the Transmittal Letter.

4.1.6 Location

RFP Reference: 4.1.6 Location

HPES will provide a professional business environment to facilitate a productive, well-organized working atmosphere, allowing us to deliver the highest levels of member and provider service to BMS and its stakeholders. Our worksites will readily accommodate the required BMS and local HPES staff members and facilitate interaction between local and off-site staff members and vendors.

The HPES team proposes the following primary facilities to support contract requirements:

- **Temporary site for start-up and DDI functions—**HPES will lease a site in Charleston after contract signature to immediately start work on the West Virginia replacement MMIS and fiscal agent operations. This site will house our local staff members and provide a hub for remote staff members supporting the DDI work.
- **Primary site for operations and turnover—**HPES proposes the Pinnacle Center at 820 Lee St. in Charleston to serve as our primary site of operations and for turnover functions at the end of the contract, as needed. This location is within a five-mile radius of the West Virginia State facility at 350 Capitol St. HPES selected this location because of its proximity to BMS' main location and its ample available space. The location is less than a mile from 350 Capitol St. and located near Interstate 64, providing easy access for HPES team members and the BMS staff.
- **Primary data center—**Our facility in Orlando, Fla., is built to meet Uptime Institute's Tier III rating for the demanding power and cooling needs of the next-generation computing environment and offers redundant power and cooling configuration, enabling concurrent maintainability without the risk of facility downtime. It is integrated with HPES' data center architecture to provide for fail-over and redundancy for our global operations. In October 2010, this HPES U.S. Public Sector Data Center Services became the first full U.S. Public Sector Data Center to become ISO 20000:2005–certified. The Orlando data center has 85,000 square feet of raised floor space and offers the following:
  - Roof that is rated for 160-mph winds, walls that are 8-inch reinforced concrete and beamed, and a building that is approximately 100 feet above sea level
  - 2.8 MW jet-turbine generators
  - Two UPS plants with 12 total UPS modules, ranging from 500kva to 750kva per module
  - Expert technical services personnel who support the hosting infrastructure (servers, storage and network) and verify that application database services are available 24 x 7
  - Reinforced building featuring a data center facility that is reinforced with dual power feeds, dual communication feeds, and redundant generators, and air conditioning systems
- **Disaster recovery data center—**Our disaster recovery site is in Colorado Springs. This recovery facility, which rates at Tier III on the Uptime Institute facility scale, has more than 20,000 square feet of total space and offers the following:
  - Backup UPS and generator with redundant site power fed from two power grids
  - Redundant cooling with generator backup
  - Temperature and humidity control and central monitoring
  - Dedicated full-time security personnel
  - Video monitoring
  - Keycard access
  - Full on-site disaster recovery rehearsal areas
  - Centrally monitored independent fire control with five zones of smoke detectors and gas fire suppression under a raised floor
- **Subcontractor worksite—**Our subcontractor, Fenwick Technologies, Inc., will augment our operational staffing with personnel at HPES' primary site for operations and turnover, as appropriate. Arkansas Foundation for Medical Care (AFMC) will provide survey services from their Arkansas-based offices in Little Rock or Fort Smith.

HPES will locate operations in these facilities to fully support BMS in meeting the replacement MMIS responsibilities.

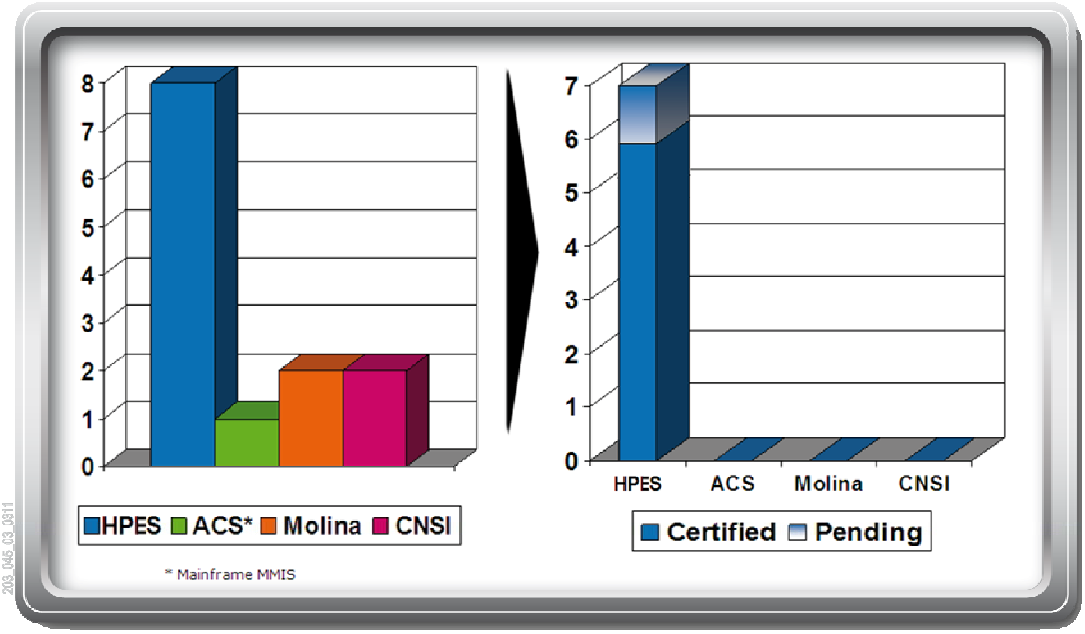
4.1.7 Vendor Capacity, Qualifications, References and Experience

RFP Reference: 4.1.7 Vendor Capacity, Qualifications, References and Experience

The West Virginia Bureau for Medical Services (BMS) needs a Medicaid Management Information System (MMIS) vendor with solid experience and a proven reputation for successful design, development, and implementation (DDI) and fiscal agent operations. In this section, we present proof of our ability to meet BMS' needs.

As seen in the following figure, HPES has the most successful record of implementing modern MMISs and achieving Centers for Medicare & Medicaid Services (CMS) certification.

MMIS Implementations from 2006 to 2011



HPES has a strong commitment to West Virginia. For example, since 2003, we have supported the South Charleston office of the U.S. Department of Housing and Urban Development (HUD). Each month, we manage and operate HUD's enterprise infrastructure for all 50 states and U.S. territories. Additionally, HPES manages and operates the following:

- 465 TB of data
- Heavily virtualized support of 1,000 servers
- Multiple mainframes
- 1 and 10 GB LAN backbone
- Dashboard management
- 20 to 30 active projects

Current customer satisfaction surveys average 94 percent positive responses, and we have consistently provided a stable, available computer environment meeting the service-level agreements (SLAs). HPES has maintained a constant HUD data center that has not been affected by local disasters—tornados, hurricanes, earthquakes, or flooding.

Since 2002, HPES has implemented 12 modern MMISs—more than any competitor. Nationally, seven of the last 10 MMIS implementations have been HPES interChange implementations. Given our history, experience, and success with multiple large implementations, HPES has a repository of more than 250 best practice assets assembled from implementations that speed configuration and development, providing us a starting point for our implementations that reduces risk and accelerates "go-live."

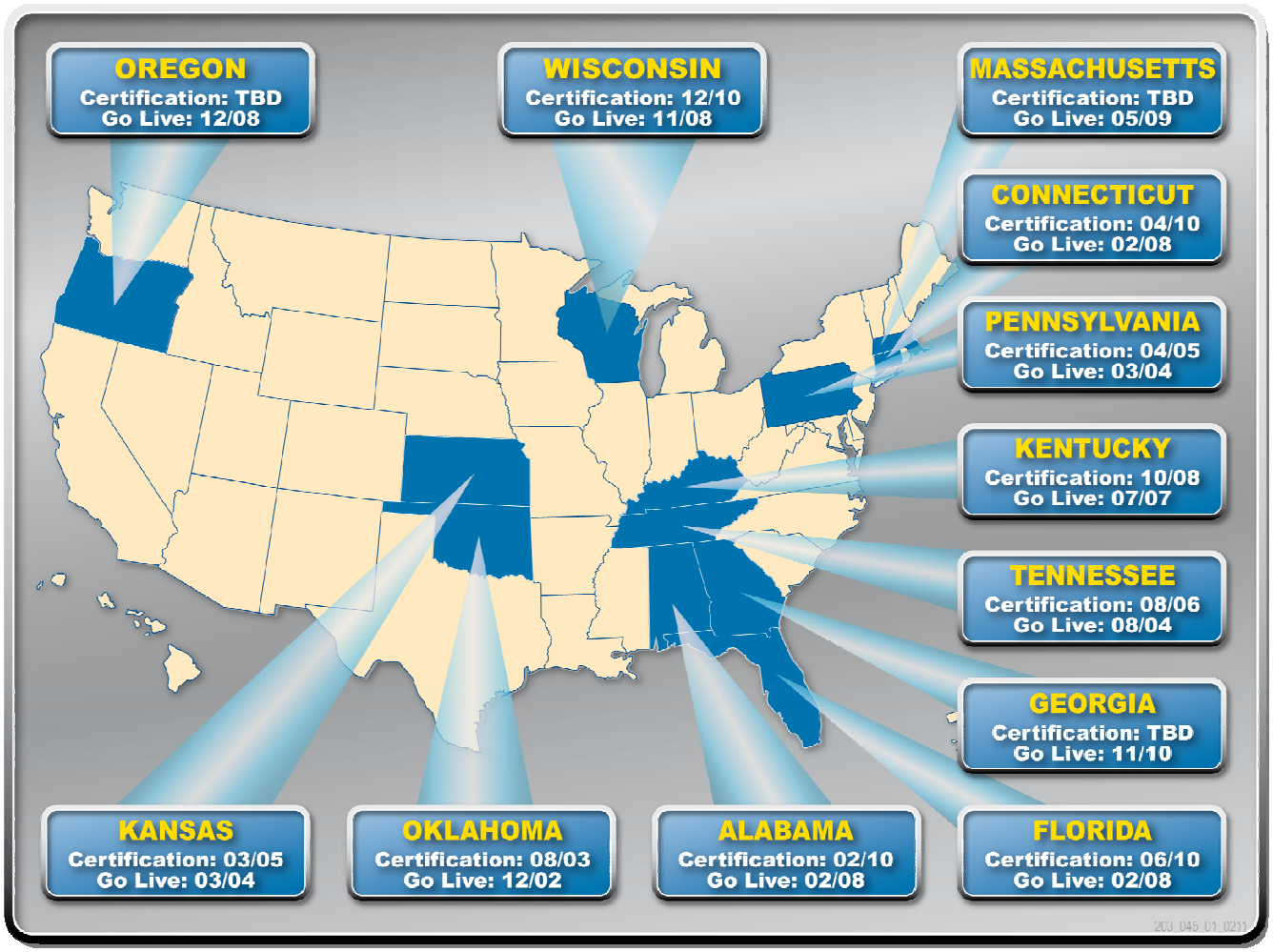
Because of this extensive background, HPES can scale and support multiple simultaneous implementations as evidenced in 2008 when HPES implemented five MMIS solutions in a single calendar year, all of which are CMS-certified. No other company can come close to these results or numbers. By using this intellectual property, we can confidently propose a 30-month

implementation of the WV-iC. A recent example of this approach is our successful Georgia interChange implementation that went live in November 2010 and is serving as a reference in this response.

New MMIS implementations present challenges. With HPES and our outstanding combination of industry-leading products and subcontractor expertise, those challenges are successfully addressed. To date, we have implemented the interChange MMIS without missing a single payment cycle to Medicaid providers. Bottom line, providers were paid accurately and on time, and Medicaid members continued to receive the care they needed.

The following figure shows the nationwide success of the HPES interChange platform. The interChange MMIS is CMS-certified in nine states: Alabama, Connecticut, Florida, Kansas, Kentucky, Oklahoma, Pennsylvania, Tennessee, and Wisconsin.

HPES' interChange Implementations and Certifications



Management Structure and Ownership

HPES provides details of our management structure and ownership in section "Business Organization" accompanying the Transmittal Letter in this proposal.

Business References

BMS seeks an MMIS vendor that is trustworthy, has deep and proven MMIS DDI experience, and successful fiscal agent services experience. With 22 State Medicaid customers, we carefully reviewed and narrowed our references to three that best demonstrate HPES' abilities to support West Virginia's vision for the provision and protection of the health of West Virginia's low-income and disabled residents. We will support BMS in supplying health insurance coverage and increasing healthcare access while improving quality and controlling costs.

4.1.8 Staff Capacity, Qualifications and Experience

RFP Reference: 4.1.8 Staff Capacity, Qualifications and Experience

Per addendum 3, we provide our project staffing solution in our response to RFP section “3.2.3 Project Staffing” in tab “4.1.10 Solution Alignment with BMS’ Business and Technical Needs.”

We include our “Draft Staffing Plan” in the “Sample Deliverable Formats” tab.

4.1.9 Project Approach and Solution

RFP Reference: 4.1.9 Project Approach and Solution

Statement of Understanding

HP Enterprise Services' (HPES') understanding of the work requested began with a thorough review of the West Virginia Bureau for Medical Services' (BMS') objectives for the scope of work: to assume operations without disruption to the providers or members, achieve certification retroactive to day one, comply with the Health Insurance Portability and Accountability Act (HIPAA) requirements, demonstrate timely development of provider-facing components, improve efficiency, and minimize risk. Our discussion of our understanding of the work requested is organized as follows:

- Proposed Medicaid Management Information System (MMIS)
- Design, develop, and implement (DDI)
- Operations
- Certification
- People
- Facility

Proposed MMIS

We carefully evaluated BMS' objectives to select the proposed MMIS transfer system and are confident that our selection of the Wisconsin interChange system as the base transfer system is the best fit for West Virginia. As demonstrated in "Appendix E: Business and Technical Requirements," the base transfer system has a high degree of capability with the functions requested in the requirements. With the features of the proposed West Virginia interChange (WV-iC) MMIS, BMS can be confident in a system that will stay current with regulatory requirements and standards, respond to the changes of healthcare reform, and respond to the needs of West Virginia, accommodating additional programs and initiatives.

The architecture of the system is detailed in our response to Requirement 2 in section "3.2.1 Proposed West Virginia MMIS." With this architecture, BMS has a solution that aligns with Medicaid Information Technology Architecture (MITA), employs a service-oriented architecture, and will meet BMS' integration needs. The foundation of the system is a 24 x 7 relational database. With this architecture, the system has the flexibility to meet BMS' current and future needs. It is secure, available, flexible, and responsive and will meet the service-level agreements (SLAs). It will comply with security, privacy, West Virginia Office of Technology (WVOT) requirements, data retention, the Rehabilitation Act, and HIPAA requirements.

DDI

The base transfer system is just the starting point. Through the DDI, BMS and HPES will work to make the WV-iC the system that supports BMS' strategic direction and vision while improving efficiency. We describe our Enterprise Systems Development Life Cycle (ESDLC) in subsequent sections, and through the ESDLC we will meet the deliverables listed in Appendix C. The same methods we use during the DDI to develop quality products will be used during operations to develop the changes and enhancements, providing quality products and consistently updated deliverables and documentation. Project management is fully integrated in our ESDLC and in all we do, a concept we share with BMS. Our project management methodology is based on industry standards filtered through a best practices compendium developed and refined from nearly 50 years of leadership in the MMIS market. This methodology will easily integrate with WVOT standards.

We look forward to working with BMS and the MMIS Re-procurement Project Management team, and the current fiscal agent to instill the project management disciplines across each DDI activity. In support of BMS' goal for timely design and development of components affecting providers, HPES is proposing to implement the provider enrollment application components at month 23 of the DDI, with full implementation of functional capabilities at 30 months.

Operations

Since 2002, HPES has successfully implemented 12 new, real-time MMIS applications and fiscal agent operations, more than all other MMIS vendors combined. Our experience offers BMS the lowest implementation risk transition to operations as we apply our documented, proven processes and lessons learned. In operations, BMS will enjoy an MMIS that meets each service level, is available and performs to standards, and meets the operational requirements as described in our response to section "3.2.7 Fiscal Agent Operations."

Certification

Our response to section "4.1.7 Vendor Capacity, Qualifications, Reference and Experience" details our unmatched track record of success with certification. The Wisconsin MMIS is the first and only state to be CMS-certified under the new MITA guidelines. The way Wisconsin approached and executed certification of the new CMS checklist was deemed by the CMS reviewers "an industry best practice." Wisconsin had 17 checklists and more than 1,200 validation items reviewed and certified—back to day one.

People

We highlight the value of the experience that we bring in our response to RFP section "3.2.3 Project Staffing" in the "4.1.10 Solution Alignment with BMS' Business and Technical Needs" tab. In that section we describe how HPES will fulfill the requirements for key, continuously dedicated support staff members. We also have the right level of staffing with the right experience to meet the SLAs. We meet the RFP requirements for staffing in each area. Notably, we have staffed a Project Management Office (PMO) that will work with BMS and WVOT staff members to integrate the project management disciplines and provide accurate, complete, transparent, and timely reporting of status. We have designated a certification lead, as our experience tells us that the best approach to certification planning and achievement results from holding this focus throughout the DDI and initial operations. We also know that testing an MMIS is a large, complex effort that requires specialized resources, and we have proposed a testing lead to manage each phase of testing from planning through results reporting.

Facility

Our facility plan is detailed in our response to section "3.2.4 Project Facilities." In Charleston, we will have a secure facility to support DDI and operations that provides for a high degree of collaboration between BMS and HPES. Our primary and backup data centers provide the security and continuity of operations that will meet the SLAs. These facilities provide the foundation for the MMIS to perform at its best and our people to deliver at their best through the DDI and operations.

Detailed Proposal for Providing the Services

Section "4.1.10 Solution Alignment with BMS' Business and Technical Needs" presents our proposal response for providing the services described in the RFP and is organized in the following sections:

- **Proposed West Virginia MMIS—**Provides an overview of our proposed solution architecture, our extensive experience with the proposed solution that minimizes risk to BMS, and our ability to support BMS MITA goals and objectives. The interChange MMIS is the premier foundation for flexibility, performance, and reliability in an MMIS platform.
- **HPES' project management methodology and approach—**Details our approach to project management, which is based on industry-standard professional project management standards, methodologies, and processes. Our ESDLC methodology also is presented. These methods, together with our unmatched experience and outstanding project team, provide BMS with a project that is delivered on time and meets BMS' quality and functional expectations.
- **Project staffing—**Highlights our staffing plan that brings experienced Medicaid managers and professionals to verify that the work in DDI and operations meets RFP requirements and demonstrates how we will be ready to start after contract award and continue to provide those services throughout the contract.
- **Project facilities—**Addresses our primary operational site in Charleston that will promote a high degree of collaboration with BMS. It also describes our primary and backup data centers.
- **Project phase overviews for the DDI, fiscal agent operations, and turnover and close-out—**This section describes our approach to each phase of the ESDLC during the DDI, and a smooth transition from DDI to operations where we will meet the service levels, culminating in certification within 12 months of operations.
- **Drug rebate—**This section defines HPES' industry-leading, state-of-the-art, CMS-certified, MITA-aligned subsystem that provides a streamlined, innovative, and fully integrated solution for claims processing and drug rebate.
- **Vendor-proposed services and BMS optional service—**We demonstrate our thought leadership that will help BMS prepare and manage program evolution and healthcare reform.

Gantt Chart

HPES has provided a detailed project schedule Gantt chart in our response to proposal section "3.2.2 Project Management." Additionally, our response to Requirement 6 in section "3.2.1 Proposed West Virginia MMIS" provides a high-level overview of the duration of each major project phase.

Requirements Checklist

We include the completed Attachment II - RFP Requirements Checklist that demonstrates our ability to meet the mandatory requirements in our response to section “4.1.14 RFP Requirements Checklist.”

4.1.10 Solution Alignment with BMS' Business and Technical Needs

RFP Reference: 4.1.10 Solution Alignment with BMS' Business and Technical Needs

3.2 Scope of Work

The West Virginia Bureau for Medical Services (BMS) has documented its goals and objectives for this Medicaid Management Information System (MMIS) Re-procurement Project, which includes the identification of 14 business processes across five functional areas—member management, provider management, contract management, operations management, and program management—targeted for improvement from Medicaid Information Technology Architecture (MITA) maturity Level 1 to Level 2. HP Enterprise Services (HPES) has studied West Virginia's State Self-Assessment (SS-A), and through our request for proposal (RFP) response, we highlight our proposal features to reinforce the benefits of our offering, including moving along the MITA maturity path.

Our proposed solution—the West Virginia interChange (WV-iC) MMIS—is based on the first certified MMIS using the latest Centers for Medicare & Medicaid Services (CMS) certification checklists. It will enable BMS to transition to successively higher levels of MITA maturity during this project. Implementing the WV-iC MMIS will provide an opportunity for an early migration path for many of the 14 processes. We use the MITA Maturity icon to identify in our response where and how our solution supports MITA maturity for those processes, and at other points where our experience with MITA will provide unparalleled support for BMS' MITA maturity plans.

HPES has taken MITA's guidance to heart when building the WV-iC MMIS solution. We have aligned the functional areas around the business areas that MITA recognizes. We have built the processing platform on a true service-oriented architecture (SOA), supported by web and business services. Through data translation adaptors, we can readily transform data from one format to another, allowing a more interoperable data exchange.

3.2.1 Proposed West Virginia MMIS

RFP Reference: 3.2.1 Proposed West Virginia MMIS

The WV-iC solution is a proven, certified base MMIS that exists today and is capable of providing many of the immediate benefits BMS desires. We have enhanced our demonstrated capability with MITA-aligned tools that can be integrated into other aspects of the MMIS as business needs require. We meet mandatory requirement 3.1.10 to host the WV-iC MMIS and maintain a secure site and backup site within the continental United States. HPES also will comply with mandatory requirement 3.1.36 to give ownership of data, procedures, programs, and materials as required in the RFP and developed during DDI and operations to BMS and the initial licensing for installed COTS products. We understand that manufacturers' support and maintenance for the proprietary COTS software licensing subsequent to the initial install must be provided only for the life of the contract.

Understanding of the Overall Need and Purpose of the Project (Req. 1)

In the RFP, BMS has outlined the key objectives used in developing the scope of work for the replacement MMIS. As a team, we studied the objectives and determined the most effective way to demonstrate to BMS how HPES will meet these objectives is to highlight how our team successfully approaches these challenges with each project—more importantly, how we meet similar objectives with each MMIS implementation and fiscal agent turnover.

The assumption of Fiscal Agent operations without disruption in provider payments or member access to appropriate care and services.

HPES has successfully implemented 12 interChange systems in the past 10 years. With these interChange system implementations, we have not missed a single payment cycle to Medicaid providers—removing barriers for providers to continue delivering member services during the change in system and operations processing. A transition from a legacy MMIS to the interChange system can be complicated and cumbersome to a novice; however, HPES' experience has taught us how to successfully deliver project management integration, scope and change management processes and controls, and a proven systems development life cycle approach.

In every interChange MMIS implementation, HPES implemented the system without missing a single payment cycle to Medicaid providers.

For example, our team beat the target implementation date of July 1, 2008, for the State of Florida interChange Design, Development, and Implementation (DDI) project. The Florida MMIS went live June 20, 2008, for pharmacy point of sale (POS) and eligibility verification

processing. We went live for the other claims June 26, 2008. The first financial cycle executed on June 28, 2008.

Achievement of Federal MMIS certification and approval for the maximum allowable enhanced FFP within 12 months of cutover to the replacement system retroactively to the day the system becomes operational.

Each interChange implementation has received the official seal of approval from CMS—certification back to the first day of operations (with a single two-week exception in Kentucky). The most recent certification is the Wisconsin interChange MMIS—the transfer system that we are proposing for West Virginia. Additionally, Wisconsin became the first state to complete and pass certification using the new CMS checklist and process. No other vendor can equal these achievements.

Compliance with all HIPAA requirements.

The WV-iC is designed to comply with the current and final technical guidelines established by CMS for a system compliant with the Health Insurance Portability and Accountability Act (HIPAA) for transactions, code sets, identifiers, privacy, and security requirements. HPES provides a double set of assurances concerning compliance with HIPAA requirements through the functional capability built into the interChange MMIS solution and through our personnel, who meet the standards for privacy and security each day.

We have a thorough understanding of the final and proposed HIPAA requirements. Through our involvement in standard-setting organizations and other industry groups, we often anticipate future changes to HIPAA requirements. In our work during the past decade, the HPES team has assisted states and other healthcare organizations in analyzing the effect of HIPAA on their systems and operations. From this analysis, our teams have developed appropriate and HIPAA-compliant systems and operational solutions that meet the healthcare program's strategic needs.

Timely design and development of components affecting providers, e.g., web portal, web-based claims submission.

HPES is an industry leader of web-enabled HIPAA transactions. We were first in the nation to accept 270/271 and 276/277 transactions, as demonstrated in the Massachusetts Recipient Eligibility Verification System (MassREVS) project. Throughout our healthcare accounts, web functions include claim submission access for multiple claim types, claim status inquiry, member eligibility verification, prior authorization (PA) submission and inquiry, and the capability to allow providers to upload 837 transactions for processing.

The following testimonial received after implementing interChange for the Massachusetts Executive Office of Health and Human Services (MassHealth) demonstrates the positive effect of our web-based solutions on the provider community.

"The new system makes our daily dealings with MassHealth much more efficient and effective. The updated automated web solutions through the Provider Online Service Center accessing functionalities such as but not limited to electronic claims entry and payment, eligibility verification, security, provider updates to the provider file, and reporting are just the sort of improvements providers were looking for to aid our business transactions. These system implementations and developments have allowed providers like us to become more self-sufficient than ever."

— Jason Schofield, Manager, NewMMIS Corporate Facilitation High Point Treatment Center

MMIS that improves efficiency and convenience for BMS staff through reduction of manual processes, increased automated processes, increased workflow capabilities, and increased system capabilities and efficiency.

Business processes are the focus of MITA, and HPES sets out to work with each customer to increase efficiencies, reduce manual efforts, and grow the maturity level of processes as follows:

- The new Connecticut interChange increased the real-time and near real-time processing capabilities for claims. Previously, Connecticut did not have real-time processing for any claims type except for pharmacy. Before interChange, nonpharmacy claims were processed in batch every two weeks. With interChange, editing and auditing is performed in real time for web submission and near real time for electronic batch uploads, enabling providers to work through the web portal to correct claim issues before financial processing.
- The design of the new MMIS brings significant enhanced features to the State of Oregon, including real-time claims processing to replace legacy batch claims processing, user-configurable benefit plans to replace hard-coded business rules requiring programming effort to change, online claims resolution to replace paper worksheets, real-time eligibility updates to facilitate timely update of critical data, and enhanced access to data through consolidation of data from multiple sources into the MMIS.

The interChange MMIS provides a scalable architecture that can grow and change with the Medicaid program—for example, new benefit plans such as those administered in a state's breast and cervical cancer program. By implementing a few table changes to the system, the state can add a new category of eligible individuals.

Experience and Working Knowledge of the Solution and Approach (Req. 3)

HPES will deliver a CMS-certified MMIS solution with a proven DDI approach. Through our interChange system projects and deliveries, we continually use our lessons learned to get better at what we do—listening to our customer, developing a sound project plan, and delivering on that plan. Please see proposal section "4.1.7 Vendor Capacity, Qualifications, References and Experience" for details about our experience and approach with interChange MMIS implementations. The following table summarizes our interChange solution projects and implementations—all successful—during the past 10 years.

HPES' Proven interChange Solution and Approach

State Medicaid Program	interChange Go Live Date
Alabama	02/2008
Connecticut	02/2008
Florida	06/2008
Georgia	10/2010
Kansas	03/2004
Kentucky	07/2007
Massachusetts	05/2009
Oklahoma	12/2002
Oregon	12/2008
Pennsylvania	03/2004
Tennessee	08/2004
Wisconsin	11/2008

A successful solution and DDI approach that moves smoothly into operations can only happen if the efforts are supported by technically skilled, functionally knowledgeable professionals who are focused on a successful outcome. Experience indicates that HPES has those people. We will devote the resources and bandwidth to successfully support West Virginia and our other state customers with the following:

- More than 7,000 healthcare IT experts to support conversion to 5010, ICD-10, MITA maturity, and other enhancements, such as health information exchange (HIE)
- More than 4,300 dedicated fiscal agent operations staff members and healthcare professionals to support continual program improvements
- More than 200 professional clinicians—physicians, dentists, pharmacists, nurses, and social workers—to provide care management, disease management, and utilization management services

We assign experienced, expert leaders and staff members to each of our projects, and they develop and maintain a productive, open, and positive relationship with Medicaid program personnel. As with our other recent successful implementations, implementing the WV-iC will require a team of highly skilled people with a combination of interChange implementation experience and demonstrated skills in project management and account leadership. We have them, and they are ready to make the WV-iC implementation and fiscal agent operation our next success story.

MITA Requirements (Req. 4)

The National Medicaid EHI Healthcare (NMEH) Workgroup recently concluded in its "Value of MITA" report that Medicaid programs are in an unprecedented season of change. SOA and MITA are revolutionary approaches to system design that will enable this change and support Medicaid agencies in their ongoing mission to provide better healthcare while reducing the overall cost of healthcare.

HPES is proposing a solution to meet the ever-changing business needs of state healthcare. We remain adaptable to the architectural standards changes required by MITA, the American Recovery and Reinvestment Act (ARRA), the Health Information Technology for Economic and Clinical Health Act

(HITECH), the Affordable Care Act (ACA), and other health mandates. We detail how our proposed WV-iC MMIS solution positions BMS and the HPES MMIS staff for business process maturity in functional areas such as provider enrollment, enhanced communication, and advanced data access and reporting. We know MITA maturity is measured through the effectiveness of the improved business processes—the technical and information architectures are a means to deliver the business architecture of healthcare for the State of West Virginia to its neediest residents.

Examples of our solution components that will help drive business process improvements, targeted by BMS for achieving a higher level of MITA maturity, are noted in the following table.

Highlights of the WV-iC Addressing Areas for BMS' MITA Maturity

WV-iC Solution Component	Focus of Business Process Improvement
Healthcare Portal	• Inquire member eligibility • Manage provider information • Inquire about provider information • Manage provider communication • Manage provider grievance and appeal • Perform provider outreach • Manage payment information • Inquire about payment status
Document management	• Prepare remittance advice report • Manage drug rebate
Correspondence management	• Manage provider information • Inquire about provider information • Manage provider communication • Manage provider grievance and appeal • Perform provider outreach • Perform potential contractor outreach • Manage drug rebate
interChange benefit plan administration rules engine	• Edit or audit claim • Prepare COB • Develop and maintain benefit package

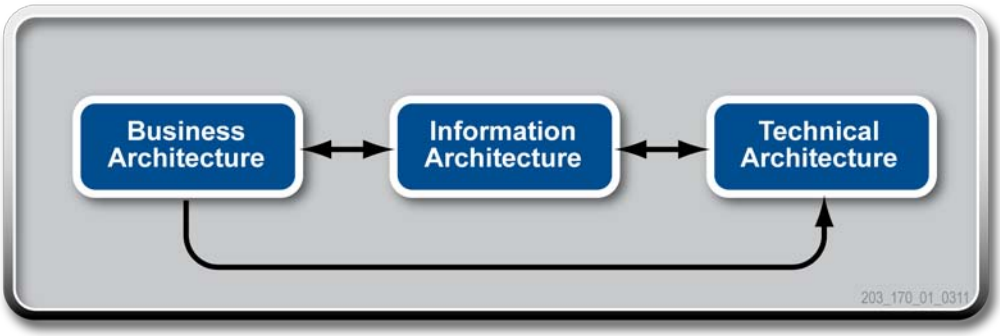
This table highlights the 14 business processes selected by BMS for enhancement; however, the total WV-iC solution is capable of supporting future growth and maturity throughout the eight business areas of the Medicaid enterprise.

Industry-Based, Open Architectural Standards

Our solution is a standards-based approach to healthcare architecture. The WV-iC system is based on MITA principles and the CMS-certified transfer MMIS built and running in Wisconsin. HPES has helped define the architectures and approaches that will allow MITA to be more than just a framework. We use these experiences in designing and developing our evolving interChange system as it becomes the WV-iC. This solution emphasizes the MITA-aligned architecture and the business processes required for the State of West Virginia. MITA itself does not dictate a specific technology policy, just the required technical capabilities. This guidance allows the WV-iC to be extended to encompass the customized needs of BMS and still support the MITA requirements.

Through the progression of the interChange MMIS development, HPES has adapted to changing industry data standards, such as National Provider Identifier (NPI) and ICD-10 code sets, further demonstrating the ability to develop technology to maturing business needs. The WV-iC also will use the shared HPES BES for EDI processing data exchanges, using the industry-standard ANSI Accredited Standards Committee (ASC) X12 healthcare and National Council for Prescription Drug Programs (NCPDP) transactions.

HPES Business Architecture



Business Architecture

The starting point of the MITA framework is the business architecture, in keeping with the guiding principle that MITA, according to CMS, "represents a business-driven enterprise transformation. The Business Architecture describes the needs and goals of individual States and presents a collective vision of the future." The business architecture also is the most mature and has been approved at the 2.01 level by CMS.

The MITA business architecture provides a framework for improvements in the Medicaid program operations designed to produce better outcomes for stakeholders. West Virginia has used the business architecture to assess its current business capabilities and determine future targets for improvement. The existing SS-A reviewed the business models and processes used in West Virginia to identify the gaps against the MITA business processes. Through the SS-A, West Virginia identified the specific business processes measured at a particular technical capability to define the target MITA maturity level for a given business process. This "To-Be" state establishes the measurable target for business transformation on the MITA compliance road map.

Information Architecture

The core WV-iC components will be transferred from our Wisconsin interChange MMIS. The Wisconsin interChange system is the only MMIS-certified system under the new CMS MITA Certification Toolkit. At the heart of the Wisconsin MMIS is a healthcare-specific relational data model, targeted to meet the business needs of healthcare but adaptable to the information architecture changes required by MITA, ARRA, HITECH, ACA, and other healthcare mandates. The WV-iC information architecture is highlighted by the following:

- **Logical relational model—**Stored and maintained in the ERwin data modeling tool, accessible online using HP Development Center, and refined through 12 interChange MMIS implementations in the past 10 years
- **Physical relational data models—**Stored in Oracle and derived from the logical model through an automated database change control process
- **Data interface web services—**These interface web services allow external systems access to claim, provider, member, and prior authorization data in a consistent view

The WV-iC comprises our interChange data structures that optimize the storage of the detailed data to maximize its effectiveness. Besides how the WV-iC handles data exchanges through our established EDI gateway for the standard healthcare transactions, our interChange data structures optimize the storage of the detailed data to maximize its effectiveness. For the WV-iC nonreporting database, the data model is organized using OLTP structures that focus on highly efficient transactional processing. The data structures are optimized and organized to support the standard healthcare transactions. Included in the core of the WV-iC transaction data model is a table-driven, rules-based configuration solution.

Technical Architecture

The purpose of the technical architecture, as defined within MITA, is to provide a separately layered MMIS for greater overall flexibility. The WV-iC MMIS architectural solution provides a logical separation across layers that are implemented independent of the underlying platform. The defined services are initiated using standard methods in the invocation of one of the functions supported by the service.

As part of our response, we have made use of the published MITA technical architecture schematic templates as a basis for conveying the specific HPES WV-iC solution. The technical architecture—including the data, application, and network

architectures—support the MITA business areas defined in the RFP. We understand that technology is not applied just for the sake of using technology, but must be intelligently and economically used to improve business functions and services.

Modular Components

The WV-iC is a demonstrated n-tier architecture that places an emphasis on reuse and flexibility, thereby increasing the return on BMS' investment. Its framework facilitates the use and reuse of modular solution components, saving development time and minimizing risk for BMS and the HPES team. This approach reduces long-term investment cost because solutions can be used across business areas within the WV-iC. Addressing the goals of maximizing reuse and business service flexibility, the WV-iC makes extensive use of COTS packages.

Each package has been selected carefully through our HPES product team evaluation, review of leading industry evaluations, and our real-life experiences with the tools. Through our MMIS architecture, BMS will find that the proposed WV-iC has a high degree of reusability and flexibility across the many MITA business areas, providing the best long-term economy of investment.

Because of our approach to COTS integration within the WV-iC solution, the healthcare program can respond faster to statutory, programmatic, and technology changes. We have selected to integrate best-in-class, leader-quadrant COTS packages that enable business services that are adaptable and extensible. A combination of the layered approach, web services, and an integrated security and privacy solution provides enhanced access to data and information.

Relational or Object-Oriented Database

HPES designed the interChange MMIS based on an Oracle relational database. While other systems may be retrofitted to a table structure, the system proposed for West Virginia was designed specifically to meet the program challenges faced by Medicaid customers. This design approach allows for rapid processing of modifications and minimizes the level of effort and program dollars required to implement changes. With HPES' innovative design that makes extensive use of shared-object libraries and parameter-driven edits, BMS can implement program changes quickly.

WV-iC's healthcare-specific relational data model is organized into basic business areas—aligned to MITA. Besides the healthcare-specific relational data model aligned to MITA, it is our approach to data sharing that will help BMS achieve its vision. By providing a set of common data interface services, the WV-iC shares data through an SOA that facilitates a common and consistent view of the data.

Web and Real-Time Processing

As healthcare is transforming, members and providers have become more comfortable with business-driven interaction through a web portal. Nearly a decade ago, HPES transformed the market with the first Medicaid real-time claim adjudication for claim types through a web portal. We have continued to expand the business functions members and providers can use to make their interaction with BMS' healthcare program easy to navigate and use.

By using the Internet to process Medicaid claims, providers can submit claims interactively through a user-friendly and secure web submission method—claims will pay or deny. With denied claims, providers can immediately make the necessary modifications—for example, adding a missing units field and resubmitting the claim. Outside claims submission, providers can use the Internet to verify eligibility, request prior authorization, view claim payment information, and retrieve recent 835 transactions. Using the Internet in this user-friendly and secure manner further encourages electronic submissions, leading to cost savings in the reduction of paper and material requiring manual processing.

One of the main advantages of the proposed WV-iC solution is that it is based on the Wisconsin interChange system. Starting with a fully CMS-certified MMIS positions BMS to be a leader in implementing new SOA and MITA capabilities as detailed specifications begin to be defined, eventually evolving into web service definitions. Our plan is to enhance and update the information architecture or data models that constitute the WV-iC to support and implement MITA Level 3 web service definitions as they become part of the defined MITA framework. This enhancement will be handled as part of the overall MMIS enhancement change management process in which BMS will set the priorities for which projects are worked through the enhancement pool.

Rules Engine Management

The proposed WV-iC is a web-accessed client/server healthcare management system that integrates purpose-built claims adjudication rules and a COTS business rules engine to provide the right rule at the right time. The following table highlights the core SOA-enabled COTS packages HPES proposes for rules engine management functions.

HP Development Center

The use of HP Development Center by our Requirements Validation teams has delivered value to previous HPES interChange MMIS projects. This tool has worked as a repository of system requirements documentation that is easy to navigate, interpret, and maintain throughout a project. Within the project management environment in HP Development Center, requirements will be documented and integrated with HP Quality Center for testing. The WV-iC solution objects will be individually linked to the RFP requirements in HP Development Center and show how the requirements are associated with the business processes. HP Development Center will interface with HP Quality Center for system testing and performance testing.

HP TRIM

HP TRIM serves as the document repository. The tool enables HPES to secure content while automating records management and integrating to other tools, such as HP Quality Center and HP PPM. It provides versioning and streamlines content management. We use HP TRIM for types of documents that typically require updating and versioning and are referred to as "living" documents. This collection and integration of collaborative tools provide a complete set of documentation capabilities throughout the project life cycle.

PMO Governance

We meet mandatory requirement 3.1.31. Our project management methodology and integrated tool suite deliver a plan that meets stakeholder expectations and allows monitoring and control of actual progress against the plan. We actively balance project scope, quality, effort, resources, schedule, budget, and risk. During the first 30 days from the contract start date, we will collaborate with the BMS' Re-procurement project manager to review and finalize the status report formats and content and confirm the timing for the weekly and monthly status reports. For more details on project status and reporting, refer to the "Draft Communications Management Plan" in the "Sample Deliverable Formats" tab.

PMO governance is a structure of work groups and processes that govern decision-making around business priorities to include vendor relationships, project management, change control, and other important IT implementation and operational areas. HPES brings this value to BMS to illustrate how an effective governance model provides a structure that enhances decision-making and enables more effective coordination and leadership. As part of our PMO governance approach, we keep our commitment to a strong collaboration with the MMIS Re-procurement project manager and the BMS project teams at the forefront. We understand the challenges and constraints faced by the MMIS Re-procurement project manager and team, and we have selected our leadership team to provide individuals committed to working with the MMIS Re-procurement project manager and team, current fiscal agent, and stakeholders to plan for and accommodate these challenges, functioning as a single entity in achieving BMS' objectives.

Our PMO approach enables our customers and stakeholders to govern in real time with effective, collaborative processes using standardized workflows, request types, dashboards, and multiple levels of input, review, and approval. The following figure depicts our approach, which emphasizes proactive communication and clear lines of responsibility to enable BMS to make business decisions and manage the Medicaid Program.

Project Management Plans

RFP Subsection 3.2.2.1	Project Plan Title	Description
1	WBS and Dictionary	• Microsoft Project schedule is outlined by a WBS. The WBS dictionary will provide the summary descriptions of the work to be performed. • The WBS breaks down the work into logical tasks and subtasks. The WBS is further broken down to a list of activities required to accomplish the work on the WBS. • The activities from this effort are called work packages. The work packages are a basis for estimating, scheduling, executing, monitoring, and controlling the various project phases.
2	Project Schedule	• The schedule (work plan) for DDI is built using Microsoft Project and is a comprehensive plan based on multiple MMIS implementations. • The schedule follows a WBS based on the ESDLC. • The schedule includes the activities or tasks by ESDLC phases, the assigned personnel, durations, start dates, and finish dates linked by task dependencies.
3	Staffing Plan	• The staffing plan provides the process for: – Staff selection and assignment – Staff loading chart—roles and responsibilities – Staffing tools to track and monitor resources in the MMIS implementation and the transition to operations support • Resumes will be provided for key staff members defined in the RFP.
4	Facility Plan	• The facility management plan will describe the aspects of the facility that will be provided at the Charleston location. It also will provide information regarding the primary data center and the disaster recovery data center.
5	Documentation Management Plan	• The HPES Enterprise Document Management (EDM) solution will serve as the hub of management of documents within the BMS MMIS documentation—providing one entry point to access necessary communication, documents, and other information required for effectively and efficiently completing daily work.
6	Training Plan	• The training plan includes the process and tools for developing, maintaining, and implementing the training plan throughout DDI and operations. It will include the milestones, acceptance criteria, and approach for approval of the training plan.
7	Testing Plan	• The testing plan will document the enterprise test methodology (ETM) for each of the testing phases—System, Systems Integration, Regression, Load/Stress, UAT, and Operational Readiness/Pilot. Testing processes and procedures will include the following: – Use of the Requirements Traceability Matrix (RTM) and validating linkage from testing to requirements, including documentation updates

RFP Subsection 3.2.2.1	Project Plan Title	Description
		– Test automation and use of test scripts – Test data development using a sample of preliminary converted files – Defect identification, tracking, and resolution – Test results reporting procedures
8	PM Subplans	• Descriptions of the subsidiary plans are documented in the integrated management plan and include the following: scope management, schedule management, cost management, quality management, human resources, communications management, risk management, issue management, change management, and integration management.
9	Workflow Management Plan	• The workflow management plan describes the process, tools, and procedures to execute workflow management. Our approach to workflow management takes into consideration the MITA concept of business process management (BPM). Rather than focusing on individual workflow configuration, BPM focuses on creating business services that encapsulates a process.
10	Transition Plan	The plan defines the business process changes that need to occur in response to the change in technology including the following: • **Overall transition management—**Actively manage, monitor, and oversee the transition to the new replacement systems and processes • **Transition roles and responsibilities—**Identify the roles and responsibilities of the transition team or workgroups • **Transition activities—**Identify the actual activities by business function that need to take place for a successful transition to, and operation of, the WV-iC • **Training and performance support—**Activities that support employees to develop the behaviors, skills, capabilities, and knowledge required to effectively perform new or improved ways of working and prepare them for taking on full responsibility of operating the WV-iC
11	Weekly Status Report Template	• A sample of the "Weekly Status Report Template" is provided in the "Sample Form Templates" tab.
12	Monthly Status Report Template	• A sample of the "Monthly Status Report Template" is provided in the "Sample Form Templates" tab.

The draft project management plans will be provided to BMS early in the Start-up (Initiation) Phase with scheduled work product reviews to aid in providing the details of the processes within the plans and helping to answer questions from the BMS Re-procurement manager and team members.

Project Management Life Cycle

The project management life cycle complements the phases of the ESDLC as depicted in the RFP response section 3.2.1.1. The project management life cycle activities are organized in the following four summary work elements: start-up, planning, execution, and close-down.

The summary work elements and the lower-level work elements are not strictly sequential. Although some sequence exists, project management is an iterative process. For example, during the execution of a project, events such as replanning milestones or change requests can cause the project to perform some of the planning work elements again.

Start-Up

Start-up, also called initiation and planning, sets a project in motion and establishes the project's operational framework. At this point, the project manager and the customer establish the initial expectations for the project deliverables, establish the scope and internal procedures, conduct the project kickoff meeting, and organize the team that will complete the planning activities. With these activities, the tools will be set up and configured to support the project.

Planning

The scope, standards, procedures, and other components of the project plan are refined and integrated to make sure that customer expectations are satisfied. The integrated management plan facilitates communication among stakeholders; documents approved scope, cost, and schedule baselines; and guides project execution.

Execution

The project manager, the project team, BMS, and cross-project personnel carry out the project plan. The project manager directs, monitors, adjusts, documents, and controls changes to the scheduled activities to promote compliance. The project manager and BMS continually monitor communication of status, issues, risks, variances from the project plan, and change requests.

Close-Down

The project manager discontinues the project in an orderly, controlled manager by reviewing the project's process and outcome and by archiving the project workbook for future use. Follow-on business is documented and a post-project review identifies areas to be improved and measures customer satisfaction.

Work Breakdown Structure and Deliverable Dictionary (Req. 1)

We meet mandatory requirement 3.1.24. Our Deliverable Dictionary defined in the following section includes the deliverables and milestones in Appendix C. This dictionary outlines and describes the deliverables and milestones and provides a reference to the WBS in our proposed project schedule, demonstrating that we will supply the deliverables and meet the milestones as described in Appendix C of the RFP. Any additions to the deliverables list in Appendix C will require a change order as it impacts the scope of the project as defined in our change management plan.

The WBS, illustrated in the following figure, provides the graphical depiction of a deliverable-oriented grouping of project phase components that organizes and defines the total scope of the West Virginia MMIS Re-procurement Project. The WBS in our proposed project schedule is constructed based on the project phases – Phase 1a through to Phase 1e within the ESDLC and comprises taking the major activities and breaking them down into smaller, more manageable components until the activities are completed within the lowest-level task at a duration of 10 business days. The activities from this effort are called work packages. The work packages are the basis for estimating, scheduling, executing, and monitoring and controlling the project phases.

Staffing Plan (Req. 3)

Highlights

- Depth of expertise and experience of team developing staffing plan
- Use of proven processes, tools, and methodologies

The purpose of our staffing plan is to provide the appropriate mix of positions and people to meet BMS' requirements. This plan addresses the selection and assignment, roles and responsibilities of the staff and the tools, equipment, and processes used by the staff. This plan builds on the base processes and techniques outlined in the HR management plan and provides further details as to the specific staffing plan to provide the right staff, with the right skill set, at the right time for each particular project phase. Nothing is more important to service excellence than the caliber of the people who deliver it. No competitor can match the experience, dedication, and attention to customer care than the people HPES brings to this project. The leadership team will determine staffing requirements based on approved project requirements, skill sets needed, work estimates, and the proposed solution. Managing employee demand is a proactive, iterative activity where HPES leaders forecast, identify, request, and continually adjust personnel to support the business needs and goals.

Our process begins with the creation of a staff loading chart, based on the staffing plan determined to meet the needs of the RFP. As HPES moves through development and defining of requirements, project managers—using the PMBOK process—will be updating the project plans, staffing plan, and staff loading chart accordingly.

During selection and assignment, managers match candidate's behaviors, skills, and career goals to the requirements and expectations of the position. Our managers use the principles of behavioral interviewing in this selection and assignment phase. A mix of candidates, from various sources, is used to verify that we have the right mix of skill sets. Our internal HPES staff uses Primavera Evolve, which is the professional services work force automation tool used across HPES. Additionally, we recognize the relationships BMS has developed with the incumbent's knowledgeable staff members. Our goal is to select, hire, and transition existing qualified incumbent contractor staff members.

After the appropriate staff is identified, we understand that employees have a real need for communication between the business functional area teams, BMS, and their account leaders if a project is to be successful. Communication is about delivering the right information to the right audience at the right time. We use various communication tools to verify that our HPES staff is as productive and effective as possible in its daily performance.

Besides communication, our employees are provided the necessary tools and processes to perform their roles successfully. The integration of our application suite of COTS tools interfaces with our corporate time-tracking system. This will allow the project manager to view actual effort against the schedule and proactively work issues with their team that could affect the staffing plan. The processes used are documented and embedded within the integrated tool suite.

For further details, reference the "Draft Staffing Plan" provided in the "Sample Deliverable Formats" tab.

Facility Plan (Req. 4)

BMS is investing in its MMIS Re-procurement Project and has required its vendor to deliver services and products necessary to design, develop, implement, and operate the new solution. An important element of the new contract is acquiring, establishing, and maintaining appropriate facilities that will house the project and its operations for each phase.

HPES will acquire facilities that will provide a professional business environment to facilitate a productive working atmosphere and deliver the highest level of member and provider Medicaid services. As required by the RFP, our selected facilities for the MMIS Re-procurement Project are outlined in the draft facility management plan within our proposal response.

Our plan contains the following content:

Highlights

- Facilities that provide a professional business environment
- An understanding that the operations facility directly affects performance and efficiency

- **Approach to securing workspaces and meeting facility requirements—**We have carefully considered space options and have selected facilities that will house operations for the three phases and meet BMS' facility requirements.
- **Proposed work site descriptions—**As an experienced contractor delivering quality services to support state Medicaid projects nationwide, we understand that the operations facility is part of the project infrastructure and directly affects performance and efficiency. We describe our primary Charleston operations facility, where the following work will be performed:
  - Business operations
  - Claims receipt (hard copy) and prescreening

- Mail room
- Data entry
- Imaging operations
- Exception claims processing
- Call center operations
- Provider enrollment and re-enrollment
- Provider relations
- Member relations
- Account management
- Quality assurance
- Designated system modification and enhancement activities described in Section 3.2.7.3, including staffing requirements
- Financial management

- **Work performed off-site—**HPES will perform operations of the WV-iC application and supporting disaster recovery and business continuity functions off-site at the Pinnacle Center operations facility. We have established data centers that house other MMIS production environments. HPES will perform our high-quality processing timely in accordance with BMS' defined SLAs. We provide details about both data centers.

For further details, reference the "Draft Facility Plan" in the "Sample Deliverable Formats" tab.

Documentation Management Plan (Req. 5)

Documents present BMS with unique challenges. They come in various formats requiring specific handling such as scanned images, reports, generated letters, spreadsheets, emails, word processing documents, presentations, and multimedia files. Additionally, many documents must be managed as records for compliance or legal activities.

The HPES documentation management plan is a comprehensive approach to manage the incoming and outgoing BMS documents supported. Our solution comprises the integration of the best COTS and custom applications available, as summarized in the following table.

HPES Documentation Management Plan Components

Product	Use
HP TRIM	• Provides the core document management solution for each type of electronic format that can be captured and retrieved from the system including images, office documents, host outputs, and multimedia files • A workflow supporting BMS to create, review, and approve documents before publication or sending to external stakeholders • Provides the ability to index, search, and retrieve documents including exposing this capability to external stakeholders securely • Provides records governance to facilitate trustworthiness, accuracy, and compliance with BMS-defined records retention policies
HP Exstream	• Delivers accurate, consistent, and effective correspondence using reusable templates • Automates interactive, on-demand, and batch letter generation capabilities • Supports multiple languages and can output in 21 different formats • Can be invoked as a web-based application, web service, or using Java Message Service (JMS)
HP Development Center	• Provides accurate, comprehensive, current documentation that allows uninterrupted operation, support of system security requirements, and validation of software changes made according to management controls and priorities • As a centralized online repository for project information and documentation, provides project members with immediate results as updates are made to the content of HP Development Center

Product	Use
Document Imaging Mavro MavBridge, Open Text fax server, RightFax Edition, and SunGard FormWorks	• Integrates OPEX Scanner and RightFax to industry-standard outputs that allow predefined integrations with the SunGard FormWorks application and HP TRIM • Automates the flow of faxes into and out of the WV-iC environment using dedicated fax modems, fax over IP (FoIP), and HP multifunction printers (MFPs) • Converts paper and fax claims to electronic data interchange (EDI) transactions with high accuracy and efficiency using forms management techniques; allows additional key from image data entry and correction in a single workflow

For further details, reference the "Draft Documentation Management Plan" in the "Sample Deliverable Formats" tab.

Training Plan (Req. 6)

HPES will use the training strategy and the training needs assessment information to identify learners' knowledge gaps and refine and further develop our WV-iC MMIS training draft to create an education and training plan that satisfies the strategic learning needs of BMS and the individual learner. We will structure the final training plan, agendas, and materials to meet the needs of the WV-iC MMIS user community and the West Virginia provider community.

Highlights

- Satisfies the strategic learning needs of BMS and the individual learner
- Features a training work plan integrated into the overall implementation plan

Key areas of our finalized training plan will include the following topics:

- Identifying the framework and methodology we use to develop training
- Defining BMS and HPES roles and responsibilities
- Defining the strategic approach used to develop the training work pattern and use of the survey results
- Identifying the number of users to be trained by type of training
- Listing the standard training courses and course duration
- Describing the training delivery methods and the strategy for delivery, including the format and content of training materials
- Defining the evaluation of the training development process
- Establishing the training schedule
- Defining the quality assurance process and integrating improvements determined through training session evaluations into future training

We will develop a detailed training work plan to manage and evaluate progress on the WV-iC MMIS training activities and monitor progress based on milestones and key dates. The detailed training work plan will include the following:

- Schedule for development and approval of training materials
- Key training-related system implementation dates
- Schedule of training opportunities and time frames
- Training plan documentation and associated materials
- Task and subtask descriptions
- Activities and work steps

We will integrate the training work plan into the overall implementation plan to verify that interrelated and dependent tasks remain linked and that training is delivered as intended. We will seek BMS feedback and approval of training plans, schedules, and materials, and will focus our educational efforts on building meaningful user and provider skill sets.

For further details, reference the "Draft Training Plan" in the "Sample Deliverable Formats" tab.

Testing Plan (Req. 7)

The purpose of our master test plan is to describe the scope of testing for the West Virginia MMIS Re-procurement Project. The plan will outline the testing methodology, specific testing activities, and the test management and control processes to be adopted for testing. Additionally, the master test plan summarizes the overall project test strategy and approach and documents the aspects of testing that are common to test phases and levels and the deliverables from each phase or level. The master test plan will be developed, reviewed, and approved by each stakeholder.

Highlights

- Comprehensive testing methodology
- Early testing engagement during the Planning Phase

The master test plan development process will begin with documenting the testing approach that will be used for WV-iC testing. To promote consistency across each testing level, we will use our ETM, which is our comprehensive methodology dedicated solely to testing software solutions. The ETM will help BMS and HPES achieve service excellence by providing a testing framework that is comprehensive enough to support consistency, yet flexible enough to allow for tailoring that adapts the ETM to meet the specific testing needs. The value of the ETM is in its capability to enable projects, programs, and even organizations to define the most appropriate testing approach for their needs, formalize testing requirements, and execute and manage testing across efforts. Because the ETM defines testing activities across deliverable components throughout the entire development and deployment life cycle, it helps testing personnel clearly define, execute, and manage testing activities, lowering risk and increasing solution quality.

Besides the approach, the plan will include the following:

- **Scope—**Describes the testing types to be used by the Testing team (functional and nonfunctional)
- **Master test plan development activities—**Provides guidance and establishes a framework within which the testing activities can be defined, planned, and executed
- **Entry and exit criteria—**Details entrance and exit criteria to be met before an individual phase or level of testing can start and complete
- **Resources, roles, and responsibilities—**Identifies project testing roles and responsibilities for HPES and BMS
- **Test deliverables—**Documents what testing deliverables will be issued, timing to deliver them, and to whom from BMS
- **Test environment requirements—**Describes the integrated testing environment (ITE) that will be used for each phase or level
- **Test tool utilization—**States which test tools will be used on the project
- **Defect management—**References the defect management processes to be followed
- **Test metrics—**Outlines the test metrics to be produced and to whom they will be reported
- **Test assumptions and constraints—**Lists detailed testing assumptions and constraints made regarding the project on which the test estimates and cost model are based
- **Test risks and issues—**Creates and references testing risks and issues logs associated with the MMIS Re-procurement Project and identifies escalated risks and issues
- **Testing requirements traceability matrix—**Describes the use of the BMS requirements traceability matrix

For further details, reference the "Draft Testing Plan" in the "Sample Deliverable Formats" tab.

Scope Management Plan (Req. 8a)

The purpose of the scope management plan is to establish processes required to verify that the project includes the activities required to complete the contract successfully. It is primarily concerned with defining and controlling what is included in the project. HPES works with the workgroups and the BMS staff throughout the ESDLC to identify, document, and review the WV-iC activities as defined in the WBS. The WBS organizes the work required for the WV-iC into manageable, deliverable phase components to effectively manage and control scope. During project start-up, the PMO facilitates a scope overview meeting to verify that stakeholders are aware of the project scope and gain a common understanding of what is involved in meeting the project objectives.

Scope management is a process by which scope is defined, documented, approved, baselined, and managed throughout the project life cycle. We work with the project teams and stakeholders to identify, document, review, implement, and manage changes in the WV-iC environment. When properly implemented, scope management maintains the overall integrity of the project scope. The amendments, modifications, alterations, or changes to the scope of work in the contract will be in writing and signed by both parties. When defined, approved by BMS, and baselined, the project scope can be effectively managed through our scope management process.

The two types of scope are product scope and project scope. Product scope is managed using the RFP requirements that are loaded into HP Development Center, validated during requirements validation sessions, and maintained throughout the project. This allows mutual review and oversight by the project stakeholders. As design documents are approved, they become the detailed product scope definition. Project scope is managed using the project schedule (work plan). Changes to the milestones, deliverables, or release dates in the project schedule are project scope changes.

As a scope change is considered for approval, the HPES team provides effort, staff members, and schedule impact estimates to BMS. When a scope change is approved, we incorporate the schedule changes for that item into our project schedule and update the baseline. This enables us to confirm that other project schedule tasks affected by changes are adjusted accordingly. The changes are then reflected in our regular status reporting and formal communications.

The objectives of the scope management plan are as follows:

- Confirm that project requirements are defined, documented, and baselined
- Validate that changes to scope and requirements follow the defined change management process
- Identify and resolve inconsistencies between the requirements and project deliverables
- Subdivide the major DDI deliverables and work into smaller, more manageable components (WBS structure)
- Evaluate scope issues and risks to determine the effect to the project
- Formalize acceptance of the completed DDI deliverables

Highlights

- HP Development Center is the main repository for requirements, allowing easy update and transparency to BMS.
- Common understanding of scope is provided during the joint scope overview meeting, setting the project direction up front.
- Defined process and tools help evaluate the effect and risk of scope changes.

For further details, reference the "Draft Scope Management Plan" in the "Sample Deliverable Formats" tab.

Schedule Management Plan (Req. 8b)

The schedule management process conforms to West Virginia's CIO Project Management Methodology, PMBOK, SEI's CMMI, and our ESDLC. Our schedule management methodology will establish a rigorous, repeatable process to accomplish timely completion of the MMIS Re-procurement Project. Our process is supported by the project management and schedule management features of Microsoft Project and HP PPM schedule management tools.

The basic approach of scheduling techniques is to form a network of activity and event relationships that graphically depict in Microsoft Project the concurrent relationships between the activities or tasks in the project. The ESDLC defines the structured format for the master schedule and subsidiary schedules based on an iterative development phased approach. Within the development phases, the activities or tasks are linked by a series of predecessors and successors to create a project network diagram from the beginning of the project start date to the close-down date.

Our network diagram—Critical Path Method (CPM)—output of the schedule is a powerful tool for planning, monitoring, and controlling the project with the following benefits:

- Identifies and documents network dependencies among schedule activities or tasks
- Estimates the type and quantities of personnel required to perform each scheduled activity or task
- Estimates the effort hours that will be needed to complete individual schedule activities or tasks
- Verifies the duration of the activities or tasks
- Determines the critical path and the tasks on the critical path for monitoring
- Tracks actual effort and duration to the baseline implementation master plan weekly
- Identifies the specific schedule activities or tasks and sequences that need to be performed to successfully implement the MMIS project deliverables and complete the milestones

Highlights

- Rigorous, repeatable process for schedule management and control
- Integration of schedule management tools such as Microsoft Project and HP PPM
- Work breakdown structure

We will analyze activity sequences, efforts, durations, resource requirements, and utilization and schedule constraints to create the project schedule. It is an iterative process that determines planned start and finish dates for project activities. Schedule development may require that effort and duration estimates and resource estimates be reviewed and revised to create an approved project schedule that serves as a baseline against which progress can be tracked. Schedule development continues throughout the project as work progresses, the CCB approves changes, anticipated risk events occur or are eliminated, or as

new risks are identified. The Schedule Management module of the HP PPM tool is used to manage the planning and execution of the project schedule.

For further details, reference the "Draft Schedule Management Plan" in the "Sample Deliverable Formats" tab.

Cost Management Plan (Req. 8c)

Highlights

- Accurate and timely detailed contract cost reporting
- MMIS experience on successful implementations, providing historical data and lessons learned for estimates
- Adherence to accounting principles and auditing standards

The purpose of a cost management plan is to define how the costs on a project will be managed throughout the project's life cycle. It sets the format and standards by which the project costs are measured, reported, and controlled. The plan serves as a mechanism for making sure that audiences and stakeholders are aware of their responsibilities for managing, reporting, and approving changes to project costs. The HPES cost management plan provides a well-documented and agreed-on cost management road map.

Our approach to cost management for projects includes developing a cost management plan that outlines the processes to estimate, collect, measure, manage, and report pertinent project cost information promptly. It also establishes the framework and operating mechanisms to make certain that the appropriate approvals are obtained related to project costs.

Cost management is a process by which costs are planned, controlled, and managed during the life cycle of a project so that the project is completed within budget. The cost processes are in accordance with the Generally Accepted Accounting Principles (GAAP) and Federal Accounting Standards (FAS) and aligned with Generally Accepted Auditing Standards (GAAS).

The cost management plan defines the processes as follows:

- **Cost estimating—**Developing cost estimates through the initiation of an Enhancement Request Worksheet from BMS. The HPES systems manager will assign the request to the appropriate project manager. With the technical and business experts from the team, the project manager will work with BMS to detail the high-level requirements and assumptions, as defined in the scope management plan, required to develop a sound estimate.
- **Cost budgeting—**Creating the cost baseline. The project manager uses the estimates produced and completes the resource planning function to allocate the number of person hours to a modification or enhancement project. We create the cost baseline by accumulating the costs and assigning person (effort) hours to each enhancement.
- **Cost Control—**Controlling costs by monitoring cost performance, evaluating actual to estimate variances, and taking corrective action as appropriate. It also is integrated with scope control and records changes against the cost baseline and manages cost changes.

The process will enable our PMO, BMS, and the Delivery team to have a clear understanding of cost management and how it will be planned, managed, and controlled. The cost management process is automated in HP PPM. The benefit and value of HP PPM is that it enhances the efficiency and accuracy of having change requests in a web-based system that is integrated with HP Quality Center for requirements, business processes, and system objects, making it a smooth, integrated system from documenting requirements and changes to the requirements through to impacts on the projects.

The HPES quality manager, as part of the PMO, is assigned to make certain program performance is tracked, monitored, and reported against contract service-level agreements (SLAs), quality standards, and performance metrics. Through this structure, the quality manager can document performance issues and operational defects and facilitate corrective actions, when needed. Consistent implementation of standards across projects will enable BMS to collect data that is meaningful, resulting in accurate reporting of SLAs.

For further details, reference the "Draft Cost Management Plan" in the "Sample Deliverable Formats" tab.

Quality Management Plan (Req. 8d)

The purpose of a quality management plan is to establish processes required to validate that the project includes the quality activities required to complete the contract successfully. For more than 40 years, HPES has been evolving a quality management methodology that stresses early involvement of our customers and stakeholders, careful attention to our customers' needs and interests, and precise application of strong standards. Through this comprehensive quality management program, HPES will deliver meaningful monitoring and performance measurement; on-demand, iterative, and flexible quality reporting; and collaborative, continuous improvement processes. These program features, combined with robust COTS tools, enable HPES to bring a best-in-class quality management methodology to the West Virginia MMIS Re-procurement Project.

The value that the HPES quality management methodology brings to quality management is our focus on defining the standards, processes, metrics, and reports to manage quality throughout each phase of the project. The following are the main focuses of quality management:

- **Quality planning**—This is the process of identifying quality requirements or standards for the project and product, and documenting how the project will demonstrate compliance. Quality planning is performed with the other project planning processes.
- **Quality assurance**—This is the process of auditing the quality requirements and the results from quality control measurements to make sure appropriate quality standards and operational definitions are used. The quality managers—medical/dental quality manager and the POS quality manager—will oversee the quality assurance activities and provide support to the project teams and the BMS staff on quality activities. Quality assurance also provides an umbrella for continuous process improvement, which is an iterative means for improving the quality of each process. The following are types of quality assurance audits:
  - Verification—The purpose of verification is to make sure that selected work products meet their specified requirements. Verification is accomplished using work product reviews (walkthroughs), unit testing, and integration testing. These activities are used to make sure that we built according to requirements, standards, and criteria.
  - Validation—The purpose of validation is to demonstrate that a product or product component fulfills its intended use when placed in its intended environment. Validation is accomplished using formal acceptance testing and other mechanisms as appropriate, such as prototyping and simulation. Validation makes sure that "we built the right thing."
- **Quality control**—This is the process of monitoring and recording results of executing the quality plan activities to assess performance and recommend necessary changes. Quality control is performed throughout the contract. Quality standards include project processes and product goals. Quality control is performed by the HPES quality managers. Quality control activities identify causes of poor process or product quality and recommend or take action to eliminate them. Quality control measurements are the results of quality control activities. They are used to analyze and evaluate the quality standards and processes of the performing organization.

Highlights

- Promote and institutionalize the use of common quality and project management tools and templates
- Provide senior leadership with necessary information for strategic and tactical decision-making and program quality
- Maximize quality and minimize risk
- Analyze performance to recommend corrective actions when necessary

For further details, reference the "Draft Quality Management Plan" in the "Sample Deliverable Formats" tab.

Human Resources Management Plan (Req. 8e)

The purpose of an HR management plan is to establish processes that attract, develop, and retain the best people. The project team comprises the people with assigned roles and responsibilities for completing the project. Based on the strength and integrity of our people and our experience in Medicaid, we will work with BMS to implement the WV-iC system and provide ongoing efficient operations as the fiscal agent for BMS and West Virginia's providers and members.

Throughout the HR staffing and acclimation process, activities focus on people, with a strong emphasis on communication. HPES recognizes that the acclimation can be a dynamic and stressful time for those involved. Providing in-person, virtual, and two-way communications during the acclimation allows employees to remain focused on business continuity and helps diminish the anxiety that can accompany change. Communication throughout the time period from project start-up (initiation) to operations will be the backbone for the recruitment and retention strategies.

Highlights

- Focus on our people to retain our top talent
- Provide staffing stability for planning and achieving BMS objectives
- Use the Primavera/ Evolve tool as a single source for staffing needs

HPES' approach to HR management is an effective management process because it makes the essential information available for forward-looking decisions and prioritization. Appropriate resource management makes accurate forecasting of personnel possible so that response to demand can be better managed. This benefits leaders and project managers by providing stability for planning and achieving functional responsibilities and BMS objectives.

Work force planning enables HPES leaders to deploy quality, competent personnel who have the right experience, education, training, and skills needed to meet requirements. While work force planning activities provide a method for deploying the

appropriate personnel, our corporate and internal training processes and procedures result in sustained competency and quality of personnel.

The HR management process provides the structure and guidance on the following major functions of staffing:

- **Acquire personnel—**Managing employee demand is a proactive, iterative activity where HPES leaders forecast, identify, request, and continually adjust personnel to support the business needs and goals. The HP corporate work force planning process and tool, Primavera/Evolve, is used as the standard method to employ work force planning activities.
- **Develop personnel—**This process improves the competencies, team interaction, and overall team environment to enhance project performance. Teamwork is a critical factor for project success.
- **Manage personnel—**This process tracks member performance, provides feedback, resolves issues, and manages change to optimize performance. One of the key aspects of managing personnel is retaining the personnel we have acquired for the project. Retaining motivated employees is key to effective management.

This HR framework is connected to our business and work force planning, talent management, and career and professional development processes. Together with strong leadership and an innovative culture, HPES' performance management approach contributes to a talented, engaged, and competitive work force that delivers value to customers and shareholders alike.

For further details, reference the "Draft Human Resources Management Plan" in the "Sample Deliverable Formats" tab.

Communications Management Plan (Req. 8f)

Highlights

- Real-time communication using web-based tool
- Project transparency through timely and accurate communication
- Encouraging customer participation

The HPES communications management plan outlines the communication process and the communication methods we will use during the life cycle of the project. The plan serves as a mechanism for making sure that audiences and stakeholders are aware of their responsibilities for communicating project-related information to meet the needs of the project stakeholders.

Communication management is critical to the success of the project. We will continuously provide real-time communication based on our web-based reporting dashboards, reports, status meetings, and board meetings as depicted in the governance model that is defined during project start-up. The HPES communication management plan provides a well-documented and agreed-on communications road map. Effective communication must occur throughout the entire project.

Throughout the HPES organization, we emphasize frequent and effective communication. We define effective communication as that which is clear, understandable, and appropriately focused at each management level. Our goal is to precisely state what we are going to do, when we are going to do it, and clearly explain what has been done. Our staff is available to BMS to readily address questions or concerns, along with easy access to our reporting tools that communicate immediate and accurate information about the status and progress of the project.

The PMO will instill a disciplined approach of program and project management communication as part of overall governance across the MMIS organization. Based on HPES' PMO philosophy of open communication, BMS will receive timely and accurate communication of a project's status and overall results.

Project transparency through timely and accurate communication of project status is essential. In a PMO capacity, HPES establishes regular meetings for teams to discuss project status. We seek customer participation for discussions on project issues, project risks, and progress on key tasks. We have found that customer participation in these meetings is essential to foster continuing communication that maintains the working relationship necessary to successfully address problems as they arise.

The communication management process provides the structure and guidance on the following major functions of communication:

- **Identify stakeholders—**Identify the people or organizations impacted by the project, and document relevant information regarding their interests, involvement, and impact on project success
- **Plan communications—**Identify the information needs of the stakeholders and determine a suitable means of meeting those needs; define who needs what information, when they will need it, how it will be given to them, and by whom
- **Distribute information—**Make relevant information available to project stakeholders as planned, including implementing the communications management plan and responding to unexpected requests for information

- **Manage stakeholder expectations—**Communicate and work with stakeholders to meet their needs and address issues as they occur; helps to increase the probability of project success by managing expectations and making sure that the stakeholders understand the project benefits and risks
- **Report performance—**Collect and distribute performance information, including status reports, progress measurements, and forecasts; involves the periodic collection and analysis of baseline versus actual data to understand and communicate the project progress and performance and forecasts the project results

For further details, reference the "Draft Communications Management Plan" in the "Sample Deliverable Formats" tab.

Risk Management Plan (Req. 8g)

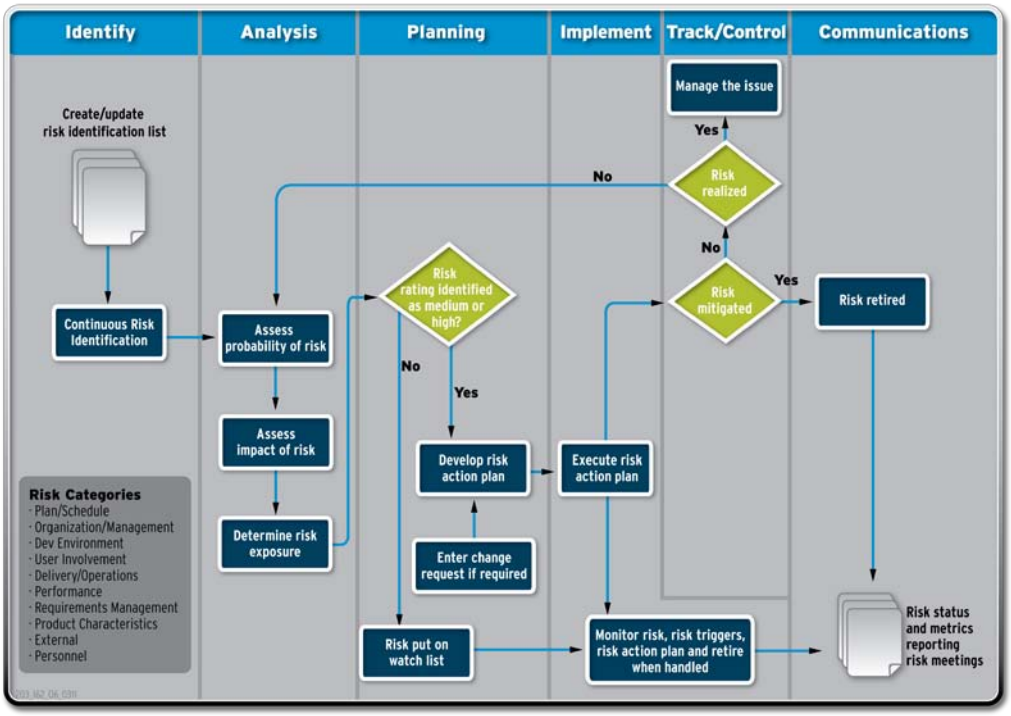
The risk management plan is a subsidiary plan to the project management plan and outlines the methods and techniques that will be used to identify, document, analyze, accept, avoid, mitigate, transfer, track, and report risks.

Risk management is an essential component of our PMO delivery. HPES uses a standard, repeatable risk management process and a sophisticated risk-tracking and reporting tool that results in the identification of risks consistently across the entire portfolio of projects. BMS will gain from the use of our methodology because we identify corrective actions early to address them when there is less risk exposure. Our risk management methodology is a closed-loop process, as indicated by the following figure, where risks are documented, evaluated, appropriately handled, and reported through closure.

Highlights

- Risk management approach and methods based on PMBOK
- Sophisticated risk-tracking and reporting tool—HP PPM
- Risk identification and proactive mitigation during the project life cycle

Risk Management Process



Our approach to risk management helps the enterprise identify, plan for, and take action on project risks. In projects of this size and complexity, risks and issues will occur; however, our focus on early proactive identification of risks and issues and continuous management oversight helps to minimize the overall impact to the project. We emphasize the need to collaborate with the project teams and BMS to quickly identify, assign, analyze (qualify and quantify), and mitigate risks affecting areas such as technical or functional, scope, schedule, resources, and quality throughout the life cycle of the project.

The methodology we use for risk management has been demonstrated on thousands of projects, including multiple MMIS projects. We incorporate process knowledge and lessons learned from previous implementations into our approach. Coupling the methods and processes with a tool as robust as HP PPM provides BMS with a high degree of flexibility for risk management, with a focus on the areas of specific interest.

For further details, reference the "Draft Risk Management Plan" in the "Sample Deliverable Formats" tab.

Issue Management Plan (Req. 8h)

Highlights

- Sophisticated risk-tracking and reporting tool—HP PPM
- Issue identification and proactive mitigation throughout the project life cycle
- Issue management approach and methods based on PMBOK

The issue management plan outlines the methods and techniques that we will use to identify, document, resolve, track, and report issues. Issue management is critical to the success of the MMIS Re-procurement Project. An issue represents a problem that is occurring and having impact at the project level.

Our issue management plan is a method to resolve problems encountered by the project teams to minimize possible negative effects to the MMIS Re-procurement Project. Issues can be the result of risks being realized or unforeseen problems that arise on the project. Left unresolved, an issue will impede or prohibit project-related progress or development by affecting scope, budget, schedule, resources, or quality. We actively manage and resolve issues to keep the projects and phases on track. The issue management plan defines the process of how a specific issue should be identified, documented, resolved, tracked, and reported.

Through our solid project management practices and collaboration with BMS, we will provide visibility into issues using our HP PPM tool. Issue management spans the entire life cycle of the project and includes iterative processes and activities. We apply a disciplined, rigorous, and control-based methodology to this important management function. Our approach includes interaction and coordination with BMS on issue management to improve the quality of the MMIS and lower delivery risk.

Our issue management approach is a closed-loop process that is focused on promptly reporting and managing issues before they have a negative effect on the project. The approach focuses on working with the project teams to quickly identify, assign, and resolve issues affecting the project across the multiple phases. Coupling the methods and processes with HP PPM provides BMS with a high degree of flexibility, oversight, and control for issue management, with a focus on the areas of specific interest.

Our issue management process focuses on early identification, structured issue tracking, and prompt resolution procedures to reinforce the closed-loop structure. Our project management and systems experience enables the project team to proactively identify issues, quickly identify and analyze resolution alternatives, and make resolution recommendations.

The issues management process steps include the following:

- **Identify issue—**Issues are captured from stakeholders throughout the project.
- **Document issue—**HP PPM will be used to document and track issues.
- **Analyze issue—**The issue is analyzed and assigned to an issue owner.
- **Escalate issue—**Escalation may occur throughout the issue management process based on the need for approvals or the urgency of the issue.
- **Resolve or defer issue—**The issue is resolved or deferred to a later date.
- **Obtain agreement on project issue resolution or decision—**Relevant stakeholders agree with the resolution or decision.
- **Track issue resolution—**HP PPM will track issue resolution.
- **Close issue—**The issue is closed in HP PPM and resolution is distributed.

For further details, reference the "Draft Issue Management Plan" in the "Sample Deliverable Formats" tab.

Change Management Plan (Req. 8i)

The HPES change management plan outlines a sound change management approach that maintains the overall integrity of the project. Further details on change control also are covered in the integration management plan to make sure that change is controlled throughout the project—from project start-up through to operations.

Change management is a key component of successful program and project management. If change is not properly managed, downstream work activities can be impacted. Change management begins by having clearly defined business requirements so that a solid baseline is established on which to measure change. The baseline requirements for the project are derived first from the West Virginia RFP and subsequently from the requirements validation process conducted early in the project.

Highlights

- CCB review data is readily available in HP PPM for quick, efficient decision-making.
- Change management begins with baselined requirements.
- A joint CCB reviews, analyzes, and approves changes before a work owner is assigned.

We offer BMS a proven, easy-to-use process that effectively manages change to help maintain the overall integrity of the baseline project scope, schedule, cost, quality, and configured items. It is critical to identify, analyze, track, and manage changes that could affect the project's scope, cost, schedule, quality, or configured items, whether the change results from an issue resolution, risk contingency plan, business process or regulatory change, or other system-related change.

The change management process steps include the following:

- **Identify change request—**A change can be identified from various internal and external sources.
- **Document change request—**As soon as a potential change is identified, it will be documented by the change initiator in the change management tool, HP PPM.
- **Review change request—**The review team considers and validates the change information and verifies the priority of the change request.
- **Analyze change request—**The change owner will conduct a thorough impact analysis of the change and document the results in HP PPM. Impacted deliverables are assessed.
- **Decide disposition of change—**The CCB, comprising BMS and HPES leadership, reviews and approves the change per the governance process. Review data is readily available in HP PPM for quick, efficient decision-making.
- **Communicate status—**The disposition of the change request is communicated to the affected stakeholders.
- **Incorporate approved change into plan—**The change owner incorporates the changes by updating the project schedule, budget, and scope documentation to document the change.
- **Implement and migrate change—**The work owner makes the changes following the appropriate ESDLC processes so that the change is appropriately implemented across the impacted system and phase.
- **Update documentation and requirements traceability matrix—**The change owner is responsible for updating documentation for the impacted items.
- **Verify change request incorporated into plan or complete—**The ESDLC process is used to implement and migrate the change into production, per the release schedule.
- **Close request—**The CCB will cross-reference the change request to life cycle documentation to verify proper implementation before formally closing the request.

For further details, reference the "Draft Change Management Plan" in the "Sample Deliverable Formats" tab.

Integration Management Plan (Req. 8j)

The HPES integration management plan is a comprehensive document that describes the various project management processes and activities that are used to plan, manage, and direct MMIS implementation projects. The need for integration in project management becomes evident in situations where individual processes interact. For example, change requests need to involve the effect of the business process or the system object and the impact of the change request effort to the project schedule. The project managers also need to consider risks and issues as part of the requirements validation in the Analysis Phase and how these risks and issues affect the project's scope, schedule, and quality.

The key activities within the transition plan are as follows:

- **Transition plan—**Defines the business process changes that need to occur in response to the change in technology
- **Overall transition management—**Actively manage, monitor, and oversee the transition to the new replacement systems and processes
- **Building executive leadership commitment and manage change—**Involves the tasks and deliverables needed to understand and define the behaviors required to achieve the change and prepare, support, and coach the leaders to effectively lead the change
- **Process and organization design and development—**Transforming the way people work, making sure that individuals adopt and own the new processes, technology, and ways of working associated with the change
- **Training and performance support—**Activities that support employees to develop the behaviors, skills, capabilities, and knowledge required to effectively perform new or improved ways of working

For further details, reference the "Draft Transition Plan" in the "Sample Deliverable Formats" tab.

Weekly Status Report Template (Req. 11)

The PMO facilitates weekly project status meetings, and one of the inputs to these meetings is the MMIS Re-procurement Project Status Report. The weekly status report sample demonstrates to BMS the overall health of the project depicted at the summary level, as Red/Yellow/Green. The report data will be derived from HP PPM and will provide the required components such as schedule metrics, issues, risks, and deliverable information for a defined period of time. Task and deliverable information is presented as to what tasks or deliverables were completed in the period, late for the period, behind schedule, or ahead of schedule. Schedule information at the ESDLC phase level also is presented to display what percentage of the work planned to date has been completed, what the variance is, and variance between the baseline start and end dates compared to the actuals.

Throughout the project life cycle, the report will include information on conversion tasks and progress, interface tasks and progress, and, toward the end of the report, testing tasks and progress including defects. The defect information from these tests also is summarized into a table showing the total number of defects by severity and by each functional area.

The draft weekly status report template is provided in the "Sample Form Templates" tab.

Monthly Status Report Template (Req. 12)

The PMO provides a monthly report for the MMIS Re-procurement Project that provides a summary view of the overall health of the project. This report depicts the overall project health by graphical charts that illustrate the following:

- Compares the number of tasks scheduled for completion to the actual number of tasks completed
- Displays status of issues past due the issue resolution date
- Displays the risk heat map including the priority of risks and their impact and probability of occurring
- Lists the number of change requests by status for each month
- Shows testing progress such as test cases run, passed, failed, and not complete
- Displays the number of open to closed testing defects
- Shows number of defects by severity

Similar to the weekly report, the monthly report also will provide schedule metrics and status on conversion tasks.

The draft monthly status report template is provided in the "Sample Form Templates" tab.

3.2.3 Project Staffing

RFP Reference: 3.2.3 Project Staffing

In this section we respond to the following RFP requirements:

- Vendor response requirements identified in RFP section "3.2.3 Project Staffing"
- Section 3.1 mandatory requirements that apply to staffing
- Personnel resumes for key positions identified in RFP section "3.2.3.1 Key Staff"

Approach to Staff Retention and Continuity of Staff (Req. 5)

In this section, we describe our approach to staff retention and promoting continuity of staff members among key project phases. Retaining motivated employees is key to effective management. Employees engaged in their work, satisfied with their environment, and focused on personal development prevent losses in cost and productivity associated with employee-initiated attrition. HP's people strategy focuses on attracting the best and retaining them across time. This strategy is built on three basic steps—stabilize, mobilize, and energize:

- **Stabilize (the foundation)—**The first step to retaining people is to attract, develop, promote, and retain the best professionals. We remain an employer of choice by consistently presenting HP's brand values, validating that we have leading-edge HR management in place, and maintaining a well-defined diversity policy. After we hire the best people, the task is to stabilize the existing work force by giving employees a voice through our Voice of the Employee (VOE) survey. VOE surveys are an important means for employees to share their thoughts with HP leaders.
- **Mobilize (high-performance workplace)—**There is a consistent focus on producing a high-performance workplace by integrating the "what" and "how." "What" refers to clarifying the team goals, objectives, and priorities and then connecting the team to those business goals. The "how" is addressed through our HP Performance Management Cycle using the following four step approach:
  - Set goals
  - Track and monitor
  - Review performance
  - Rewarding and recognize performance
- **Energize (best place to work)—**Becoming the "best place to work" is critical to our retention strategy. We strive to achieve this by doing the following:
  - Promoting a healthy work-life balance program through flexible work arrangements
  - Listening to employees through periodic climate surveys, annual employee satisfaction surveys, and other channels
  - Providing employees with tools, resources, and a supportive environment that values diversity and good citizenship

Employee Satisfaction

As our main touch point with customers, partners, and communities, our employees put HP's best face forward daily around the world. That is why HP fosters an environment where people are empowered to make decisions that positively affect our customers. Empowered employees are more satisfied with their jobs and feel a greater sense of ownership in their environment. The following corporate initiatives play a critical role in motivating and retaining employees:

- **Recognition and appreciation—**HP's recognition and appreciation programs include individual and team recognition for performance as well as overall site or program recognition for morale or team building. Recognition may or may not be monetary. For example, some effective non-monetary recognition items are achievement certificates, tickets to a sporting event, lunch with leaders, or a designated parking spot.
- **Work-life balance—**We offer our employees a variety of programs and services to assist them as they manage personal needs and the demands on their time, such as adoption assistance, diversity day, and flex work options. HP also supports employees and their families by providing benefits such as vacation time, wellness programs, leaves of absence, discount programs, flexible spending accounts, and comprehensive health and dental benefits. Because needs of employees differ around the globe, benefits may vary by geography, site, business unit, and job type.
- **Social and community activities—**HP encourages employee participation in a variety of social committees or activities that support the work environment or the community at large. Committees may spearhead fundraising efforts for local charities, organize after-work social activities, or produce team newsletters
- **Communications—**We understand employees have different needs and expectations of an employer. Our retention strategy is based on effective and regular communication with employees. HP consistently communicates account, team, site, and corporate news items to connect employees across the globe. Established communication vehicles include in-person town halls, the Global Broadcast Network (GBN) events and meetings, and several electronic newsletters.

Ensuring Continuity of Staff Among Key Project Phases

The strongest approach to promoting continuity of staff members from phase to phase is to make the West Virginia project a great place to work by providing satisfying career paths and professional and personal recognition. In short, employees will stay

to implement the provider enrollment business function in month 23 of our 30-month implementation. The early implementation of the provider enrollment function will incorporate the early implementation of the following additional business processes:

- Provider enrollment
- Production of manuals and handbooks
- Creation of the web portal
- Infrastructure creation
- Quality assurance processes that support provider enrollment
- Performance reporting that supports provider enrollment

Our experience in recent interChange implementations—including Florida and Georgia—indicates that early implementation of business functions assists providers in adapting to new system features and functions and actually improves their acceptance of the new MMIS.

3.2.6 Phase 1: MMIS Replacement DDI & CMS Certification Planning

RFP Reference: 3.2.6 Phase 1: MMIS Replacement DDI & CMS Certification Planning

The following subphases for Phase 1 are discussed in this section:

- Phase 1a: Start-Up (3.2.6.1)
- Phase 1b: Analysis and Design (3.2.6.2)
- Phase 1c: Development, Testing, Data Conversion, and Training (3.2.6.3)
- Phase 1d: Implementation Readiness (3.2.6.4)
- Phase 1e: CMS Certification Planning (3.2.6.5)

After the Phase 1a: Start-Up, we present the comprehensive and initial plans for the following:

- Security, Privacy and Confidentiality
- Configuration Management
- Data Conversion
- Disaster Recovery and Business Continuity
- Data and Records Retention

3.2.6.1 Phase 1a: Start-Up

The contract signing represents the start of Phase 1a for the project start-up (initiation) activities or tasks. HPES brings an experienced staff to BMS to execute and deliver the activities and tasks associated with the MMIS Re-procurement Project. From the contract start date, our focus is on creating and finalizing the project charter and conducting the project kickoff meeting to communicate the project's goals and objectives that meet BMS' expectations.

Because we have the experience and work products created from our project best practices, we bring proven planning deliverables that BMS will have confidence in, reducing the amount of BMS time required for review and approval. The following are benefits of these Phase 1a work products:

- Reduce project start-up time by sharing and tailoring project start-up documents
- Create consistent deployment start-up and planning documents
- Enable process delivery improvement by continually improving best practice assets
- Enable Project Management Office (PMO) activities that will provide governance, tracking, oversight, and management of project start-up

Completion of the Phase 1a Deliverables and Milestones (Req. 1)

Prompt and accurate communication of project status is essential to building successful deliverables, which promote quality customer service. As part of the Start-up Phase, the PMO will work with BMS to define the deliverable development process, template format, review, and approval processes including criteria that can be used to measure deliverable acceptance.

Our customers have found success meeting the deliverables management challenge by using the IEEE-, PMBOK-, and CMMI-recommended practice of creating, submitting, and getting approval of a comprehensive deliverable expectation document (DED) ahead of actual deliverables. A comprehensive DED, covering each deliverable, will define the template design format, table of contents, acceptance criteria format, and review timetable and identify the review owner and date the review will be completed.

During this phase, we will collaborate with BMS to walk through the deliverable management methodology and process flow as defined in the project management plan that will be used consistently throughout the WV-iC project life cycle. The deliverable management process is set up as an automated workflow within the HP PPM tool, and the WBS deliverable activities or tasks are planned through the project schedule.

After the development of a draft or new deliverable, the deliverable will be ready for BMS to review. The HPES document owner will notify BMS and post the deliverable on HP PPM. Based on our standard deliverable management process, the first draft review allows 10 business days for BMS to review and provide comments.

Before the start of the first review period, we will conduct a work product review of each deliverable document. Our experience shows that a deliverable work product review allows for dialogue, questions, and thorough explanations of the document's content. After the work product review is complete, if no comments are received by the end of the 10 business days, the deliverable is considered accepted. If comments are received, updates to the document are completed by the author and a second review process begins. The second review process allows five business days for BMS to review and provide comments. The time frames for the first and second reviews should provide BMS adequate time for review of the deliverables.

A final version of each deliverable will be submitted to BMS after the first and second reviews are completed. If a second review is not required, the PMO will submit the final deliverable document for BMS approval. The PMO performs several steps within HP PPM when a final version document is ready for formal delivery to BMS. We will provide five business days for the final deliverable review and approval by BMS.

Tasks required to complete Phase 1a deliverables and milestones will be outlined in the MMIS Re-procurement Project schedule and defined further in the WBS deliverable dictionary. The WBS deliverable dictionary document is in our response to section "3.2.2 Project Management."

Obtaining BMS Approval and Milestone Acceptance Criteria (Req. 2)

The development of the MMIS Re-procurement Project schedule is based on our ESDLC, as depicted in the systems development methodology response in section "3.2.2 Project Management." Our ESDLC encompasses the entire process of taking systematic steps to develop, implement, and maintain software, application, or integrated systems and processes in a current or planned IT infrastructure.

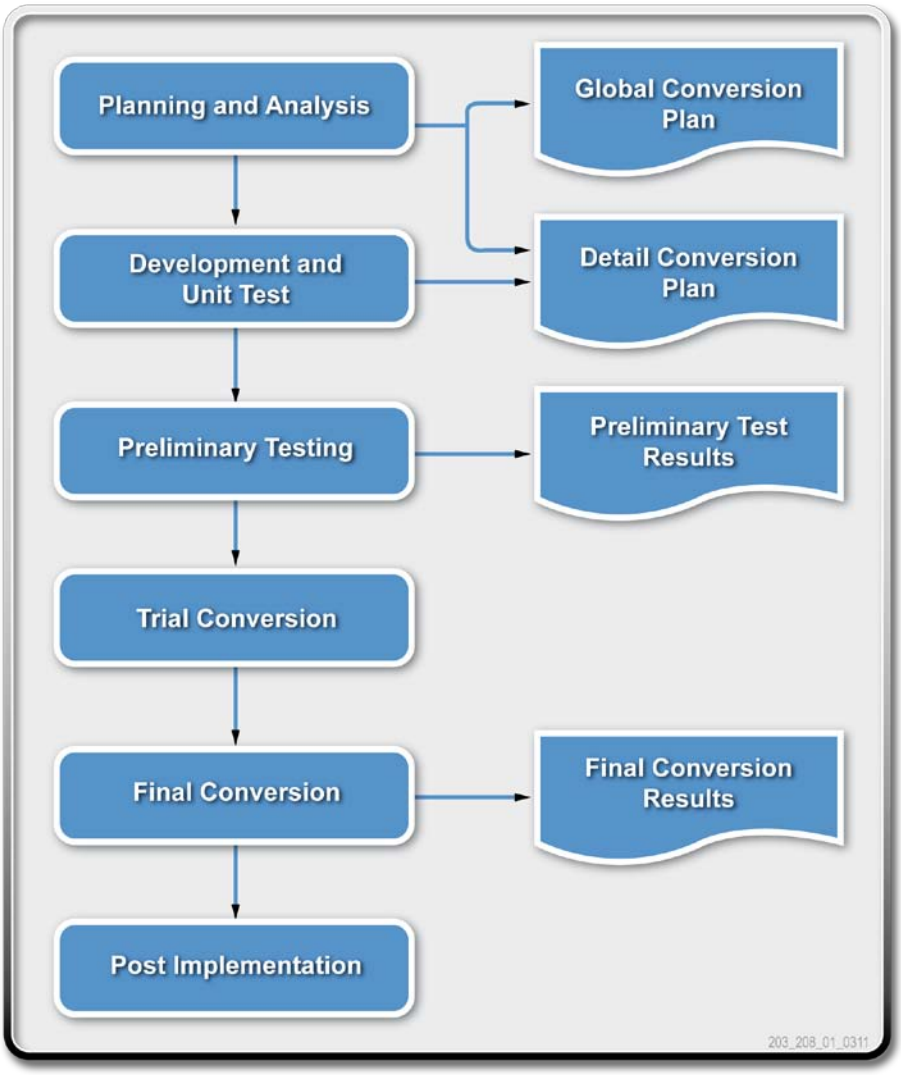
In our project management schedule, we cross-reference the RFP deliverable in a column for traceability to the RFP requirements. After each deliverable, a milestone is used for the approval task of the deliverable by BMS. Milestone acceptance is based on the completion of the activities or tasks that support each deliverable and the final approval of each deliverable by BMS.

The milestone completion of Phase 1a will be based on the completion and approval of deliverables and activities or tasks within this phase. At the closure of the phase, we will conduct a phase review to gather information needed to move the project forward to the next phase or decision point. Effective reviews are central to the success of a fast-paced software development project and serve as the following:

- Quality control checkpoints where quality of execution is the focus
- Prioritization decision points
- Points where the path forward to the next stage of the process is decided, along with resource commitments
- Successful accomplishment of phase deliverables and milestones
- Risks that have been identified with mitigation plans for the next phase

The phase review process depicted in the following figure is a milestone-driven decision point in which implementation activities are reviewed to make sure that the acceptance criteria—also referred to as exit criteria—for the phase have been met. The acceptance criteria are defined and agreed on at the beginning of the phase. Each review is an independent confirmation (including relevant stakeholders) that the required project reviews, deliverables, and deliverable milestones have been successfully completed as defined in the phase acceptance criteria. The output from the phase review provides the inputs for BMS for the formal notice to proceed with Phase 1b to move forward to the next phase.

High-Level Flow of Our Conversion Process



Updating the Data Conversion Plan

The data conversion plan will be created based on the business and technical requirements. The plan will evolve as HPES gains more knowledge of the existing MMIS and BMS gains more knowledge of the interChange product. Changes to the plan will occur throughout each phase of the project. The resulting changes will be made to the plan regardless of the project's phase.

Development or Use of Conversion Programs

Data will be accepted in native format from the existing MMIS. HPES will use a proprietary tool to transform and load the raw data to an intermediate relational database. This intermediate database will be used to perform data analysis and profiling that supports the mapping specifications and requirements.

Validation of Data Conversion Software

HPES incorporates a thorough and rigorous testing methodology that demonstrates the function and performance of the developed software. It includes three phases of testing—unit, system, and preliminary. Unit testing and system testing are HPES internal phases whereby the validation of the software is done individually and integrated with small sets of data. The preliminary or trial conversion puts it together in a "mock" execution using larger volumes of data. Preliminary conversions are executed many times during the project and also are used to provide data for other testing environments such as Systems Test and UAT. Our approach includes the use of production data through each phase of testing.

Contingency Planning

A risk and contingency plan will be developed as part of the implementation planning task. The HPES approach is to minimize risk leading to go-live by performing frequent preliminary conversions and supplying converted data to other environments. This serves several purposes, including the validation of the results in functional environments and the smooth execution of the final conversion.

Conducting Trial System and Subcomponent Runs

HPES will conduct trial conversion testing efforts to validate the results of the conversion. The HPES methodology uses converted claims to build the trial claim input transactions. This provides an invaluable validation method of the conversion data results.

Data Cleansing

HPES will create a specifications document for each functional area. This document will include the mapping specifications such as source and target elements and transformation or cleansing that will be needed.

Development and Use of Data Conversion Test Scripts

HPES incorporates a thorough, rigorous testing methodology that demonstrates the function and performance of the developed software. This methodology includes the creation of function-specific test plans that BMS will review and approve.

Support for UAT of Converted Data

The Conversion team will support UAT by loading the required converted production data to the UAT test environment.

Updating the Data Conversion Requirements Document

HPES will use the requirements specification document (RSD) and detailed system design (DSD) documents to establish and document the data conversion requirements. The contents and structure of this document are outlined in the data conversion plan deliverable.

Data Conversion Reconciliation Approach

Trial Conversions

Preliminary or trial conversions are executed many times during the project and also are used to provide data for other testing environments such as Model Office and UAT. Our approach includes the use of production data throughout each phase of testing.

Results Reporting and Analysis

Each trial conversion will result in the creation of a status report for each functional area. The status reports will include detail statistics, record counts, and errors encountered in the execution.

Verification of Pilot Implementation Data

Throughout the course of the conversion development phases, the HPES team will use the production MMIS data for testing. Each trial conversion is essentially a pilot of the conversion steps necessary for implementation. Status reports will be created for each trial conversion.

Verification of Systemwide Implementation Data

Throughout the course of the conversion development phases, the HPES team will use the production MMIS data for testing. Each trial conversion will include systemwide data needed to operate the WV-iC.

Strategy for Data That Does Not Convert

During the review of the test results, data that is not converted will be analyzed. Corrective actions or strategies for the data will be made for each instance.

Approach to Development and Use of Data Conversion Test Scripts

HPES incorporates a thorough, rigorous testing methodology that demonstrates the function and performance of the developed software. This methodology includes the creation of function-specific test plans that BMS will review and approve.

analysis. We start with the business "As Is" process documentation BMS has invested in and will share the MITA framework that has been built. With our implementation experiences, we have found that it is important for stakeholders to have a common understanding of what our goals are at the start of the process so that we can achieve a successful conclusion:

- Build a common understanding of how requirements validation fits within the overall ESDLC
- Define a common understanding of the requirements
- Gain a common understanding of the business processes to be supported by the solution
- Confirm a common understanding of how the WV-iC MMIS solution objects fulfill the requirements

The joint requirements validation sessions will be conducted in a manner that fosters discussion and exploration of the WV-iC solution. Our teams have found that the use of tools that support the presentation of the topics and help organize the salient discussion points into meaningful documentation is the optimal way to meet. The first portion of the requirements validation sessions will be a training session. HPES team members perform the training and cover the following topics:

- The overall requirements validation work pattern
- The purpose of the COTS tools
- Requirements validation session meeting roles and responsibilities
- The determination of what is needed to complete the sessions

The interface and interaction of BMS' teams are guided by the work pattern the HPES team brings to the requirements validation process. The work pattern organizes the discussion by groups of business processes and the detailed requirements that support those processes as a means of providing logical groups to requirements. The business area owners and SMEs will review each detailed requirement linked to the business process. This process enables the team to review and confirm program and policies. Relating the requirements to the business process will help the team members put into context the requirement statements. Based on our experiences with multiple states, the conversations now tend to be interactive among SMEs using real-life examples as a means to clarify the requirement. Often the clarification regards part of the business process being discussed, bringing the whole understanding to light. The participants of the session can validate in real time that the clarification statement is accurate and complete.

Together, we confirm where the transferred baseline interChange application meets RFP requirements, where configuration is needed, where there is a gap, and where changes are needed. This analysis results in the WV-iC baseline requirements. We also analyze other requirements updates that may have occurred after the RFP release and business model or process changes and approved changes to the current Medicaid since the RFP release date. The following table lists potential requirements gap scenarios and actions that will be taken to close gaps.

Gap Analysis Scenarios

Scenario	Action to Close Gaps
RFP requirements are mapped to the business processes and solution objects are mapped to the requirements.	The status of the RFP requirement is set to "signed-off." Clarification statements are added when needed to provide insight into the original requirement statements.
An RFP requirement and solution object exist without a corresponding "As-Is" business process.	The RFP requirements drive DDI scope. So the DDI can be properly tracked to the business process, the team begins the process of creating a "To Be" business process to close the gap.
An "As-Is" business process and solution object exist but with no corresponding RFP requirement.	Evaluate the gap analysis and work through the change management process to determine the action to take to close this gap. If BMS wants to retain the scope of the business process in the WV-iC system, define the requirements and estimate their scope and evaluate if there is an impact to the project. As changes to the original scope are identified, we will use our change management processes to review, assess, and communicate the project impact to BMS, along with a decision on how best to handle the change request.
An "As-Is" business process and related RFP requirement exist but with no existing solution objects.	The gap analysis teams will start the process of defining solution objects to meet the requirements.

During the Analysis and Design Phase, the business and functional requirements are validated and documented, and changes to the interChange baseline functional and data architecture are captured in our requirements repository. This is a quantifiable method to measure BMS' satisfaction with the MMIS Re-procurement Project.

Requirements Traceability Matrix (RTM)

Accurate business requirements traceability and management provide BMS with the confirmation that each of the requirements specified for the WV-iC is documented, implemented, and tested. Maintaining a requirements repository throughout the life of the project makes sure requirements continuously reflect the approved project scope. The HPES team uses our corporate knowledge from previous successful MMIS implementations and experienced staff members to provide comprehensive, accurate requirements traceability throughout the ESDLC. We will collaborate with BMS to collect and document the business requirements and link them to design, implement, and test work products and deliverables to make sure that the WV-iC meets BMS' needs. Our solution enables BMS to verify that requirements are captured, managed, and tracked throughout the ESDLC.

The final deliverable of the requirements traceability matrix to BMS will be a validation of the joint efforts that the BMS and HPES team performed together for each of the business processes. Ultimately, the final deliverables are linked to system objects and business processes that verify that requirements specification document requirements are traceable to RFP requirements.

Requirements Management and Tracking System

HP Development Center is our requirements repository and will serve as our requirements management tool throughout the life of the project. We will manage requirements through the inherent integration available within HP Development Center. Although everyone can view the requirements, role-based security enables only designated team members to perform updates and verifies that documentation is accurate from requirements specification through the Operations Phase.

During the Requirements Validation Phase, we will validate, refine, and agree on system requirements through requirements validation sessions. These detailed system requirements become a component of the detailed system design and are documented. During the Design Phase, we will document required system changes as work items. Requirements that result in system modifications will be cross-referenced to the actual work item, allowing requirements to be traced throughout the entire systems life cycle.

During development, the primary method of tracking requirements will be through work items, which are created for each of the requirements that will require modification to the base transfer system. The work items are linked directly to the requirements managed through HP Development Center. During testing, we define the requirement information and detail what needs to be tested. We link test cases to requirements and individual test case requirements and obtain complete traceability. Manual test cases and automated test scripts can be tied back to the requirements, promoting coverage of requirements. This consistent, repeatable process is used for gathering and tracing requirements to business processes and system objects, planning and scheduling tests, analyzing test results, and managing test findings and issues.

During the Operations Phase, as changes to the original scope are identified, we will use our change management processes to review, assess, and communicate the project impact to BMS and determine whether the work is in or out of the scope of the original baseline project documented in the repository.

Whether a project is in its initial design and implementation or it has progressed to ongoing maintenance and support, the elemental process does not change—requirements are captured and managed in HP Development Center. A complete historical picture of the requirement can be viewed, and the original requirement will always remain for audit trail purposes. Dated clarifications identifying who is contributing the additional information will be added directly to the requirement.

Detailed System Design Document

System design is a successor to the requirements validation. During design, the HPES team will develop a DSD that includes identification of system files and processing architecture, a general narrative of the entire system and the flow of data through the system, and a detailed description and diagram of the system architecture identifying how components are integrated to meet RFP requirements. The DSD also features general and detailed subsystem narratives describing each function, process, and feature. Additionally, the DSD has a security design description for each business area that defines access control including specifying roles, role locations, and a matrix of roles by inputs or outputs.

The DSD includes a flow diagram of each subsystem, identifying the major inputs, processes, and outputs. The document lists the inputs and outputs by subsystem, details hardware and software, and offers a high-level data model and a detailed, physically specific data model. The DSD also includes a detailed description of the business processes, workflow and system processes, data dictionary, data model, screen layouts, edits, and other functions of the WV-iC. The design documents will be

developed according to MMIS business areas as a way to logically group and size the deliverable activity. During the detailed system design activities, we will maintain a continued focus on the WV-iC and integration of BMS ancillary systems.

The design walkthrough review sessions will be held with the stakeholders. The organization and general flow of these design review sessions are similar to the requirements validation sessions. Design document reviews will be an interactive, iterative, online review of the design materials stored with the business process flow repository, the requirements management repository, and the associated solution objects that combine to form the scope of tasks to be completed during the development portion of the implementation. By having the solution object design material online and relationally linked to the detailed RFP requirements and the defined business processes, stakeholders have complete access to the solution.

The detailed specifications from the design process feed directly into the development and configuration of the solution. The final goal of the design activity is a complete set of specifications that the HPES team will follow during the development task to create the West Virginia-specific release of interChange—WV-iC.

Creation of Validated Data Models (Req. 5)

HPES will use Computer Associates (CA) ERwin Data Modeler for developing the conceptual, logical, and physical models produced for the MMIS Re-procurement Project. An important feature of ERwin is the capability to separate the logical design layer from the physical design layer and provide a traditional, combined logical physical model. This feature allows for the correct alignment between business requirements identified during the logical modeling exercise with database design represented through the physical model.

Separation of the logical and physical designs supports business and technical views of the proposed system features, allowing nontechnical users a tool to better understand the underlying data associated with business process and function and confirm the data requirements. As the project moves to technical design and implementation, maintaining separation supports traceability from logical business design to the technical solution and implementation of business process and function.

3.2.6.3 Overview of Phase 1c: Development, Testing, Data Conversion and Training

In this section, we discuss the following tasks for Phase 1c: Development, Testing, Data Conversion and Training:

- 3.2.6.3.1 Development Task Phase 1c
- 3.2.6.3.2 Testing Task
- 3.2.6.3.3 Data Conversion Task
- 3.2.6.3.4 Training Task

3.2.6.3.1 Development Task Phase 1c

This section describes our approach to completing the Development Task within Phase 1c, where the base transfer system software components are modified and enhanced to meet requirements, as defined during the Analysis and Design Phase. We continue to use the ESDLC to guide our efforts. The ESDLC provides a road map to delivering our quality solutions and is an enterprise framework that integrates the functional work streams across the ESDLC phases. It is a foundation with repeatable, consistent, and measurable processes that incrementally applies to each project phase, including development. The ESDLC delivers best practices as we take systematic steps to complete major tasks and deliver complete iterations of work products with documented deliverables and phase gates. Using this ESDLC will help us successfully deliver a comprehensive technology solution that satisfies BMS' solution requirements and minimizes risk during the development cycle.

Our approach is to identify changes to be applied to the base transfer system, document these changes as work items, and schedule, monitor, and track the work items as tasks in a project management schedule. The changes are confirmed during the Requirements Validation sessions during the Analysis and Design Phase. During development, inputs from the detailed business and technical design documents are used by the developers to make the code changes required for the transfer and change base software code. Organizing the development work by business process, the team works on the associated solution objects related to a business process so the release and testing of the work is done as a unified business process. As work is produced and constructed for the WV-iC, unit testing will be conducted by developers. After unit testing is completed, the code is propagated into the integration test environment for integration testing.

Based on our MMIS experience, communication is important in this phase so that BMS and stakeholders obtain project status on progress, issues, risks, and testing through project dashboards and weekly and monthly status reports. Please see the "The Proposed System Development Methodology" section in our response to "3.2.1 Proposed West Virginia MMIS" for additional details about the ESDLC, our methodology, and tools to be used during this phase.

Completion of the Development Task Deliverables and Milestones (Req. 1)

The input to the development activity is detailed design documents that were created as the deliverables of the design step of the project. HPES will conduct iterative analysis and design processes with BMS. Our sessions will result in the generation of the foundation deliverables, as delineated in Appendix C, including updating deliverables generated during the Analysis and Design Phase. The primary purpose of the deliverables is to convey the understanding of the solution, document the consensus that is reached during this phase, and prepare for the testing.

Throughout the project, HPES will update and keep current the deliverables as changes and enhancements are processed within the ESDLC. The formal notification and tracking of the deliverables activity will be orchestrated by the workflow component of the HP PPM tool. Using HP PPM to formally notify the assigned stakeholders of deliverable status increases the communication efficiency and provides a permanent audit trail for official status reporting. Stakeholders will be notified by emails as to the action to be taken during each stage of the review process. These actions are captured in HP PPM.

Obtaining BMS Approval (Req. 2)

As with the requirements validation and design steps of the process, the development activity is organized by business process. Each logical grouping of the work items is pulled together to support a business process. The associated web page, process, reports, letters, and processing rules are paired with the corresponding physical table structure and updated with configuration code values when required.

The work is assigned and managed as a business process grouping of development activity. Using our established developer work pattern documentation, the concepts of the ESDLC are taken from the conceptual level to the tactical level. The work pattern has been established and refined during many interChange implementations and provides consistency across the staff. This results in quality work products that have addressed the testing definition and walkthrough documentation mandated by our process. Only after these checkpoints are successfully passed do the parts of the development enter the promotion paths that are used to finalize development. Our walkthrough procedures verify that development activities follow the defined standards. HPES will conduct a phase gate review at the end of the development task to verify that Appendix C-defined deliverables and milestones have been achieved and confirm that BMS reviews and approves the deliverables in each phase.

Software and Hardware Configuration (Req. 3)

Our proposed WV-iC solution is a powerful combination of a proven base application, a forward-looking technical architecture, and a resilient supporting infrastructure that best positions BMS to accommodate the current and future program needs throughout the contract. HPES meets mandatory requirement 3.1.16 in which the WV-iC will be installed on HPES hardware and supported by staff members at the BMS and HPES locations. HPES will maintain WV-iC and perform regular maintenance and software support to sustain effective operations. We also meet mandatory requirement 3.1.33 to provide a solution that is upgradeable and expandable to meet current and future needs. This includes hardware, software, and network, as well as necessary upgrades to the system and COTS packages. HPES also will verify that the database software is properly maintained and supported. The DBAs work with developers to meet the physical performance standards and access and maintain rigorous data practices regarding normalization.

HPES is responsible for the technical operational aspects and infrastructure side of the WV-iC and will perform maintenance activities efficiently and responsively for BMS in areas such as installation and operation of hardware, disk, and tape storage and operating system software; system performance tuning, improvement, and balancing; changes to operational job control language and scripts; file maintenance activities for updates to files; performance optimization; changes to system parameters; resource capacity utilization; configuration and support of firewalls, routers, and switches; network capacity and performance monitoring and circuitry; network topology as appropriate for the solution; resource capacity utilization and network usage and performance monitoring; design, configuration, implementation, monitoring, and operation of the networks; capacity planning and expansion; and overall change control management.

Through the WV-iC architecture solution, BMS can respond faster to regulatory, programmatic, and technology changes because HPES' proposed technical solutions and services are adaptable and extensible. Our proposed WV-iC architecture comprises application, infrastructure, network, and data, which will deliver scalability, configurability, capacity, extensibility, adaptability, performance, and availability. In the following subsections, we highlight our approach and methodology to perform system maintenance.

The interChange system has already been running in several states for many years. It is the most proven next-generation MMIS solution available in the marketplace today—proven for reliability, scalability, and configurability to meet today's demanding challenges of the state healthcare business. HPES meets requirement 3.1.15 and has incorporated into WV-iC BMS' requirements of compatibility of the hardware, software, or communications components installed for use by BMS staff members with WVOT-supported versions of the Microsoft operating system, Microsoft Office Suite, and Internet Explorer; and current technologies for data interchange. This highly sophisticated, feature-rich system will deliver long-lasting value to West Virginia.

Please refer to the "Proposed Technical Architecture Design" section of our response to "3.2.1 Proposed West Virginia MMIS" for a full description of our proposed solution.

Systems Documentation (Req. 4)

HPES places a high priority on maintaining current technical and operational documentation. Managing and maintaining documentation by our SMEs is part of our approach to delivering quality deliverables. We appreciate that detailed, accurate documentation helps produce the correct result the first time: the programmer codes a system change exactly, the enrollment specialist enrolls a provider properly, and the adjudicator pays a claim accurately. The result is that time-consuming mistakes and rework are avoided.

As the transfer system is modified and enhanced, developers and technical writers update the system documentation as part of completing work items. Examples of system documentation include data structures, entity relationship diagrams, user manuals, and business rules. The system documentation is available through HP Development Center—a module plug-in to HP Quality Center that provides a user interface to the interChange solution objects—and work item documentation, including unit test results, use cases, user manuals, and developer work pattern documentation.

User Documentation (Req. 5)

HPES will provide comprehensive, well-organized user documentation—written in a procedural, step-by-step format—that promotes usability. We will prepare manuals for each business process major program functional area, which will help users understand the purpose and operation of the functions, and further support documentation accessibility to process owners and key stakeholders. Documentation is framed during design and drafted during development, along with testing and training preparation. Our approach allows flexibility in developing and delivering content. By tying the training content to documentation, efficiencies in time, effort, and costs can be realized. Content-sharing can be directly responsive to changes driven by legislative, system, or user requirements.

Our documentation specialists are experienced in organizing and writing user manuals so users who are not information processing professionals can learn to access and interpret online web pages related to their business process. We understand the importance of accurate, current documentation to support the smooth, consistent running of an MMIS operation. We document and define acronyms, transaction codes, terms, and field identifiers consistently with the web page, report, or data dictionary descriptions.

User documentation covers system navigation, online help, and policies and procedures and will be used to prepare BMS users to conduct UAT. Documentation will be the basis for creating the UAT test plan and scripts. The documentation will help testers design and develop the test case framework and test cases during the testing task.

Our goal is to provide comprehensive training supported by user and system documentation that will prove effective as a procedural and policy reference and an outstanding training tool. The trainer and documentation specialist is responsible for developing training curricula, training materials, facilitating training sessions, and technical and user documentation. User documentation will be used to prepare for training. The draft user documentation will be finalized during Phase 1d - Implementation Readiness.

Provider Documentation (Req. 6)

We understand that a primary goal BMS has for the implementation of its MMIS Re-procurement Project is that the provider and member communities make a smooth transition from the old to the new system. The transition to a new MMIS will present various new expectations across a diverse and dispersed set of roles within BMS, its agencies, and its provider community. Our documentation specialist will develop provider documentation and user documentation as the WV-iC undergoes development. It is imperative that technical messages be communicated to stakeholders at levels they can fully understand. Our specialist will work with the Development team to clarify technical issues and help produce clear, concise provider documentation that will be

used to prepare the provider community to use the system through training. During the training task, provider training will share provider documentation, which will be finalized during Phase 1d - Implementation Readiness.

Development and Unit Testing (Req. 7)

A prerequisite of high-quality code is high-quality design, traceable to solid business requirements. The detailed design document, business process mapping, and edit rules documentation are some of the inputs into the development of the code that is then unit tested. We base unit testing activities on clearly defined procedures, using proven practices obtained from more than 40 years of application development experience within HPES. This includes application development experience from other health and human services and component-based projects, such as the experience garnered through the recent 12 implementations of the interChange solution. We apply additional techniques and proven approaches during the Development Phase for maintainability and extensibility of quality code. This is done in a controlled fashion using industry-leading tools and established procedures to edit, compile, and debug.

The focus of unit testing is on exercising different decision statements or paths. This testing is intended to uncover and identify errors or defects that occur in the Development Phase and is a method by which individual units of source code are tested to determine if they are fit for use. A unit is the smallest testable part of an application, such as an individual function or procedure. Unit testing verifies the acceptable capability of a single program, operation, or process that does not also test the effect and integration points with other programs.

Developers write, execute, and analyze the results of unit tests using their detailed knowledge of the internal structure and logic of the code. Unit test cases and scripts are created and executed by developers. The identification, development, and execution of testing at the unit test level typically require experience with relevant programming languages and knowledge of the internal logic of the system. Therefore, the development teams are responsible for the design and development of the WV-iC components for unit testing.

After a developer has completed the coding changes for a work item, the next step is a walkthrough of the changes and unit test results. During the walkthrough, the developer reviews the coding changes with other developers and BMS to verify that the business requirements have been met and applicable coding standards have been followed. The test results and walkthrough documentation are associated with the work item that triggered the change. The walkthrough procedures are stored within our documentation tool for easy, consistent access. Issues or problems that are identified during this process are documented and must be corrected before the work item can be released for testing. After the walkthrough and participants' agreement to the changes, the work item is ready to be released. HPES uses a comprehensive walkthrough checklist to guide this process. The walkthrough documentation is stored in and available as part of the collection of artifacts associated with a work item. Our walkthrough process has continually been refined across numerous implementations. After satisfactory completion and BMS approval of unit testing, the unit test results are attached, and the individually coded module is promoted to integration testing.

Design Criteria and Intended Purpose (Req. 8)

Our ESDLC provides the framework and rigor BMS requires for the WV-iC to meet specifications and, when installed, deliver the solution as designed. The final deliverables produced by HPES and approved by BMS during the Analysis and Design Phase are used as the foundation for development of the WV-iC. The deliverables, including the requirements traceability matrix, document the validation of the joint efforts of the BMS and HPES team for each of the business processes. Ultimately, the final deliverables and associated requirements are linked to system objects and business processes to confirm requirements, design, and subsequent application code are traceable to RFP requirements.

Installation and Enhancement or Modification of the Components (Req. 9)

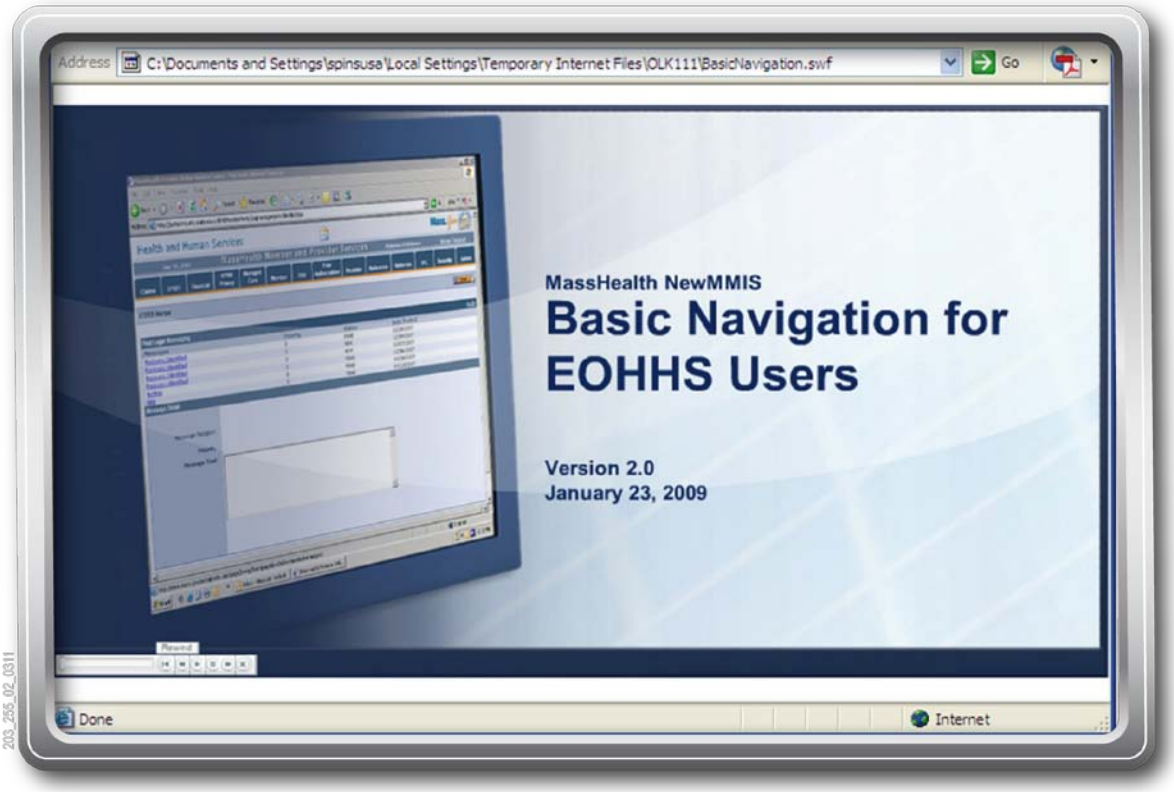
Accurate business requirements traceability and management confirms for BMS that each of the requirements specified for the WV-iC is documented, implemented, and tested as designed. Maintaining a requirements repository throughout the life of the project means requirements continuously reflect the approved project scope. The HPES team uses our corporate knowledge from previous successful MMIS implementations and experienced staff members to provide comprehensive, accurate requirements traceability throughout the ESDLC. We will collaborate with BMS to collect and document business requirements and link them to the design, implementation, and testing of work products and deliverables. Our solution enables BMS to verify that the requirements meet specifications and are captured, managed, and tracked throughout the contract.

application will work. Tests for Knowledge (TFK) will be added at appropriate places with correct feedback if a wrong selection is made. At the end of the WBT, a brief TFK will be presented with a course evaluation. On completion of both documents, a certificate of attendance will be made available. There is no pass/fail rate for the end-of-class TFK—unless BMS wishes for that to be enabled. However, the results from the TFK and evaluation will be used for feedback on effectiveness of the course material.

The first series of WBTs will be created to support the knowledge requirements of the users of the WV-iC—BMS, HPES staff members, and contractors. The material will be similar to that covered in the virtual training sessions but broken up into smaller pieces for ease of use. The second group of WBTs will focus on the needs of the providers, educating them on topics such as how to enter Medicaid member information, check for eligibility, and submit a claim.

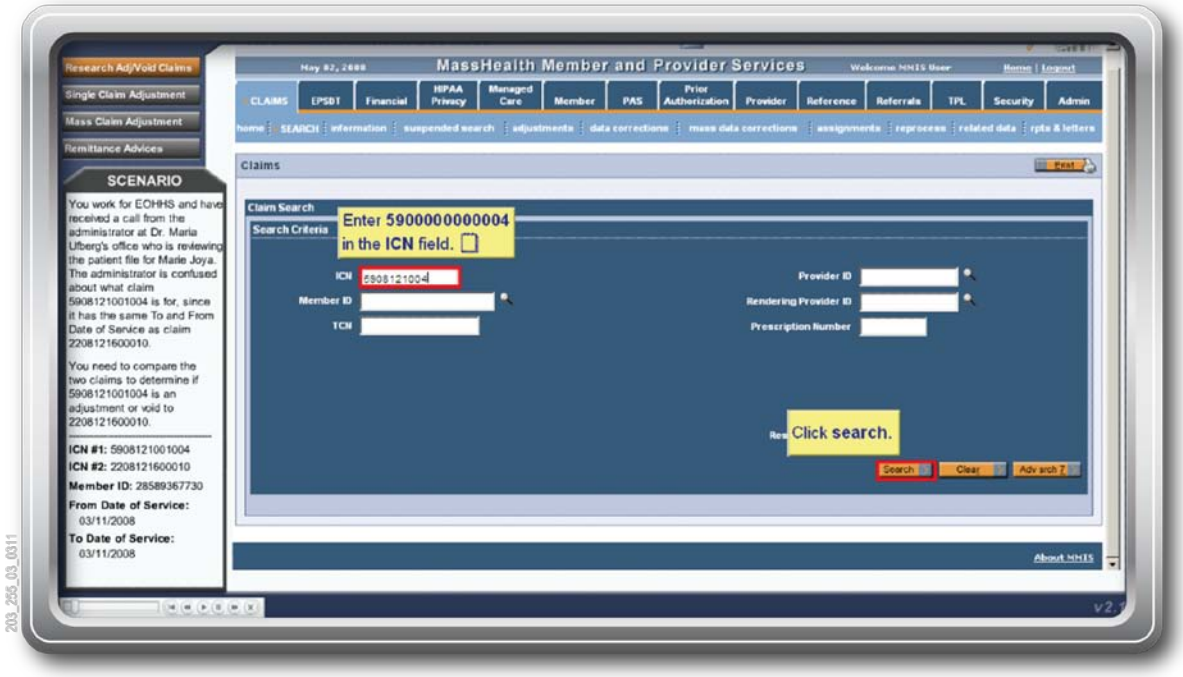
For the Massachusetts Medicaid program, our team developed a series of web-based courses that have been effective and popular with users. The following figure highlights the first page of a web-based class to guide the provider in navigating in the new environment.

Sample Web-Based Class Web Page



It is important to engage the user in the course, so we added interactive exercises to support the text training. The following figure illustrates one of the "show me" exercises from our training course.

Sample "Show Me" Exercise for User Training



Online Help and Policy and Procedure Manuals

Manuals and quick-reference cards will be available for download from the web portal. A "How To" section included on the portal will provide step-by-step instructions in written, audio, and video format for areas that are challenging or difficult. To support online access to materials and perform other training functions, we are integrating an award-winning LearnFlex™ LMS from Operitel with the MMIS portal. As new methods of learning evolve, the key to successful implementation and adoption is the support of an advanced technological infrastructure to manage the relationship between learners and content. This is why HPES chose Operitel's LearnFlex LMS for West Virginia. Our solution provides a scalable learning management system that supports BMS in the acquisition, creation, and transfer of information and knowledge—the essential ingredients for learning in a rapidly changing healthcare environment. LearnFlex registers, tracks, manages, and reports on each aspect of training and will be used to monitor providers and other system users throughout the phases of the contract.

Using the LMS, training administrators can perform the following tasks:

- Add, organize, and access courses
- Coordinate and schedule learning resources, including instructors, classrooms, and equipment
- Manage and track learner progress
- Review, print, and download reports
- Register learners and groups in courses
- Notify audience of upcoming courses through embedded email interface
- Interact with members of the user and provider communities by answering questions, providing relevant articles, and offering tips or suggestions

Using the LMS, students can perform the following tasks:

- Register and enroll in available self-paced and instructor-led learning events
- View and print a transcript of their learning history
- Search for courses within the parameter defined
- Manage their own learning paths
- Ask questions of instructors and provide advice to other members

iC and sustain a solid, responsive suite of ongoing training. The formal classes will have periodic checks for understanding and knowledge transfer, as follows.

- During virtual training, the instructor will post questions to promote understanding and support the material presented. Responses to these questions will be captured. The attendee also will be allowed to work on exercises using the training environment of the MMIS. If attendees are having difficulty with exercises, they can share their desktops so the instructor can see what they are doing or assist.
- WBT will include periodic checks for understanding. If the student selects an incorrect response, the correct answer and where that information was covered will be provided. With a correct selection, additional information will be provided to support the choice. As with the virtual training, the results of these checks will be accumulated. The WBT also will have activities using captured features of the MMIS to lead the students through a directed series of steps that mimic the process they will perform in the production MMIS. These activities also will be included in the "How To" section of the MMIS portal.
- For the ILT, instructors will check attendees' understanding of concepts and processes. In-class exercises will use a connection to a training environment of the WV-iC. The exercises will be included in the student manual for ILT attendees.

At the end of each of these courses, the attendee will be asked to complete a brief online questionnaire regarding topics covered, and the results will be tabulated. A course evaluation will be added to the post-class requirements and the results captured for reporting. Each attendee will be provided with a certificate of completion after filling out these forms.

The following are other methods we will use to determine the effectiveness of the knowledge transfers:

- At least quarterly, surveys will be sent to people who have attended the classes to determine whether the classes were valuable in helping them perform their jobs. A section of the form will capture suggestions and comments. The LMS will be used to send out these surveys efficiently and accurately.
- The Customer Service Center will answer providers' questions about using the MMIS, relying on MMIS portal self-help guides. These contacts will be logged in the HP Service Manager Contact Management System for accurate reporting and trending, and the information will be shared with the training organization so content and delivery can be fine tuned accordingly. A common example of this approach is targeting training to providers on the top 10 reasons for calling in for help.
- Regular meetings will be held with BMS and other State agencies to review common questions and address challenges, feeding the results back into our quality improvement process to improve our training outcomes.

The WV-iC portal training site will have a section for comments and suggestions. Items in the "How To" section that are accessed most frequently will be analyzed so training can be focused on those areas. Classes will be changed or added because of development enhancements, feedback, legislative requirements, or identified gaps in knowledge. These changes and additions will be submitted to BMS for review and approval.

Training Results Reporting

The Operitel LMS has excellent reporting capability that can create standard reports showing the following:

- Users who have enrolled and completed courses
- Number and location of training sessions delivered
- Use of a particular course or group of courses
- Courses successfully completed by each user
- Pathway completion dates, evaluation scores, and evaluation responses

Additionally, the Operitel LMS has a report builder and data extraction tool. The report builder allows administrators to build reports with embedded business rules to help maintain data security and context. Reports can be run on demand or delivered at scheduled intervals. Most presentation formats are supported, including XML, Microsoft Excel, and Comma-Separated Values (CSV). Using the Operitel API web services, it is possible to connect and pull data about users, courses, catalogues, achievements, and enrollments.

The LMS also can be used to track provider on-site visits. Trainers can log, track, and report provider on-site training sessions. Relevant information includes the requested visit date, who made the request, provider name, numbers, reason for visit, visit content and outcomes, follow-up action required, staff members performing the visit, and date visit made. Sign-in sheets will be used to track attendance at training events where computers for each student are not available. The trainer will enter attendee data into the LMS to keep records updated and accurate for monitoring training goals and reporting.

early—for example, provider enrollment—the automated and manual processes for that function will be fully implemented, tested, staffed, and ready to proceed.

Methodology and Approach (Req. 1 a-f)

HPES team members thoroughly studied the Vendor Operations Requirements as referenced in Appendix F of this RFP. We provide the necessary processes, reporting metrics, contingency plans, and approach for supporting a successful operation of the WV-iC MMIS, including each of the 18 component areas of Appendix F in the following pages. Our methodology and approach is the same for each component area: quality, efficiency, transparency, and service excellence.

HPES will perform the tasks necessary to operate a complete and certifiable system and make sure that transactions are processed, providers are paid, and reports are produced accurately and promptly, in accordance with federal and State policy. HPES' unmatched track record for transitioning to new systems, operations, and personnel enables BMS and HPES to implement, transition, and operate with confidence.

We bring the knowledge and experience to fully understand that a high-quality working relationship between BMS and the HPES team is essential, throughout the project, to the success of the West Virginia Medicaid Program. Our Operations team will work with the BMS on each aspect of the operation from the time of implementation of each component to the time we transfer the business function to a successor fiscal agent.

We strive daily to exceed the expectations of each of our customers, and BMS will be no different. We will perform the operations in a way that reflects positively on BMS with stakeholders and community partners. However, if BMS selects a subsequent vendor, we will work with BMS and the new vendor professionally and cooperatively. We will help devise the transition plan and uphold our commitment to excellence up to the last minute of operation. This philosophy will hold true for contractual optional periods and extensions.

HPES meets mandatory requirement 3.1.28. We will operate the MMIS within the service levels defined in Appendix G of the RFP. We also understand that agreed-on retainage can be forfeited if approved service levels are not achieved, meeting mandatory requirement 3.1.29. Our approach to quality assurance and quality management during the Operations Phase demonstrates that quality assurance in monitoring of our SLAs starts at the highest levels of the account. Our leaders set the tone for quality of our fiscal agent operations. The HPES leaders will involve the entire account team by verifying they fully understand how their actions affect the quality of our operations performance. We will monitor our performance using proven quality tools and methods, optimizing HPES' best practice and lessons learned repositories to verify we comply with the BMS-defined SLAs.

The medical/dental and POS quality managers will work with account leaders to validate that acceptable thresholds for each function being monitored are understood. RFP performance requirements is a critical input into establishing thresholds, as compliance with the thresholds will result in meeting performance expectations.

When thresholds are not met—whether it is accuracy thresholds for manual functions, system performance thresholds, or other—we will conduct thorough analyses to identify specific corrective action needed to support proper function and operation of the WV-iC. We will put escalation procedures in place to verify that the appropriate level of experienced HPES staff members are available to address claims, provider assistance, or systems-related events that cause potential risk to the performance of the WV-iC. Escalation procedures provide a means of informing and communicating issues to BMS for timely mitigation and resolution. HPES will maintain adequate staff and infrastructure to manage and support ongoing operations.

As evidenced by our staffing plans for the Operations Phase, we provide senior leaders with numerous years of MMIS practical experience managing account-based teams. These leaders and their teams will begin work preparing for the Operations Phase before implementing the WV-iC and participate in activities including testing and training to enable a smooth transition from DDI into the Operations Phase.

We carefully reviewed the RFP and the Bidder's Library to determine the staffing required to manage and support the ongoing operations of the West Virginia MMIS project. HPES has assembled a team that brings unmatched Medicaid technology, leadership, and experience that will successfully deliver on BMS' technical and operational requirements.

HPES will operate the MMIS with a goal of minimal disruption to supported users. By scheduling routine maintenance windows for the WV-iC during nonbusiness hours, the users will not have interruptions to their daily work processes. If we must perform an emergency function during the workday, we will gain prior BMS approval, give as much notice as possible, and bring the system down for the shortest duration manageable. We take production downtime seriously and aspire to meet the SLA set forth by this RFP.

We recognize and understand the importance of proactive monitoring of system performance. Our system performance will be monitored 24 x 7 so we can verify that the MMIS is meeting the established performance requirements because we fully appreciate the importance the WV-iC plays in the provider and member community.

New employees and those changing positions will receive orientation training that includes information about BMS, the West Virginia Medicaid Program, the unique needs of BMS, and how we can best support those needs. We will provide classroom and hands-on training and eLearning training that is available to the staff 24 x 7. We also will provide training programs for our system staff that focus on new and improved quality processes for reliable systems design and operation. New team members will receive an introduction to West Virginia Medicaid through an overview of the history, organization, and goals of BMS. Team leaders will provide detailed training on the specific Medicaid knowledge a new team member needs to fulfill his or her responsibilities and objectives.

HPES enjoys a wealth of experienced team members who can serve as mentors for new team members—providing ongoing training, monitoring, and support for meeting operational objectives. Technical training will be provided to our staff in multiple formats: the classroom environment, online through HPES Grow@hp or desktop computer training, and through our mentoring program for our Systems teams. A strong working knowledge of the WV-iC and BMS' needs will provide the basis for the Systems team to support system interfaces, perform systems management activities, and complete production support tasks with ingenuity and quick resolution.

Cross-training among units will improve team members' understanding of program operations and allow them to see how their actions affect other units. Team members will begin to develop a larger understanding of the overall account goals. When this occurs, people will connect the effects of their actions and the quality of downstream processes. Because of this understanding, staff members will place more emphasis on achieving their unit goals and making a positive effect on overall program operations.

As a part of our annual performance assessment, HPES will measure each employee's need for continued employee development. Managers and supervisors will work with the medical/dental and POS quality managers to address areas of concern. The monitoring of work by the various quality assurance audits will indicate areas where additional training may be needed. Training in areas of job proficiency, quality assurance, customer service, and leadership will build the foundations necessary to meet BMS' expectations. Managers and supervisors can assign employees to a myriad of relevant refresher courses and focus employees on specific areas of concern.

Following are the responses to Appendix F requirements.

General

The Wisconsin base interChange system, proposed for WV-iC, is our most recently CMS-certified system, attaining full certification back to day one in December 2010. HPES leads the nation in building innovative, efficient, and reliable MMIS solutions that achieve customer-centric healthcare expectations. Healthcare administration business processes drive HPES' operations and technology, which facilitate widespread and secure access to customer data, allowing BMS to focus on improving healthcare outcomes, attaining administrative goals and objectives, and reducing overall costs in the healthcare system. Since 2002, HPES has successfully implemented 12 new interChange MMISs, more than all other MMIS vendors combined. In the midst of the federal government's rollouts of new and changing federal rules and regulations for state healthcare reform, HPES successfully implemented these new MMISs for our state customers. We will accomplish a successful implementation of the new WV-iC by using our proven project management methodologies, demonstrated organization approach, and through our HPES account team's commitment to BMS' success.

Manage Data (Req. 1)

Data management remains a key component of HPES operations, as it has been for more than 40 years. BMS' specifications for data management outlined in the RFP provide a clear guide for data management of the WV-iC system and operations processes. HPES will provide data management including user access, user inquiry, update, retention, purge, archive, and destruction. Other relevant aspects of data management are handled according to State and federal Protected Health Information (PHI) requirements and in accordance with the BMS Data Retention Policy. As BMS identifies or approves documents for destruction, they will be transferred from the secure storage area to locked storage bins that are only accessible with a controlled key. The documents will be destroyed based on the type of media and a certificate of destruction issued in accordance with BMS requirements. HPES supports MMISs in 22 states. With more than 40 years of experience, we understand how important it is to retain content for the appropriate length of time, make it easily accessible when needed, and destroy unneeded material securely.

BMS must satisfy legal obligations to retain records, satisfy regulatory requirements to keep certain types of data (sometimes indefinitely), and permit access to older archived data. The retention of data—such as provider payment records—will be important for BMS to conduct audits and respond to legal inquiries and for the reprocessing of claims. BMS understands the older, more traditional approach of keeping years of paper information on-site or in a storage facility is inefficient and seeks a solution that will eliminate wasted storage space and allow for shredding of some documents within 60 days after they are imaged and verified.

The proposed enterprise content management solution, HP TRIM, will house the claims, adjustment, and correspondence images and reports for online viewing when the original paper document has been properly disposed of according to BMS policy. Our comprehensive approach to maintaining, storing, and archiving documentation will deliver the following benefits to BMS: provide improved access to online and archived information; enable critical WV-iC information to be properly retained and protected to support State and federal requirements; archive first-run claims and reports until receipt of certification; spell out the time period claims and documents must be maintained; detail handling procedures for records that have been involved in matters of litigation; and capture, archive, index, retrieve, present, and reproduce stored documents through a digital storage environment. We will work with BMS during DDI to fully understand the State and federal requirements to manage the process of operational archiving efficiently and properly, adhering to BMS' specific time frames and retention guidelines.

Operate Within Federal, State, CMS, and Medicaid Quality Control Requirements (Req. 2)

HPES agrees to operate and maintain the WV-iC in accordance with the existing and new requirements of federal MMIS certification requirements, the CMS State Medicaid Manual, Medicaid Quality Control (MQC), and State and federal policy outlined as known requirements in the BMS RFP MED11014 as published on January 28, 2011. As new standards and requirements occur, such as when a new federal or State regulation is promulgated, enhancements will be handled through the approved change order process.

Supply and Distribute Reports (Req. 3)

In the DDI Phase, production and operational report distribution rules will be defined per list and media delivery instructions. If a report is defined for hard-delivery, HPES will generate hard copy using the defined distribution list to deliver the report. Reports will then be stored in the HP TRIM document management repository with defined storage, retrieval, and archiving rules as defined by BMS. Authorized BMS staff members can recall reports from the repository by searching for items using keywords, such as provider ID number. This solution will provide significant new efficiencies to quickly and securely manage reporting. Reports are available electronically in PDF and Microsoft Excel formats from the repository where users can access them when and how they need them. HPES will work with BMS during requirements validation sessions to determine where hard-copy reporting distribution can be reduced and replaced with web-based electronic availability to create new efficiencies. The HPES staffing plan calls for a reports manager who will oversee production and operational reporting to include management and administrative reporting (MAR), claims, provider enrollment, call center, pharmacy, drug rebate, POS, and ad hoc reporting functions. During DDI, reports will be designed, implemented, tested, and approved according to BMS-defined specifications and report distribution schedule. Distribution time frames and formats will be agreed on and documented in the HP Development Center tool.

Provide Role-Based User and System Training (Req. 4)

System users will be provided initial training on the WV-iC MMIS before start-up and on an ongoing basis as specified by BMS. The role-based training provided by HPES will be easy to understand, complete with handouts and visual screen depictions as appropriate. Training materials will be stored in the web-based document repository for access by authorized users. Additionally, HPES will provide eLearning modules that will be available 24 x 7 on the web portal for those BMS staff members, vendors, or authorized business partners who are unable to attend a live training session. Please refer to the "Training Plan" section in our response to section "3.2.2 Project Management" for more details on the multiple training methods available to BMS.

Security of the WV-iC system and data is paramount. Our System Security team will adhere to strict system access procedures and promptly grant role-based access to BMS staff members, vendors, and business partners after receiving an approved authorization request form from BMS. Role-based user and system training will be determined during DDI and based on understanding of BMS goals for training, defining the audience and roles, creating the content, and setting up classes. We will provide delivery as efficiently as possible to include web-based, virtual instructor-led, web portal, face-to-face instruction, and obtaining feedback from training participants and BMS staff members.

During and immediately following implementation, we will use a team of trainers and SMEs from DDI to provide additional transition support and troubleshoot problems. Training will begin months before implementation, with refresher training occurring closer to the implementation dates. To support a multiphased implementation, we will customize the training to be on

topics pertinent to the appropriate phases of implementation. BMS will be invited to participate in developing the training plan, approving training materials, and participating in the training program we deliver. We will orchestrate an aggressive approach of communication, education, and outreach to make sure that BMS staff members, providers, members, vendors, and business partners successfully transition through the Implementation Phase.

Produce, Distribute, and Version Control Documentation (Req. 5)

Our documentation specialists are experienced in creating system, provider and user manuals that are written and organized so that users who are not information processing professionals can learn to access and easily interpret online screens as it relates to their business process. We understand the importance of accurate and current documentation to support the smooth, consistent running of an MMIS operation. We will document and define acronyms, transaction codes, terms, and field identifiers consistently with the screen, report, or data dictionary descriptions. HPES will develop, implement, and maintain thorough and concise system, provider and user manuals documenting the WV-iC MMIS as specified by BMS. The WV-iC manuals will contain easy-to-read text, helpful graphics, and provide valuable assistance to the reader, whether the target audience is the provider community, vendor community, business partners, or BMS staff members. Version control will be managed through the HP Development Center according to BMS specifications.

Operate and Maintain Customer Service Support Services (Req. 6)

We share BMS' goal of delivering quality support services to West Virginia Medicaid members. We have a proven customer service center industry history and are well positioned to assist members, providers, and business partners using multiple methods with our customer service solution. Our services will be delivered through a well-organized, highly specialized operational structure supported by proven technology, best practices, and a strong culture of continuous improvement. Our approach will include a standard suite of services with increased emphasis on self-service, education, and access to information and delivered through the following methods.

Call Center

- **Customer centric technology—**COTS-based solutions for call routing, automated call distribution, automated voice response, contact tracking and recording, reporting, and quality assurance
- **Customer service representatives (CSRs)—**Highly skilled and knowledgeable CSRs to provide an enhanced customer service experience, with access to CSRs managed through automated workflows to make certain that the inquiry goes to the right person
- **Operational structure—**Operationally integrate the customer service center with provider and member services, allowing for the free flow of information between CSRs supporting these customers
- **Automated voice response (AVR)—**Telephonic self-service features available 24 x 7, 365 days a year

Web Portal

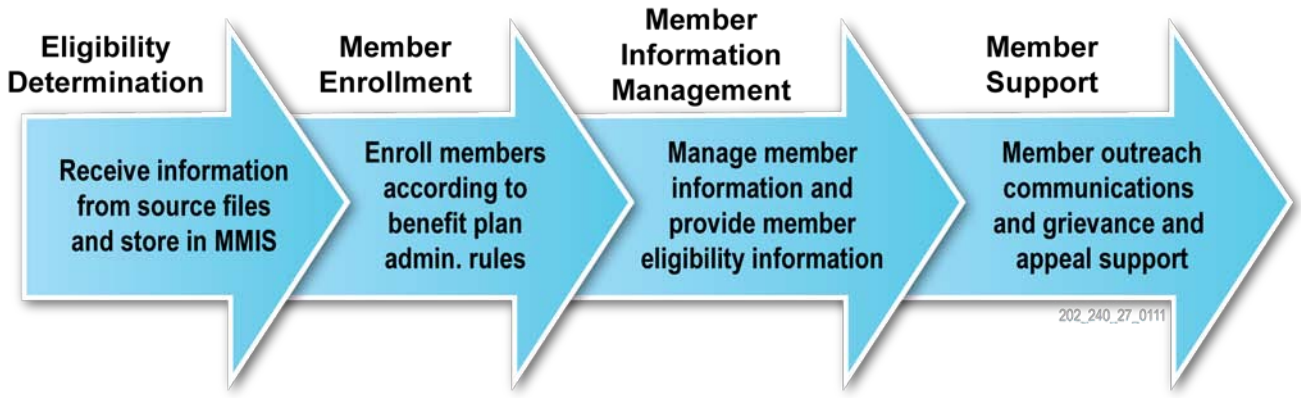
The portal will be a continually growing suite of documentation offered on the web. It will house published materials such as manuals, program information, bulletins, user guides, educational materials, and billing tips. A major component of the portal will facilitate email communication, electronic submission, and real-time adjudication of multiple transaction types, including claims, adjustments, service authorizations, and eligibility inquiries. Our extensive experience delivering customer service in 22 states allows us to bring BMS' customer community high-quality service through many contact methods. Our call center will comprise well-trained agents available through toll-free lines accessible according to the RFP requirements.

Collect and Report Operational Performance Standards (Req. 7)

HPES will report on performance metrics as defined in Appendix G, Appendix H, and other areas of this RFP according to BMS specifications and time frames. Multiple review methods and data analysis tools will be used to monitor and measure the HPES team's operational performance in areas such as claims processing and adjudication, provider and member relations, financial processes, and training.

We will use a sampling of activities and outputs to select the items to be reviewed. The sampling will vary depending on the review performed. For example, randomized sampling using system-generated reports may be used in data entry. In claim resolution areas, selection by specific error code, or selection from specific areas of interest such as an error code or provider type may be used. The actual reviews that will be used to monitor quality will vary depending on the activities being performed, the resources and processes used, and the type of staff performing the activities.

Member Management Functions



In the following table, we provide key features and benefits of our proposed member management solution.

Member Management Features and Benefits

Feature	Benefit
Maintains eligibility for multiple health programs and payers	Eliminates the need for multiple claims processing systems by offering the ability to handle member data for multiple healthcare programs and payers in a single system, enhancing BMS cost efficiencies
Provides automated interfaces to WV-iC and accepts HIPAA-compliant 834 eligibility transactions	Inherent, proven capability that reduces the risk that errors will occur during the eligibility update process
Allows for real-time, online entry of members and updates to member records by authorized staff members	Provides a secure interface by which authorized users can immediately make updates or add new records to authorize benefits or terminate participation
Offers secure access to the member and provider portal	Current, updated member information allows only the certifying members or providers to access information through the portal
Supports cost-avoidance activities by identifying responsible third parties and Medicare-eligible members and facilitates payment for premiums	Verifies that Medicaid is the payer of last resort

As we have done for many of our 12 interChange implementations, HPES will bring a proven healthcare portal to BMS. Sharing our capabilities with West Virginia provides a portal acknowledged by CMS as offering "extensive functionality." In the following sections, the HPES team demonstrates our capabilities, experience, and innovative approaches as we respond to the RFP requirements for the member management business area.

Eligibility Determination

The WV-iC system will exchange eligibility and demographic data through various automated interfaces. We also will exchange data manually as necessary from county, state, or federal agencies. WV-iC is an interoperable system that promotes data-sharing while maintaining strict security access. These capabilities allow for rapid updates in interChange and improve the efficiency of manual updates and inquiries.

Retain Member Change Transactions (Req. 1)

The HPES team will work with BMS during the requirements validation sessions to determine the specifications for processing and retaining eligibility transactions received from BMS or its designee, and the information unique to West Virginia as required by the RFP. WV-iC establishes, monitors, and reports input and output controls in a scheduled, formal process as part of operations. Audit reports are available for the data sources to perform balancing and reconciliation for transactions processed,

and also used for error resolution along with eligibility update error reports, as we detail later in this section. The following figure shows a sample audit report listing the member demographic and eligibility data received.

Sample Eligibility Transactions Audit Report

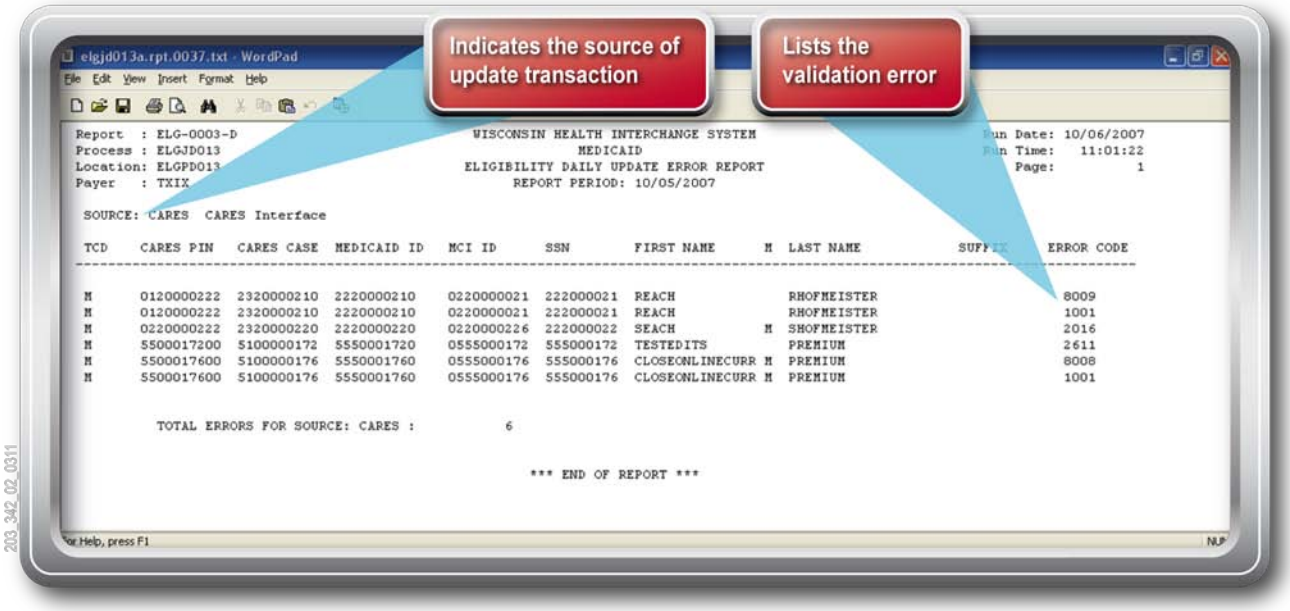
Apply Member Updates in Timely Manner (Req. 2)

HPES' WV-iC system is designed to accept and send member and eligibility transactions from and to BMS-approved external interfaces. The data exchange function inherent within the WV-iC exchanges eligibility and demographic data through various automated interfaces in a batch mode or in real time. The daily batch eligibility update cycle will be scheduled to run between 6 p.m. and 7 a.m. the next morning and as needed for emergency situations. We will work with BMS to schedule these unique occurrences. WV-iC also allows authorized users to update member data immediately by using the Member Management web panels.

Identify and Correct Errors and Resolve Error Reports (Req. 3, 9)

The transfer interChange system provides daily reports on batch and real-time eligibility transactions failing edits or validity checks for rapid online analysis and resolution. The eligibility updates would include processing for new members, reinstated members, and changes to existing member data in accordance with BMS' business rules. The following figure shows a sample eligibility update error report. The member details and error are shown with the source of eligibility transaction, so authorized HPES staff members can resolve the errors within 48 hours and manually update the member data using online member web pages as required.

Sample Eligibility Update Error Report



Supply and Maintain Eligibility Interfaces (Req. 4)

HPES recognizes that eligibility interfaces and functions are the crucial first steps in providing healthcare coverage for Medicaid and other state programs. The WV-iC system will include many forms of eligibility determination and demographics received from diverse input sources such as the following:

- Recipient Automated Payment and Information Data System (RAPIDS)
- Families And Children Tracking System (FACTS)
- Master Data Management (MDM)
- Vital Statistics File
- CMS
- MCOs and Health Maintenance Organizations (HMOs)
- Employers
- Providers
- Insurance Carriers
- Pharmacy Benefit Managers (PBMs)
- Department of Corrections
- Member

WV-iC will provide data extracts to RAPIDS, FACTS, DSS data warehouse, Medicare intermediaries, and CMS. WV-iC uses the eligibility data received from the Medicaid eligibility systems in accordance with configurable BMS business rules.

Reconciliation of MMIS Member File (Req. 5)

The WV-iC system will provide a monthly reconciliation process to compare the MMIS member data with State member data and produce discrepancy reports. This report will be reviewed by HPES staff members to resolve the errors, similar to the eligibility update process error reports. We will work with BMS to define the reconciliation process.

Enrollment/Disenrollment

The WV-iC MMIS provides the ability to structure and offer various benefit plans to members. The system handles multiple types of plans—including fee-for-service (FFS), managed care, or waiver plans—and the CMS-certified transfer system excels at supporting member enrollment in multiple plans. For eligibility add transactions processed successfully, benefit plan is assigned based on the aid category and other rules as specified by BMS. WV-iC also supports manual enrollment and disenrollment of members in benefit plans using the Member Benefit plan web panel, by authorized users.

Multiplan support is integral to the system. When a member is enrolled in multiple overlapping plans, the WV-iC MMIS will systematically determine which plan is the appropriate payer for the service billed. This hierarchy is ultimately controlled by authorized users who can directly update the processing rule parameters. The MCO enrollment function in WV-iC will support and maintain enrollment in Mountain Health Trust, Mountain Health Choice, and other special managed care programs.

HPES' solution to address these business needs includes the following:

- Auto-assign members into the appropriate MCO based on BMS-defined criteria

- Accept electronic enrollment transactions from external sources
- Process manual enrollment and disenrollment requests as directed by the BMS
- Auto-disenroll members whose eligibility criteria no longer meet the conditions and criteria for enrollment in the existing MCO
- Process exemption requests as authorized by the BMS
- Generate timely enrollment materials and notices
- Support lock-in and lock-out capabilities for members
- Automatically monitor and report on MCO enrollment counts and limits
- Answer inquiries about managed care enrollment and payment issues from MCOs, providers, and members as directed
- Provide web-based access to eligibility and enrollment information to state, MCO, county, and other authorized entities
- Provide comprehensive audit trail of enrollment activity
- Auto-reassign members to their previous MCO provider if available and appropriate for their eligibility category and other criteria

Interface between MMIS and the MCOs (Req. 6)

To communicate to the MCOs and the enrollment broker, WV-iC will use our healthcare portal to maximize BMS cost savings on postage and materials. The system will generate hard-copy and HIPAA-compliant electronic reports of members for the MCOs and provide the capability to send enrollment status information (rosters) to the MCOs monthly or on another schedule mutually defined by BMS and HPES. The enrollment broker will receive electronic and hard-copy enrollee lists and status and quality reports with managed care information weekly or on another schedule as defined by BMS.

Manage Member Information

Provide Online Access (Req. 7)

Our MMIS solution will maintain current and historical member information within the Member Management web-based pages to provide online inquiry to authorized users as designated by BMS. Regardless of the source of the member and eligibility data, we verify the integrity and completeness of data—whether the record is new or an update, through batch or real-time updates, or through data validation editing enforced by secured online web-based pages. For example, the validation process includes verifying that the date of death is not before the date of birth and that eligibility start and end dates are consistent. WV-iC disallows overlaps where BMS policy dictates. Our stringent front-end editing prevents erroneous information from entering the member record and keeps member information accurate and current. These checks include searching for duplicate member information, making sure eligibility start and end dates are consistent, and checking that program and aid categories do not overlap based on policy.

HPES' WV-iC solution maintains member benefit data to support eligibility verification, claims payment, and financial processes. The member management function within WV-iC maintains the most current and accurate member's data—depending on the submitter's accuracy of data—including the following information:

- Eligibility effective and end date
- Benefit plans and aid category
- Case and head-of-household
- Buy-in data
- Lock-in data
- LTC level of care
- Medicare A, B, and D information
- Premium data
- Managed care enrollment
- TPL
- Member cost share data—deductible, patient liability, and spend-down amount

WV-iC's Member Search web page offers extensive search capabilities based on member's current Medicaid ID, old ID, Social Security number, date of birth, partial name, and phonetic matches. Users can enter one or more data fields to search for the specific member's information. By clicking on the selected member from the Search Results, the Information page displays summarized data on that member as seen in the following figure.

Member Services

Operate and Maintain Member Services Function (Req. 10)

HPES will develop, implement, and operate a member call center with toll-free access to assist members as they interact with the West Virginia Medicaid Program. Our member call center staff will be knowledgeable with West Virginia Medicaid-covered services. The team will receive initial and ongoing training to be aware of changes to program policy and enhancements to the interChange transfer system to facilitate program or process changes. Besides receiving training on the system and West Virginia services, the staff will be well-versed in each aspect of providing high-quality customer service with compassion. We promote quality customer service by monitoring calls. Our experience and commitment to provide outstanding customer service form the basis for devising the appropriate configuration that prevents callers from receiving busy signals. Our system is flexible in its design, which allows us to add additional lines or contact center representatives should the long-term need exist. Our staff members are well-trained professionals who understand the importance of treating members with care and understanding.

Our member call center staff will perform the following duties:

- Respond to member eligibility and benefit package inquiries from members
- Contact BMS, when necessary, to resolve complex eligibility inquiries and complaints
- Log member-related inquiries into our CTMS, which tracks interactions with members including telephone calls, email, letters, and faxes. As seen in the following figure, CTMS has the ability to store the member identification, topic of inquiry, response, resolution, and notes.

For more details about our member call center, refer to the "Customer Service Support Call Center" section that follows.

The call management system and Automated Call Distribution (ACD) systems are integrated into our telecommunications system to provide enhanced reporting tools for monitoring telephone performance and standards. The integrated system provides management reports that reflect individual, group, and line activity. The following reports can be generated for member call center activities and are generated through the PBX and WV-iC daily, weekly, monthly, and quarterly:

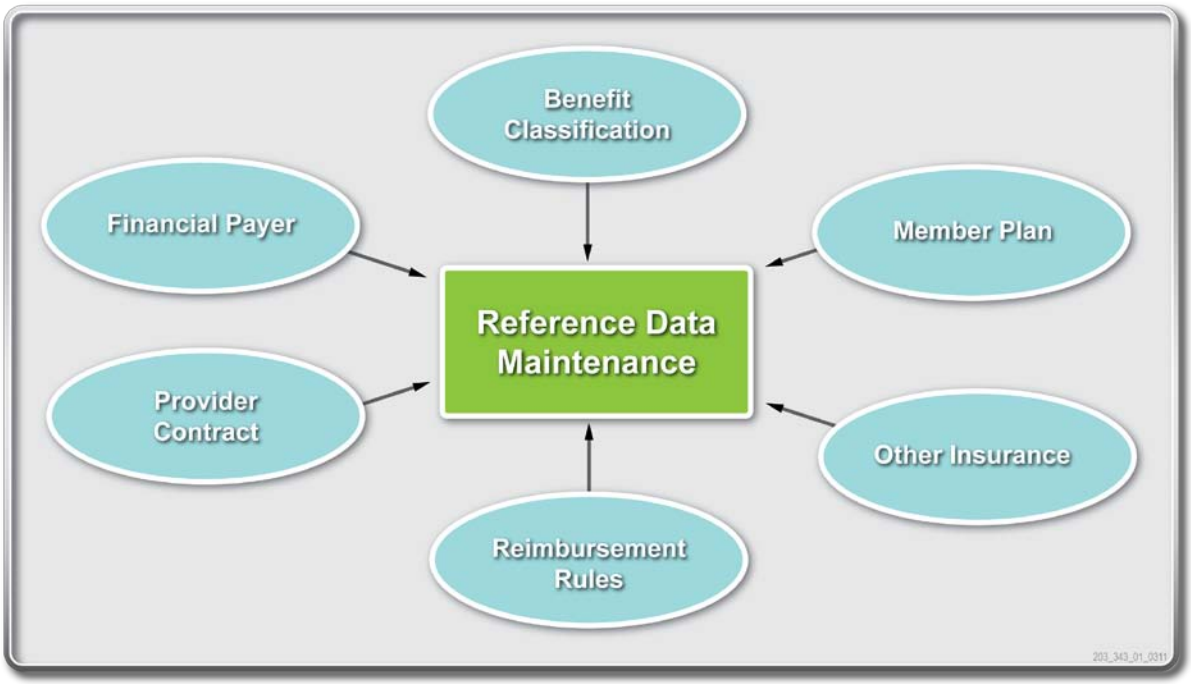
- Incoming calls received
- Incoming calls answered
- After-hours calls
- Cumulative calls answered
- Total calls abandoned
- Abandoned rate percent
- Agent hours logged on
- Average calls (inbound) per full-time equivalent (FTE)
- Average calls (inbound) per hour
- Average wait time per minute
- Average hold time in queue
- Average talk time
- Agent active and available percent
- Total outbound calls

HPES uses data gathered to produce reports for leadership to assess performance and make necessary adjustments to staff scheduling, assignments, and performance. We carefully analyze the lines, call volume, and call length. We are confident the number of toll-free and local telephone lines and contact center staff members we provide meets the call center requirements.

HPES' CTMS tracks interactions with members, including telephone calls, email, letters, and faxes. CTMS has the ability to store the member identification, topic of inquiry, response, resolution, and comments.

the new policies through the online application, reducing reliance on technical staff members and accelerating the implementation time line. Multiple programs, plans, and payer features are supported in interChange through the user interface, as shown in the following figure.

Reference Data Maintenance



The benefit package will include rules for policy, contracts, and benefit plans. Unique delivery models will be outlined in the reimbursement rules. Within WV-iC, various business rules govern each claim processed—billing rules from policy and contracts, coverage rules from benefit plans, and reimbursement rules that determine how to price and pay the claim. The authorized user can modify the disposition of edits associated with business rules that will determine whether to pay, suspend, or deny claims, according to State policy, on how each service should be adjudicated.

The WV-iC will provide the ability to pay Medicaid and non-Medicaid claims such as Limited Pharmacy (ADAP), Tiger Morton, and Juvenile Justice Services within one system. This capability enables BMS to consolidate and simplify program management and reduce administrative expenses. Our benefit plan solution will help BMS manage rate-setting and benefits more creatively and with greater specificity across the diverse spectrum of programs supported. This precise targeting of benefits and services translates into more efficient management of benefit dollars.

Monitor Changes Because of New Policy (Req. 2)

When states outline new policies, introduce changes to existing policies, or annual changes are made to code sets, a healthcare management system that can respond quickly and efficiently to change is essential. Accurate claims processing is one of the fundamental and critical functions performed by the proposed WV-iC. The benefit administration rules management allows trained users to identify, create, refine, and maintain business rules that effectively capture and enforce medical policy. HPES will offer recommendations on the most efficient and effective means of updating the business rules to reflect BMS policies.

The reference file data for HIPAA-mandated code sets is maintained using a web-based user interface, with online editing to help maintain data integrity when applying updates. The web-based user interface also provides a view to the audit trail of updates that were made, when they were made, and by whom they were made. Our design of having claim types running through a single claims engine makes the long-term maintenance and update of reference file data easier to perform than other MMIS solutions that require multiple sets of files for processing pharmacy and other claim types through separate claims engines.

If a policy changes, it is critical that the system reacts quickly to the change yet prevents illogical or inconsistent results. The WV-iC MMIS rules-authoring panels are designed to allow changes yet automatically reviews those changes against existing rules to simplify the rule or prevent overlap. Users can make and apply complex updates intuitively and simply, without unnecessary steps or complications. The WV-iC MMIS also reviews the modified rule to determine if it is inconsistent with another existing rule. For example, a user may try to load a coverage rule for a group of procedures and indicate that a medical

The HPES Provider Services team sets the tone for provider perceptions of the program. A positive provider experience can make even the most difficult situations acceptable. Our HPES team offers knowledgeable provider services staff members who provide the essential expertise to support and deliver an outstanding provider services business function.

Operate and Maintain Provider Customer Support Services (Req. 1)

Our locally based Provider Services unit will comprise well-educated representatives who have access to online resources, SMEs, and the Provider Services leadership team. Our Provider Services unit will assist providers in resolving concerns and inquiries about various topics, including provider enrollment, member eligibility and benefit packages, prior authorization, claims processing, and questions about portal registration.

Call center agents will use the HPES CTMS to document contacts with providers and offers the ability to research prior contacts. CTMS is a comprehensive system that tracks inbound and outbound interactions with providers including telephone calls, email, fax, the secure provider portal, and written correspondence. To enable agents to quickly access stored content, we will use our document management system, HP TRIM.

Our call center delivery model uses exceptional products that have a proven history of successful integration to deliver services for customers worldwide. The call center's telecommunications infrastructure is supported by an Avaya ACD to deliver calls and voice mails using Voice over Internet Protocol (VoIP). The front end of our provider call center comprises an AVRS provided by Genesys that allows providers to use self-service functions 24 x 7, 365 days a year.

Generate Outgoing Correspondence (Req. 2, 3)

Our HPES team will generate and deliver as efficiently as possible provider-related correspondence, enrollment-related notices and requests for additional information, and notifications, as directed by BMS. To support this, providers are required to indicate during enrollment—also in re-enrollment—how they would prefer to receive communications. After correspondence is generated, the approved document is sent to providers through the media they indicated during enrollment. Unless otherwise specified by BMS, provider communication will comply with their preferred method of communication—email, postal mail, or the provider healthcare portal. We also will use telephone, fax (including "fax blast"), and other channels of communication as appropriate. Additionally, billing, forms, and other state policy information will be available to providers through the healthcare portal.

HPES will generate and distribute outgoing provider-related correspondence to include enrollment applications, enrollment rejection notifications, billing instructions, relevant State policy information, request for enrollment or contracting information, mailing labels, program memorandum, referrals to appropriate licensing board, and notifications of pending expired provider eligibility. HP's Exstream document automation tool allows for the standardization of common correspondence templates, and on-demand correspondence.

Notify Date-Dependent Events (Req. 4)

With the scheduling features of HP Exstream, users can use the WV-iC workflow control panel to set selected date fields to trigger notifications. For example, re-enrollment dates can be back-scheduled to trigger provider notices using the portal, email or postal mail 30, 60 or 90 days before a provider's termination date.

Perform Provider Outreach Communication and Tracking (Req. 5)

Similar to our approach for the development of provider publications, our staffing model includes a provider services trainer and documentation specialist who will work with BMS on the development of provider outreach materials. Outreach materials can be distributed through the portal, email or postal mail and will contain (as a header or introductory section) the intended audience, the issue or topic, the purpose, a distribution date, and, if needed, a required response date. Communications will be stored in our communications database with feedback received about the communication. An example of feedback received about the communication may be the statement: "it was too long." Along with our ability to create analytical reports from the provider functional area, we also will provide BMS with the ability to target enrolled providers and identify geographical regions for provider recruitment.

The HPES CTMS will be used by provider services representatives to track correspondence to include target population, issue or measure addresses, purpose, date of distribution, and method of distribution. CTMS provides historical contact information and serves as the tool to escalate issues within BMS and HPES related to outreach communications. CTMS also provides reports that are used for trending contact data, such as most often asked questions and responses. For more detail, please see the "Contact Management" that follows in this section.

Receive and Respond to Eligibility, Claims, Prior Authorization, and Enrollment Status Inquiries (Req. 6)

Provider questions about member eligibility or claims status will come to HPES in various ways, and the Provider Services unit will have multiple ways of responding. Through an orientation campaign, we will encourage providers to use the AVRS and the healthcare portal for member, claims, prior authorization, and enrollment status queries. This is an effective method of communication because these inquiries will be answered by the web services technology of WV-iC. When a live-person conversation is required, call center representatives will be the first responders. If a question requires research, inquiries will be routed to provider support staff members.

Submit Web-Based Provider Transactions (Req. 7)

The HPES healthcare portal will include, and make available free of charge, web-based applications allowing providers to submit electronic transactions using the Internet, in HIPAA compliant transaction formats through both portal and in a batch file submission format. These web-based transactions will include but not be limited to: enrollment and provider record updates; requests for disenrollment; claims submission; claims and remittance history view; and questions for Provider Support. Providers will be able to submit claim status inquiries using the web portal, as well as by mail, telephone, fax, AVRS, or through the Provider Enrollment Tracking System.

Inform Providers About Electronic Transactions (Req. 8)

As we will with other provider notifications, those related to electronic claims submission, electronic remittance receipt, and electronic funds transfer can be posted using the provider portal, email, or postal mail, per BMS requirements for each provider's preferred method of communication.

Maintain Provider Portal and Post Remittance Advices (Req. 9)

Maintenance of and technical updates to the provider portal are addressed in our "Web Portal" section that follows. Provider service staff members will manage content updates. Provider remittance advices (scheduled by provider) will be posted automatically from finance to the portal. With the flexible design of our portal solution, banner messages can be designated by specific parameters tailored to different provider types. Messages appear on the top of the remittance advice statement that is posted electronically to the portal for view, print, or download.

Generate Paper Remittance Advices (Req. 10)

For those providers identified by BMS as requiring paper remittance advices, HPES can create a paper version of the 835-transaction data and mail it to the provider. We also will save the remittance advice as a PDF and attach it to an email if this is the preferred method of receipt.

Use Nontechnical Language on the Remittance Advice (Req. 11)

The base HPES remittance advice has been designed to present the data in nontechnical terms with a minimum of abbreviations and jargon. We also can add a BMS logo, provider services contact information, and configure the labels for columns and sections, per BMS preferences.

Provider 1099 Production

Produce and Maintain Provider 1099 Documents (Req. 12, 13)

HPES will process Federal Form 1099s efficiently, accurately, and promptly. Processing includes issuance to providers, submission of 1099 data to federal and state tax authorities, and issuance of special forms (such as "B" notices, that correct mismatched employer identification numbers). By following established HPES processes and employing BMS business rules, the WV-iC MMIS will process 1099 information and mail to providers meeting the IRS-established criteria by January 31, following the end of the preceding calendar year. Payments will be reported as medical and healthcare on the Federal Form 1099 MISC.

Using a secure file transfer protocol, 1099 files will be transmitted to the IRS (in required format) and also to the West Virginia Tax authority (using required format as needed). The process is coordinated by provider services and operationally managed by our Finance unit. Because creation of 1099s is system-defined, we can make accurate earnings estimates at any time during the calendar year for any selected provider cohort. This comprehensive 1099 financial process verifies sound BMS program management.

Provider File Maintenance, Update and Edit

Edit and Verify Provider Data (Req. 14)

The provider management business area plays a critical role in attracting and retaining providers in the Medicaid Program and providing the vital information required to validate that funds are paid to eligible providers for authorized services. We make a firm commitment to our customers that the provider registry is the source of truth for provider-based transactions. The WV-iC will enable efficient information update tasks and accurate internal transactions between claims, member and benefits, finance, TPL, and the other system components because the HPES project management data model was designed specifically to handle the complex data and relationships required for provider information management. It allows for the storage of a comprehensive amount of provider data, including data needed for the new CMS "anti-fraud" rule (CMS 6028).

The Wisconsin transfer system comes with multiple types and levels of data logic edits. These appear in the portal and user screens as tests for the following:

- **Format**—Such as the length of an NPI or tax ID
- **Duplication**—Such as a provider-requested update that has already been made
- **Appropriateness to provider type—**Such that facilities are not asked for gender and professionals are not asked for a facility license

The system's workflow or business rules tools carry the edit load for structural edits. For example, a business process rule can be created that requires a provider requesting a business name change to submit documentation from the West Virginia Secretary of State's business and licensing unit before the change can be processed.

Provide Online Inquiry and Update Access for BMS (Req. 15)

HPES meets mandatory requirement 3.1.37. Using role-based security procedures, authorized BMS staff members will have access to provider inquiry screens and then access to provider registry files. This access will be available nearly 24 x 7, except in cases where system diagnostics are occurring. Security can be granted at the file or field level as read-only or read-update capability.

Accept and Process Online Updates (Req. 16)

BMS will establish parameters (business rules) for online updates, including the fields available for update and how the update will be reviewed. Business rules will govern the review. BMS-authorized updates will include documentation in the provider's record, always captured in audit history and displayed as a record comment, a link to a repository document, or both. Provider-initiated updates that require BMS authorization will be governed by workflow rules. For example, a provider's service site address change may require BMS review and will be routed to BMS staff members as required. However, a change of address may not require BMS review but might require address verification by the provider update coordinator.

Enter Provider-Specific Payment Rates (Req. 17)

Rates and pricing arrangements are captured during enrollment and can be updated with BMS-approved direction. An example of the rate update process for Nursing Homes (NH) is shown in the following figure. Nursing home rates are associated with each nursing home and can be changed in a mass-update process that takes just hours to configure. What we show here in the Base Information NH Rate Communication panel is our ability to create transparency in the update and make available accurate data for the call center staff. The following figure of test data shows that the nursing home administrator received notification of a rate change on a specific date that the change will apply to the quarter starting January 2012. The figure also shows that authorization for the change came from state "Auditor K." The fields in these screens are configurable, fully reportable, and can be replicated for any rate type.

Provider Enrollment

The enrollment process is often the first contact that potential providers have with the West Virginia Medicaid Program. This experience can set the tone for a new provider's impression of the program and how it functions. A burdensome, complicated enrollment process can create a negative inference about the Medicaid Program, generating, from the start, a less-than-ideal relationship between the provider and BMS.

The WV-iC and operational changes that HPES brings to BMS will make a provider's first contact with Medicaid efficient, quick, and clearly understood. We have used MITA structures as a road map for our recent interChange MMIS enhancements, and our flexible solution incorporates automation throughout the enrollment process.

Starting with our Oklahoma implementation in 2003, HPES has a strong track record of helping state Medicaid programs move from paper-laden to more automated enrollment processes. We have created innovative semiautomated processes for our remaining legacy MMISs, and have enhanced our interChange systems with web-based and workflow-driven solutions. Our goal is to help our customers achieve e-application rates of 95 percent or better. At the same time, using configurable imaging tools, we continue to streamline the paper application process.

The HPES provider enrollment process is capable of enrolling Medicaid provider types defined by the BMS plus providers from whom we only receive cross-over claims. HPES will make sure that the provider registry is the sole source of truth for the system processes that involve provider data.

Enrollment and Workflow Tools

HPES provider portal wizards create a PDF document that is then sent to HP TRIM and, simultaneously, the healthcare portal populates some of that same data into the interChange provider base application database. The WV-iC workflow process business rules will control the enrollment process from the moment information touches the system. As an application moves through workflow and its status designation changes—for example, from "in credentialing review" to "ready for BMS review"—update information can be inquired on through the provider portal and the workflow user interfaces. Data is active in the system; that is, available for tracking and reporting. This type of flexibility allows HPES to monitor our own activities and promotes accurate reporting.

New enrollment data is sent to the WV-iC workflow tool, which accepts the new record and adds it to the task list for the HPES provider enrollment clerks. The provider's information is routed to the workflow database and its rules engine. The latter matches the provider type to a predetermined list of required documentation. This creates the provider enrollment checklist, which will be used throughout the enrollment process. Workflow rules then determine what happens with the application by directing the application and the enrollment checklist through the workflow tool to the most available HPES enrollment clerk. Additionally, routing can be controlled or redirected by the supervisor. When assigned, the clerk is responsible for completing the enrollment tasks defined by the workflow tool.

Because the WV-iC workflow management solution is integrated within the user interface components, the user can track the routing of an enrollment application, a recertification form, a disenrollment request, or an information update through the workflow work list panel. The following figure shows a typical panel. Each task in the work list has a status assigned to it. These statuses are assigned automatically by the workflow tool based on user activity.

generated in advance so that providers have adequate time to return re-enrollment information. The number of days in advance the notice will be generated and the number of notices that need to be generated are configurable based on BMS' needs. Although BMS may want to specify how many days in advance we generate the recertification notice, it has been our experience that most states use 60 or 90 days.

The re-enrollment notice reminds the provider of the pending renewal, describes what is needed to maintain continuous eligibility as a provider in the Medicaid Program, and describes what will happen if re-enrollment fails. After receiving the notice, a provider can re-enroll using the healthcare portal, use the portal to download a paper application, or, if the BMS permits, request a paper re-enrollment application by mail, telephone, or fax. Hard-copy and fax recertification forms are scanned into HP TRIM and associated with the provider's record.

Processing of a re-enrollment application or form mirrors the provider enrollment process, including BMS review and approval. The process is managed in workflow and credentialing is performed as appropriate by provider type. If a new trading partner agreement or electronic claims submission application has been submitted, it is scanned and associated with the provider's registry record, put into the workflow tool for validation and follow-up, so that at the end of a successful re-enrollment process, providers are notified by their preferred method of communication of the status of their re-enrollment application, re-enrollment status is entered into the WV-iC by an enrollment clerk, and the next recertification date is identified by the system and placed in the provider base record.

The flexibility of the WV-iC allows BMS several other re-enrollment strategies, including targeted and sampled re-enrollment. For example, providers on a program integrity "watch list" can be selected for re-enrollment annually or on another schedule, per BMS policy. This flexibility has been designed for the interChange solution as an appropriate response to the new CMS "anti-fraud" rules—also known as Rule 6028—that became effective in March 2011. Establishing business rules for re-enrollment is easily accomplished during implementation design. The strategy becomes one of several available on a drop-down list. Authorized changes in strategy selection, for an individual provider or a provider cohort, can be altered at any time by users with access to provider maintenance screens.

Support Online and Paper Enrollment for Providers (Req. 24)

Applicants can apply through multiple channels for permission to be a BMS provider—through the WV-iC healthcare portal and on paper, including mailed documents and fax. Our preferred enrollment channel will be through the secure provider portal. However, when hard-copy documents are received, HPES' automated tools enable a "green" process that will convert hard copy to electronic images and reduce the need for paper and time-consuming and costly document handling, routing, and storage. Because of known issues with copy clarity and the transmission security of protected personal information such as Social Security numbers, we do not recommend fax as an application submission mode. However, we can accept faxed documents in a secure physical environment and dedicated fax line that pushes faxed copy data directly to our scanning system.

HPES has made application through the healthcare portal a simple, secure, and highly efficient process. We estimate that use of the portal for e-applications will save BMS as much as two work hours per application compared to a paper-driven process. Further, based on our considerable experience, the use of workflow to streamline data entry and processing of paper applications can improve enrollment times by 50 percent to 75 percent. For example, it should be possible to finalize a "clean" professional application originating in the WV-iC portal within three business days. Implementation of the provider portal would be a notable achievement in BMS' move toward higher levels of MITA consistency.

As with the rest of the WV-iC portal, the online enrollment screens can be customized as needed through administrative panels or file updates. For example, cascading style sheets (.CSS files) control the look and feel of the WV-iC portal. Updates to style sheets distribute changes to each page in the portal.

Enrolling in the West Virginia Medicaid Program through the portal is a two-step process. An applicant or enrolled provider must first become a registered user of the portal to gain access to various user-controlled tasks, including online program enrollment. Registering for the portal is similar to registering for a secured financial institution's site. The user will select a user ID, password, visual token, and a set of challenge questions. This heightened level of security is necessary because of the personal and financial information entered and viewed using the portal. When registered, applicants can enroll in the West Virginia Medicaid Program by completing a wizard—guided online form—on the portal. The following figure is an example of a provider portal enrollment welcome page.

- The National Technical Information Service for DEA certification
- The CMS CLIA files for laboratory certification
- The National Practitioner Database
- The National Council for Quality Assurance (NCQA)
- The Joint Commission
- The West Virginia Secretary of State business licensing site
- State licensing boards
- West Virginia State Police (when criminal background checks are required)
- The West Virginia Bureau for Public Health

These external sources will be accessed using look-up and data exchange, depending on the source agency's IT capabilities. Within the enrollment and re-enrollment process, credentialing workflows are designed to support each aspect of credentialing and recertification. Workflow and business rules are configured with BMS staff members during implementation. Depending on the source, credentialing data can be manually entered after a website look-up, populated using an electronic interface, and associated with a provider's record as an electronic attachment. Regardless of the data capture method, the transparency and documentation capabilities of the WV-iC credentialing workflows facilitate HP supervisory review, BMS reviews, and research required for escalations and appeals.

Verify Annual Licensure Status of Licensed Providers (Req. 27)

HPES meets mandatory requirement 3.1.7. There are two industry-standard processes for licensure verification and HPES supports both—near-real-time data matching of source data and semiautomated site look-up. Using the configuration features of HP Exstream and the provider portal, licensed providers will be notified in advance that licenses must be verified. Notification can be synced up with each issuing agency's review cycle or can be set on a calendar year basis—for example, every June 15. Notifications can be preconfigured for an HP Exstream message-triggering process, and the review of licenses prepopulates a user's workflow task list. Annual licensure also can be included in some form of annual re-enrollment for targeted providers.

We will encourage providers to use the provider portal to submit an imaged copy of a current license. Paper submissions will be scanned and attached using the document repository to the provider's registry record. A provider enrollment analyst will verify license data with the issuing agent using the interface required by the source agency. Per BMS policy, problematic license data will be forwarded to program staff for review. If authorized by BMS procedures, providers with no license issues will have their license end date modified for an additional 12 months and will receive a notification of the next renewal date.

Verify Provider Federal Exclusion Databases (Req. 28)

HPES has been checking the Office of Inspector General (OIG) sanctions and exclusions databases since they were made available in the late 1980s. To these we since have added the NTIS DEA exclusions list. We also have been tracking the development and release this year of CMS Rule 6028 (the "anti-fraud" rule). Some components of the rule already exist in our interChange MMIS products, such as the capacity to capture data from criminal background checks. If BMS requires it, we know exactly which additional data elements need configuration to meet these new requirements and will work with BMS to implement them. The process of checking exclusion databases is built into the enrollment workflow. It also will be added to re-enrollment workflow and can be added to user task lists on any scheduled basis for any provider type.

Refer Provider Fraud, Abuse, or Exclusion Data to BMS (Req. 29)

As part of our due diligence protocols, and to conform with CMS Rule 6028, it is HPES standard procedure to flag, suspend, and immediately refer to BMS any enrollment application in which we discover an exclusion, fraud alert, or sanction. We also can prepare a monthly batch report, based on credentialing activities that summarizes results from queried external sanctions databases. We can add the report generation and distribution to the enrollment unit lead's automated work list. This protocol also is applied to the re-enrollment process.

Maintain Enrollment Documentation (Req. 30)

Specific documentation requirements will be determined during implementation. It has been our experience that original data from enrollment and re-enrollment applications (regardless of submission pathway) need to be retained for as long as 10 years, as do periodic provider attestations to the CMS Disclosure Questions set. We understand that paper storage can become unwieldy, and instead image the provider enrollment paper documents for online access in our robust electronic document repository. HPES also provides the capability to create paper copies of data that have come in through the portal. The electronic signature process in our healthcare portal meets CMS requirements.

Develop and Distribute Enrollment Materials (Req. 31)

As soon as a provider enrollment analyst hits the "submit" (or Save) button that indicates a provider applicant has been approved, the WV-iC will initiate a series of communications designed to welcome the provider into the West Virginia Medicaid Program. Our preferred approach will be to distribute notification letters, contracts, welcome packets, manuals, and other materials to the provider portal as messages generated by HP Exstream—including links to larger documents. Other materials include documents that enhance and promote more effective use of the portal. Document examples include how to access and use portal features, how to use AVRS, and quick-reference guides. Hard-copy material will be available for postal mail distribution. The development, periodic review, and preparation of enrollment materials will be described in the annual training plan.

Send Start-Up Packet to Accepted Provider (Req. 32)

Distribution of a new provider's start-up or "welcome" packet is triggered as soon as the application is approved. The welcome packet, which can be sent using the portal or postal mail, will include information needed to create a trading partner agreement for claims submission and other HIPAA transactions to test claims submission, commence electronic claims submission, and receive electronic remittance advices.

Assign Provider Numbers for Atypical Providers (Req. 33)

Following a successful enrollment decision (approval), the system will automatically assign a provider number to providers, including those with NPIs. This ID will be stored in the system in the assigned key table described previously. This ID enables multiple ways of searching for providers and makes it easier to locate providers with shared NPIs. The system-assigned ID will stay with that provider, as defined by name and tax ID, for as long as provider data is kept. We recommend that provider header screens throughout WV-iC be configured with the system-assigned ID and the NPI.

Provide Enrollment Reporting (Req. 34)

The WV-iC has robust reporting capabilities, and we will use these to create a weekly enrollment summary, including required business process metrics with provider name, provider number, and eligibility dates of providers terminated or suspended.

Receive and Maintain MCO Provider Information (Req. 35)

HPES maintains MCO provider rosters through a mass enrollment process that is capable of identifying participating and nonparticipating providers. Working with each MCO, we establish a data exchange protocol that is near-real-time or a batch process (roster transmission), depending on the MCO's capabilities. Precise configuration will be determined by BMS during implementation, and often includes full demographic and service location data, along with license information. The providers are enrolled with a status preferred by BMS—active, active non-participating, or MCO-only—and are linked to the MCO through their MCO's ID where the MCO is enrolled as a provider. Near real-time data entry entails an automatic population of provider record data fields. Roster transmission entails manual data entry. The roster is captured and stored as a source document in HP TRIM.

Provider Training

Provider satisfaction and retention are the fundamental results of a comprehensive, effective, and program-specific education effort by a highly qualified staff experienced in adult education techniques and knowledge transfer. The optimal benefit for a provider is the first-time submission of clean claims, which equates to faster claim processing, quicker payments, and simpler claims tracking. The benefit for HPES is the ability to rapidly respond to policy and program changes. The benefit to BMS is reduced intangible costs (such as provider frustration) and in the log run, maximum and efficient use of operational funds.

Provider Training Unit (Req. 36)

HPES will establish a Provider Services training team to serve the West Virginia provider community. This unit will include provider support representatives, a training and documentation specialist, and ongoing training development and delivery. The team will work with and act as backup for the Provider Call Center unit.

Manage and Conduct Provider Training (Req. 37, 38)

We will prepare an annual provider orientation, training, and education plan for delivery at a date specified by BMS. This training plan will be created with the customer and reflect input gathered from providers and their associations. It will include the number of monthly planned proactive provider visits, staff training, scheduled publications, anticipated workshops, target communications, and scheduled internal and customer-based meetings. We will provide the customer quarterly updates with activity data from the previous months. Topics will include the use of the provider portal and AVRS, claims submission, proper billing, prior authorization procedures, and other trading partner topics.

Provider training will be presented through various presentation methods. Coupled with regional on-site seminars and individual provider sessions, HPES has a full range of methods to offer BMS as it determines the best and most cost-efficient manner to bring knowledge to the provider community. Today's technology allows web-based information distribution and training as an efficient manner to distribute important policy information. For example, the WV-iC healthcare portal can make available self-paced learning modules and links to web-based seminars. HPES' extensive knowledge about local and national provider-related issues complements the inclusion of provider professional associations in the BMS provider training formula. Historically, provider professional associations have proved to be a valuable conduit to sharing state program messages for the provider community. We will work with BMS to determine which professional associates in the West Virginia community with whom to build relationships.

Offer Targeted and Specialized Provider Training Sessions (Req. 39, 40)

As part of our due diligence protocols, it is HPES standard procedure to flag, suspend, and immediately refer to BMS any provider with a claims activity that exceeds BMS-established levels for denials and suspensions. We also can place a "watch" on providers with a sudden increase in paid claims for a certain procedure or member. In both instances, our Provider Support team is experienced in making recommendations to BMS for remedial provider training and carrying out that training. We also will recommend training interventions for providers with a sanction that permits the provider to remain active in the program but with service or billing limitations.

Through daily interactions with our providers and stakeholders, we learn about issues foremost on their minds. It is through this grassroots issue identification effort that we recognize and define education and training needs and potential topics for provider bulletins and announcements. One of the main outcomes of grassroots issue identification is the need for individualized provider training, which we will include in weekly (or other schedule) recommendations to BMS. Our recommendations include delivery methods content and learning goals, metrics to determine training effectiveness, and follow-up plans.

Provide Annual Provider Training and Training for Designated Organizations (Req. 41)

We will provide at least one annual all-provider training session, which is a simple process using HP virtual meeting room tools. With BMS, HPES also will determine the training needs for major stakeholders, including the approximately 100 BMS MMIS users. In the past we have designed these annual training events around new program rollout, pre-implementation sessions on new billing policy, global rate and payment modifications, and system changes (MMIS users). Additionally, HPES has the capacity, with BMS approval, to bring in our national experts in CMS certification and ACA.

Deliver Claims Billing Training (Req. 42)

One of the most important call center tasks is to research and resolve provider billing issues. Billing issues fall into three categories: simple (such as "How do I bill for this?"), complex (such as changes to billing procedures like lab codes), and system-related (such as when a claims edit does not appear to be working). Call center staff members must know when and how to address each category. Indeed, more complex billing questions cause considerable worry for provider staff members, and when we can successfully resolve these issues with responsive training, we increase provider trust in the WV-iC and the whole West Virginia Medicaid Program.

Ongoing claims billing training is how we manage the volume and content of billing issues. With the self-help features available on the secure provider portal, we expect that most of the simple billing questions will disappear, which will free call center and provider support staff members for research and problem-solving on complex issues and system processing questions. We use web-based workshops, and self-paced documentation aides to address complex issues, where staff members work with content specialists such as a claims analyst. Group and individual sessions often are needed to work through system processing questions, and we will schedule these as needed and as approved by BMS.

Develop Provider Training Questionnaire and Process (Req. 43)

A robust and active quality improvement process is part of HPES' provider services operations. For training and other educational sessions, participants will be invited to complete a training evaluation at the end of sessions. Results from these evaluations will be used to determine the quality of training and guide us in recommendations for improvements and future training events. Results of these evaluations will be shared and discussed with BMS.

Maintain Records of Provider Training Participation (Req. 44)

The WV-iC is capable of creating several descriptive datasets to describe and store provider information. One which we will configure for BMS is a log or tracking list of provider education, in-service events, and training. This is besides educational credentials, which are stored with the enrollment application. We have created such a tracking tool for Medicaid and

commercial customers. Provider participation at various events can be recorded by field representatives and accessed for reporting by individual provider, by provider type or by defined provider cohort, such as HCBS providers.

Provider Publications

HPES will coordinate and produce provider handbooks, publications, and other provider communications. We will work with BMS to develop a formal process of reviews and approval steps. These steps will be defined and drafted during the Development, Testing, and Data Conversion phases and finalized during the Implementation Readiness Phase.

Write and Distribute Provider Materials (Req. 45)

We will create, print, and distribute or post to providers materials that meet industry, State of West Virginia, and BMS publication and printing standards. Whether printed commercially or in-house, provider materials will have the quality of commercial typeset–printed material. We will coordinate with the State during the development of printed materials and electronic media and submit such materials to the State for final approval.

Our approach to the development of provider outreach materials is multifaceted and includes soliciting input from BMS, providers, and stakeholders. It is through these grassroots efforts that we can identify education and training needs, and identify appropriate topics for provider bulletins, public service announcements, and enhancements to business processes. During the DDI Phase, we will work with BMS to develop materials that support provider use of the self-service tools available on the healthcare portal.

Continued review and enhancement of training materials will take place throughout the year to make certain that the training material produces optimum results with maximum cost-effectiveness. Each change to previously approved training material will be captured and historical files will be updated to track the development and ongoing enhancement of the material.

Create and Issue Provider Bulletins (Req. 46)

Our HPES team documentation specialist will create and issue quarterly bulletins for BMS. We will share existing publication processes across our existing MMIS accounts and bring the best practices that we have used successfully to deliver quality publications. Additionally, we will develop and submit for BMS an annual bulletin work plan. A review and approval process will be established including input from pertinent stakeholders.

Maintain Provider Manuals and Other Related Materials (Req. 47, 48)

Our goals for provider manuals maintenance are as follows:

- Communicate BMS-approved policy changes clearly and rapidly
- Respond to provider requests for clarity of a policy or the content of selected text
- Verify that manuals are current and readily available online

The HPES team publication coordinator will update and maintain user manuals throughout the contract. This information will be available to the provider community through the provider web portal, unless otherwise directed by BMS.

Our HPES Provider Services team will mail provider manuals or manual updates as instructed by BMS. For portal distribution, manuals will be available in PDF. For hard-copy and PDF manuals, appendices will capture old text and reference current modifications. We have found that adding a cross-referenced log of changes as addenda to manuals greatly enhances the provider's ability to see new policy and also to not lose the text from replaced policy. Original manual material is never lost.

The provider portal also will contain documents that enhance and promote more effective use of the portal—for example, how to access and use portal features, manuals and supplements, and how to use AVRS and quick-reference guides. The provider web portal also includes an area devoted to search for provider outreach material (such as provider newsletters) and a frequently asked questions section.

Provide and Maintain Web-Based Publications (Req. 49, 50)

Successful provider service requires HPES to deliver accurate information with a focus on provider self-service. We take seriously our requirements regarding BMS provider documentation and strive to make the provider portal the "go-to" place for policies, manuals, and other information. Web-based information and publications will be developed collaboratively with BMS, one outcome of which will include a schedule for publication review. Our annual training plan will include the communications and publications update processes.

Establish and Staff POS Pharmacy Provider Help Desk (Req. 1)

The HPES pharmacy (provider) help desk will be solely dedicated to BMS and serve no other vendor or customer. The HPES approach to customer service is based on HPES pharmacy business knowledge and applies the staffing strengths needed to offer pharmacy providers and prescribers advanced customer contact management. The HPES pharmacy help desk will be staffed by two trained and experienced HPES team members who will offer providers the following:

- Quick, accurate responses to inquiries
- Follow-up when promised or expected
- High-quality service from first contact
- Tools to be successful
- Special assistance when needed

Providers will be treated respectfully and professionally. As with members, providers will not be shuffled around from department to department as they attempt to find answers. Providers can expect smooth interaction at each level, from the call center staff to the provider services manager. The customer service staff members will be linked into the CTMS and interChange, allowing the customer service representative to work with different staff members in resolving the customer's issue. The HPES customer service solution offers an imaging, report, and document retrieval solution to allow for immediate access to program information necessary to respond to calls.

The customer service staff will receive comprehensive training before commencing work on the telephone lines. The staff members will receive specific training on benefit plan policies and billing procedures particular to their primary and backup skill sets. The call center staff also will receive training on "soft skills," such as effective communication with callers, appropriate methods for working with providers on the direction and focus of the call, and appropriate manners on the call.

Our point-and-click browser-based technology will allow users to easily navigate through the WV-iC. Call center staff members will log and track contacts with providers using the CTMS. Our call center staff members can quickly switch from CTMS screens to claim status, eligibility, and other required web pages and panels to address each caller's questions.

Maintain and Implement Preferred Drug List and State Maximum Allowable Cost Pricing Files (Req. 2)

To bring a combination of outstanding claims processing administration, clinical expertise, and analytical services for the State of West Virginia, HPES is proud to work with Goold Health Systems (GHS). We work with GHS on other HPES accounts. The clinical and technical services provided by HPES and GHS will deliver an integral component of pharmacy benefits management.

HPES will provide interface capabilities to GHS for the import and export of the Preferred Drug List (PDL) and State Maximum Allowable Cost (SMAC) data files. After the PDL data has been imported into the system, WV-iC will process drug claims against the PDL data file, supplied by GHS, to determine if claims should pay or deny. Drug claims submitted in the NCPDP format will be compared to the PDL database during adjudication. The interChange system will allow for easy maintenance of PDL changes or updates through the browser-based panel, PDL Master. HPES also will provide the ability to audit and review PDL information using the interChange reporting system. interChange accepts the download of NDC-level rebate data, and the data will populate the appropriate browser-based window as a PDL NDC. Supplemental rebates will be loaded to interChange rebate tables before quarterly invoicing.

SMAC updates imported by GHS will be integrated into the drug reference database for pharmacy claims pricing. The interChange POS function will be capable of supporting multiple pricing methodologies for pharmacy claims. Updates to SMAC pricing can be easily accommodated by the user-friendly interChange panels. The WV-iC system will provide the operational development and oversight of pharmacy-related operations including the platform for efficient maintenance and management tools for PDL and SMAC claims processing.

Maintain and Update Drug Reference File (Req. 3)

The WV-iC will use a comprehensive source for drug reference data, including legend, over-the-counter (OTC), and injectable drugs. First Data Bank (FDB) is a foremost authority in pharmacy pricing and information management. HPES has extensive experience working with FDB to produce the desired results in pricing accuracy and comprehensive drug reference information. HPES will employ the services of Medi-Span to provide the Average Wholesale Price (AWP) because FDB will no longer publish AWP after September 2011 as desired by BMS. HPES will use the file transfer process (FTP) across a secure website to receive the file weekly from FDB and Medi-Span. The batch update is first added to the UAT office environment for quality assurance processing by a member of the HPES team.

The WV-iC also will accommodate updates from other sources, such as the interface with the CMS drug rebate file or updates from BMS staff. Immediate updates or corrections can be made online in real time through user-friendly browser-based window. In this section, HPES meets mandatory requirement 3.1.13.

The POS drug reference file will be independent to BMS. HPES will develop and maintain the drug reference file to meet the specific needs of BMS. This reference data is used in claims processing for editing pharmacy and physician claims, DUR alert processing, reimbursement, and to support the drug rebate functions of the system. HPES will work with BMS and other vendors such as GHS to verify that the Drug Reference panel accurately displays the appropriate NDC-related information for accurate claims processing and reimbursement according to BMS-defined policy and in accordance with applicable federal guidelines.

The WV-iC drug data set includes the required data elements such as 11-digit NDC, brand and generic name, dates and specific indicators for NDCs to align drug coverage, claim processing, and pricing. HPES will work with BMS during the design task to identify drug attributes that are required for accurate processing of pharmacy claims. The system includes the injectable drugs listed by NDCs and the Healthcare Common Procedure Coding System (HCPCS) Level III codes.

With BMS, HPES will develop rules and criteria for accepting entries in the production database based on market entry data and criteria for end-dating drugs based on market removal dates or termination data from CMS. HPES will maintain the ability to cross-reference between the brand and generic drug name so that relevant information such as brand name, dosage form, strength, and associated pricing methodology will be displayed when generic names are used.

Correct Drug Data File Errors (Req. 4)

With the easily modifiable web panels in WV-iC, the authorized user can update the drug data file errors deemed critical by BMS in the two-hour time frame if the number of drug data file errors is within reason to be manually updated; otherwise, HPES will follow the appropriate change control procedures. The following reports can be generated from the FDB update process, listing the elements and changes that occurred in an auditable report to quickly identify and address potential errors loaded into the drug data file.

Reports Used in Drug Reference File Quality Assurance Process

Report Name	Feature
HIC Update Report	The information in these reports and the FDB Clinical Cumulative spreadsheet is used to assess what action is needed to appropriately add health insurance claims (HICs) or generic sequence number (GSN) to the benefit configurations and compare the additions for policy enforcement of edit or processes that use these elements.
Generic Sequence Number Update Report	The generic code number (GCN) sequence number update report lists additions and updates of the GCN sequence number.
Terminated and Obsolete Update Report	The terminated and obsolete drug report lists NDCs that have been reported on the weekly FDB file as newly terminated or obsolete when compared to the drug table during the week.
Drug Detail Update Report	The drug detail update report lists critical data elements updated that must be reviewed by the pharmacist. These are the data elements that are typically used to determine impacts to coverage rule classification. The drug detail update report lists changes to NDC data on the FDB weekly file.
Drug Detail Add Report	The drug detail add report lists critical data elements added for a new drug that must be reviewed by the pharmacist. These are the data elements that are typically used to determine impacts to coverage rule classification. The drug detail update report lists changes to NDC data on the FDB weekly file.

When reviewed and corrected for potential data file errors, HPES will promote the file to the production environment and claims will begin processing against the updated data immediately. HPES will provide BMS online access to the master drug data files and access to changes that will be used to update the master drug files. Audit trail reports that list updates, deletions, and changes to the database are available in the system when manual, online updates are made.

Maintain J-Code/NDC Crosswalk (Req. 5)

The Deficit Reduction Act of 2005 (DRA) includes new provisions regarding state collection and submission of data for collecting Medicaid drug rebates from manufacturers for physician-administered drugs. Section 6002 of the DRA adds section 1927(a)(7) to the Social Security Act (the Act) to require states to collect rebates on physician-administered drugs.

HPES pharmacy and drug rebate accounts maintain and use a multisource version of the J-code/NDC crosswalk, providing a resource tool for claims processing and drug rebate invoice claims reconciliation and review. The HPES Pharmacy team's crosswalk is associated by a relationship of the procedure code—J, S, and Q codes—to a corresponding GCN sequence number. The crosswalk can be used in editing to confirm that the provider has included an appropriate NDC for the procedure code being billed. As an editing tool the crosswalk, provides a validation that the correct NDC is being submitted and is intended to reduce the rate of disputes from manufacturers in the drug rebate process.

The HPES Pharmacy team will update the J-code NDC crosswalk panels in the interChange system after the drug data file upload each week from FDB to verify that non-pharmacy claims will be appropriately edited, processed, and paid in alignment with BMS and federal policy and guidelines. The interChange system will accept NDCs on non-pharmacy claims such as outpatient, professional, institutional, and Medicare crossover claims.

The following claims processing edits help confirm that providers comply with this mandate. These edits can be changed to meet BMS' precise intent:

- NDC qualifier is missing or invalid
- NDC is missing or invalid
- NDC units of measure are missing or invalid
- NDC quantity is missing or invalid
- NDC and J-code are mismatched

During the drug rebate invoice cycle, the NDC and associated claims information is extracted for rebate purposes. HCPCS, also referred to as J-codes, can be invoiced with pharmacy claims in the invoice cycle or invoiced separately. Drug rebate claims-level detail used to resolve disputes identifies professional, institutional, and crossover claims to allow for easier identification of aberrant data. interChange also maintains a second crosswalk that is used by the drug rebate functional area to convert J-code units to the appropriate NDC units because there are hundreds of instances when the unit of measure is different. Again, this is intended to reduce the rate of disputes from manufacturers in the drug rebate process.

Change Online NDC Drug Records (Req. 6)

With the easily modifiable panels in the proposed browser-based WV-iC system, NDC drug records can be updated within one business day if the identified number of NDC errors is within reason to be manually updated. Otherwise, a system-generated process can be created and approved by BMS to efficiently and accurately update numerous NDC records.

Maintain Drugs Identified for the Auto-Prior Authorization Process (Req. 7)

BMS' award to pilot a new automated pharmacy prior authorization technology through the CMS Transformation Grant demonstrates the desire of West Virginia to acquire new health IT services to better serve its members, stakeholders, and providers.

HPES meets mandatory requirement 3.1.35. With the CMS-certified interChange system, BMS will acquire a state-of-the-art auto-prior authorization system, DUR+, with established processes and tools to efficiently integrate into the WV-iC POS pharmacy system using NCPDP D.O Standards. The DUR+ auto-prior authorization system will be available 24 x 7, except for scheduled maintenance. HPES will implement DUR+ as an auto-prior authorization solution for BMS pharmacy POS services and will maintain and update drugs identified by BMS for the auto-prior authorization process. DUR+ automates the process of matching prior authorization criteria with clinical information and member claim and drug history to determine the most clinically appropriate, cost-effective therapy. DUR+ offers the following benefits:

- Is an interactive, instantaneous process that effectively reduces costs and workload
- Does not just pay a claim based on criteria, but creates an authorization that has established units and mimics a manual process, bypassing the need for provider calls and follow-up
- Clinical criteria created and maintained through user-friendly online web pages, providing added flexibility to support new policy requirements
- Is a fully integrated component of the MMIS allowing for tighter management of the prior authorization process without increasing the administrative workload

Fully integrating the DUR+ features in the HPES POS system within the adjudication process minimizes the administrative burden on providers. Provider intervention is necessary only when the claim fails the DUR+ process; in this case, the provider is advised to request a prior authorization. DUR+ offers the following features:

- **DUR+ Criteria – Age—**The Age Criteria step in the DUR+ evaluation logic provides parameters to be set for age allowances or establish a prior authorization based on the member being within a specific age range—for example, Ditropan XL for members between 6 and 18 years of age.
- **DUR+ Criteria – Diagnosis Primary—**The Primary Diagnosis Criteria step in the DUR+ evaluation logic provides parameters to be set for included or excluded diagnoses. An included diagnosis allows for a drug to be authorized for an appropriate use. An excluded diagnosis prevents an authorization from being created if it would be considered contraindicated. As many as three individual diagnoses or a group of diagnoses representing a series of codes can be applied. Diagnoses are obtained directly from historical physician and institutional claims—for example, use of COXII in rheumatoid arthritis versus osteoarthritis.
- **DUR+ Criteria – Step Therapy 1—**The Step Therapy 1 Criteria step in the DUR+ evaluation logic creates an automatic authorization based on previous drug history. Line One Drug Therapy can be included or excluded as follows:
  - Inclusion may be used for a step therapy type of prior authorization. For example, criteria for authorizations of a new family of non-steroidal anti-inflammatory drugs (NSAID)—COXII—require previous use of two different NSAIDs. DUR+ allows for inclusion of a Therapeutic Class Group (GC3) and can count two different GCN sequence numbers out of the Therapeutic Class Group within a specified time period. The criteria count will look for the number of distinct GCN sequence numbers in the member's claim history. The criteria count cannot be greater than the number of criteria used.
  - Exclusion may be used for a situation where concurrent use of specific types of drugs may be contraindicated with the DUR+ drug. For example, the DUR+ may be for Central Nervous System (CNS) stimulants. It is not necessarily appropriate for a member also to be receiving a CNS depressant. With exclusion, the CNS depressant GC3 can be excluded as first- or second-line drug therapy.

  Step therapy can be set to look at a policy-specific number of days in history.
- **DUR+ Criteria – Step Therapy 2—**The Step Therapy 2 Criteria step in the DUR+ evaluation logic provides the same fields and field definitions as Step Therapy 1 Criteria, except this panel is specific to Line Two Drug Therapy. The Step Therapy 1 and Step Therapy 2 panels can be used to link an "included" Line One Drug Therapy and an "excluded" Line 2 Drug Therapy. The excluded Step Therapy 2 drug might be contraindicated with the Step Therapy 1 drug, so a member should not receive that drug. Claims will look at the member's drug history, and if history claims contain the drug specified in Step Therapy 1 but not the drug specified in Step Therapy 2, the current claim is considered for payment, and an auto-prior authorization is granted. If the member's claim history contains the drugs specified in Step Therapy 1 and Step Therapy 2, the claim will deny and require a manual prior authorization review. For example, the State does not want to authorize payment for two long-acting narcotics. If a long-acting narcotic (Line 1 drug) approved and paid, the DUR+ system will be coded to deny the second long-acting narcotic (excluded Line 2 drug) if filled within 30 days of the first long-acting narcotic. These specific parameters can be state-specific.
- **DUR+ Criteria – Co-morbid—**The Co-morbid Criteria step in the DUR+ evaluation logic allows for specificity to the medication dose and the consideration of a co-morbid condition. A co-morbid condition is having two or more disease conditions that occur simultaneously within the same person. This panel establishes a review for related disease states and indicates whether the diagnosis is included or excluded—for example, COXII may be included if the member has a diagnosis of gastric hemorrhage and the required first-line drug therapy of NSAIDS would be contraindicated. Alternatively, CNS stimulants may be excluded if the member has a history and diagnosis of drug abuse.
- **DUR+ Criteria – Taxonomy—**The Taxonomy Criteria panel establishes the prior authorization based solely on the prescribing practitioner specialty. For example, an auto-prior authorization is generated for a 5HT3 receptor antagonist drug, such as ondansetron, if the member does not have a diagnosis of cancer but the prescription is written by a provider with a taxonomy of hematologist or oncologist.
- **DUR+ Criteria – Grandfather—**The Grandfather Criteria step in the DUR+ evaluation logic can create a new auto-prior authorization if a previous manually reviewed and entered prior authorization has expired or is close to its expiration. The grandfathering criteria allow for each criterion to specify how soon before or after a prior authorization must have existed to trigger the creation of a new authorization. The grandfathering criteria will compare the date of service on the claim to the existing prior authorization in the system. A new authorization is created if the specific criteria window falls within the date range.

When interChange electronically captures the transaction, a message is sent to the provider giving direction for follow-up regarding the prior authorization request, including the appropriate telephone or fax number for appropriate routing of the prior

authorization request. Claim transactions that fail because of a "prior authorization required" status return the corresponding NCPDP reject code and supplemental information with direction on how to contact the pharmacy help desk.

BMS contracts with the West Virginia University School of Pharmacy Rational Drug Therapy Program (RDTP) for prior authorization services. HPES will successfully integrate the WV-iC solution within the RDTP-required roles and functions to provide a cohesive tool that will provide access to the needed online resources to support and improve RDTP's role in the pharmacy prior authorization process.

interChange's solution enhancements will provide the ability to access and modify prior authorization records with appropriate user security. Authorized staff members are provided access to prior authorization records for modification using the online WV-iC MMIS browser-based windows. Access to this information is determined based on security profiles and job functions. Online updates made through these windows are subjected to data validation and verification editing to verify data integrity within the prior authorization database tables. Additionally, updates are automatically captured in audit trail tables for viewing online. The interChange system is designed to assign system-generated, unique prior authorization numbers regarding prior authorization requests. Additionally, the prescribing provider ID, dispensing provider ID, and member ID are part of the interChange prior authorization data set and are displayed in the prior authorization browser-based windows.

Editing will be performed on pharmacy claims to verify that a prior authorization record exists for the patient and the type of service, or the claim meets prior authorization requirements before the claim can be approved for payment. Additionally, editing can require a diagnosis to be present on the claim as a condition for payment in place of prior authorization or besides prior authorization. When a claim requires a diagnosis, the system is capable of interrogating as many as nine occurrences of diagnoses on an incoming claim, editing on each separately or dependently.

The interChange system has the ability to identify a drug requiring a prior authorization by any one or combination of criteria. Users access the Prior Authorization Maintenance browser-based window to determine if a drug requires a prior authorization. The prior authorization criteria can include the following:

- GCN, GCN sequence number, HIC, GC3, or individual NDCs
- Procedure code
- Diagnosis code
- Program
- Dates of service
- Age
- Gender

The WV-iC POS claims processing and prior authorization components are fully integrated—claims are processed with current prior authorization information. Claims processing is predicated on interactive updates to the database that are accessed during adjudication. After the prior authorization approval is generated, the database is immediately updated with the approval. Because interChange is a true relational database and MITA-aligned, the claims adjudication process simply accesses the prior authorization tables to determine if approved prior authorizations exist for the billed service. The system provides online-updatable tables in various system functions, including prior authorization. These tables provide flexibility and a more accessible means to make updates based on the State's Medicaid program changes.

WV-iC will help West Virginia members receive timely authorizations for services while allowing BMS to control expenditures. The interChange prior authorization system provides the following capabilities:

- Online maintenance of program-specific information by benefit plan
- Easy entry and update of prior authorization information
- Multiple input methods, such as standard HIPAA transactions, automated voice response, and fax
- Online maintenance of prior authorization information
- Ability to pend transactions for additional information
- System-generated notices
- Accurate editing to support program policy
- Fast access to status and approval and reduced response time to providers
- Real-time processing

Provide Direct Access to the Prior Authorization System for Help Desk Staff (Req. 8)

The WV-iC will provide support to the following pharmacy prior authorization processing functions to verify that West Virginia's members receive timely authorizations for services. The help desk staff will have secure online access to the pharmacy prior authorization claims information. With the user-friendly point-and-click feature of the interChange system, help desk staff members can easily retrieve and update prior authorization information to successfully respond to real-time provider requests. The HPES interChange system can accommodate and electronically manage faxes, telephone requests, or online requests. Faxes can be systematically scanned and delivered to the workflow manager. Each fax can be time-stamped and presented in the queue in the order in which the faxes are received.

deletions. After BMS approval has been received, changes will be moved to the production environment. The following table includes some of the many benefits and features of the reference files maintained within the WV-iC.

Reference Key Features

Benefit	Feature
Reliable system performance, integrity, and flexibility	• Provides BMS the benefits of investments made by HPES staff members to establish user-configurable functions that provide choice and reflects industry best practices • Flexible rate-setting configuration that allows effective disbursement of funds and overall cost containment coordinated and tailored for BMS policy objectives, and enables greater flexibility in the customization of rates for services based on provider types, benefit plans, and other criteria
Ease of use	• The WV-iC methodologies keep simple tasks simple. This approach enables users to make and apply complex updates intuitively and simply, without unnecessary steps or complications.
Reduces administrative time and expenses	• Online, real-time web panel reference changes reduce program costs and contribute to accelerated implementation of new or changed policy. • Maximum user configuration capabilities are provided without technical intervention, which reduces implementation time and cost. • Online audit trails capture changes made to reference data records by user ID, date, and time stamp for future research and reference. • Linking related and historical data within the system increases ease of use by reducing search and policy evaluation time. • Providing one set of reference tables for the processes to access in real-time mode allows for updates to be used immediately, enabling BMS to realize maximum fiscal impact of changes made. • By allowing accelerated implementation of policy changes in claims processing administration, this feature incorporates the use of interface update files including ICD-9 diagnosis from CMS, ICD-10 diagnosis when released, ICD-9 procedure update from CMS, DRG data, HCPC update, and revenue codes.

Reference file code mappings and cross-references also will be maintained within the WV-iC, providing BMS with valid and invalid code combinations. The following are a few examples of code mappings and cross-references that will be available on the WV-iC web panels: procedure code to diagnosis code mappings, cross-references between HCPCS and ICD-10 procedure codes, ICD-10 procedure codes to Current Procedural Terminology (CPT) codes, and revenue codes to CPT codes.

Provide Online Inquiry and Update Capabilities (Req. 2)

The HPES team will provide authorized BMS team members with direct online inquiry and update capabilities to reference file information stored within the WV-iC. We meet mandatory requirement 3.1.37. The system will provide role-based access for authorized users, providing controlled access to the data at individual and group security levels. Users with inquiry-only access to the WV-iC will be able to browse reference information through easy-to-use navigation features inherent within the WV-iC web panels. Authorized users with update authority on the WV-iC reference database will be able to add, delete, or change reference files as requested by BMS.

The following reference files reflect an example of the subset of the reference database users will have inquiry and update access to:

- Prior authorization requirements
- Revenue codes
- DRGs
- ICD-9/ICD-10 diagnosis codes
- HCPCS codes
- Modifiers
- EOBs
- Pricing file
- CPT codes
- Edit and audit criteria
- ICD-9/ICD-10 procedure codes

Within the reference web panels, the user can enter the reference data into the inquiry fields and select the search button. Available information will be retrieved from the reference database and presented on the web panel to the user. Authorized

Perform Mass Reference File Updates (Req. 4)

With years of experience in working with MMIS reference files, HPES has the know-how to perform mass updates from multiple sources to the reference files using industry-proven update procedures. Whether BMS has specified a large or small volume of updates to the reference files, HPES has a developed process to handle these requests through batch or manual updates. The HPES team will follow these proven procedures when accepting and processing mass updates to the reference files:

- The reference file updates will be specified by BMS and loaded systematically or manually into a test environment.
- Reports listing new reference file updates will be produced for BMS and the HPES team to review and BMS to approve.
- After BMS approval has been received, updates will be moved to the production environment on a schedule approved by BMS. To accurately identify updates to the master reference files, the WV-iC will sequentially read the reference file and apply the updates.
- Quality assurance analysts from the HPES team will complete postproduction verification of reference file updates through the online web panels or by reviewing the reference file update reports. When new updates are added, historical information will be end-dated and not deleted from the WV-iC.

Provide Required Reports and Listings (Req. 5)

The WV-iC solution will provide BMS with the required reports and listings of information stored on the reference files. The reference file report function will contain a core set of reports that will be tailored to meet the business needs of BMS and assist in the overall management of program operations. These core interChange MMIS reports, combined with the custom West Virginia reporting requirements defined during the Design Phase of the implementation, will be produced systematically on a frequency approved by BMS and made available using the HP TRIM reporting application. The HPES solution will provide BMS with listings of procedure code, diagnosis code revenue center code, medical criteria, and other reference data files based on variable, BMS-defined select-and-sort criteria.

Accept and Process Online Updates (Req. 6)

The WV-iC solution will accept and process online updates. Online updates that are smaller in volume will be completed by authorized users whose role provides appropriate access to the reference database and permission to add, delete, or change information as requested by BMS. For the updates, online edits will be applied to protect the integrity of the data. When complete, additions, deletes, or changes to the reference database will be verified by a reference data maintenance analyst. To complete this task, the analyst will review the online web panels or a reference file update report. If information was added in error or needs to be changed, the analyst or user with update authority on the reference team will make the correction and reverify the changes.

Within the WV-iC web panels will be "notes" sections that will allow for the tracking of changes entered by a user. The following figure provides an example of a text box on the WV-iC where users can add free-form text. HPES selected an error code web panel to illustrate this feature.

adjudication process and verifying processing timeliness requirements are met. The following defines the XXCCYYJJJTSSSSS format of the ICN:

- XX—Region code
- CCYY—Current century and year
- JJJ—Current Julian date
- T—Claim type number
- SSSSS—Sequence number, based on claim region/type

The WV-iC system ICN assignment process provides for intelligent tracking of claims from receipt to final disposition and also provides inventory and claims control reporting. We provide report examples in our response to Requirement 9 later in this section. HPES will work with BMS to gain approval of our methodology for maintaining a claims control and inventory system using the existing capabilities within the proposed WV-iC system.

Enter Electronic Media Claims in HIPAA-Compliant Format (Req. 2)

The WV-iC system accepts the entry of electronic media claims in the appropriate HIPAA-compliant formats and allows providers to submit claims and transactions electronically and through the healthcare portal. WV-iC supports the following HIPAA-compliant claim standards:

- ASC X12 837-P Professional Claim
- ASC X12 837-I Institutional Claim
- ASC X12 837-D Dental Claim
- NCPDP Retail Pharmacy Claim

As the largest government healthcare processor in the nation, HPES fully supports the accepted healthcare standards, including HIPAA. This includes data, transaction, privacy, and security. We take these standards into account as we design our systems and implement our customer-driven requirements. HPES team members participate broadly in many standards groups, including X12, NCPDP, HL7, and CAQH. We bring these standards into our development processes and customer communications to verify that our systems continually evolve to support the changes in these standards as they occur.

Verify Integrity of Claim Billing (Req. 3)

Traditionally, only pharmacy claims have been submitted interactively, with pharmacists submitting claims at the POS and receiving an instantaneous adjudication response. This adjudication included edits, audits, prospective drug utilization review (proDUR) alerts, copay deductions, and pricing.

With the implementation of WV-iC, BMS can offer this capability to providers for multiple claim types. WV-iC offers authorized providers the opportunity to access a secure website, through Internet service provider (ISP) or direct dial-up, submit any claim type for processing, and receive an immediate, full response, including adjudication and pricing—while maintaining the integrity of the claim data.

Authorized providers access the healthcare portal and complete an online claim form. On submission, the claims are transmitted to the WV-iC claims processing engines and assigned a unique ICN. Claims submitted in this manner pay or deny, similar to pharmacy POS. With a denied claim, providers can make the necessary modifications—for example, adding a missing units field and resubmitting the claim. The system assigns a new and unique ICN to the claim. It is then fully adjudicated. WV-iC edits each claim as completely as possible during the online edit or audit process rather than ceasing the process when a failure is encountered. This capability prevents providers from having to resubmit claims after each edit or audit failure.

The OPEX AS7200i eliminates the need to transport, batch, prep, and sort between extraction and scanning. In just one pass, letters, checks, claims, forms, legal-sized documents, and file folders can be scanned intermixed with little or no preparation.

For those providers who prefer the traditional batch submission approach, the EDI engine also provides a secure, encrypted method for billing. The healthcare portal eliminates bulletin boards and asynchronous protocols that do not meet the stringent security demands of private health information. However, we understand that not all providers contract with an ISP because of cost or business reasons. To support these providers and offer a method for batch claim submission, we establish a bank of remote access servers that providers can access directly without giving them access to other Internet sites. By using the ISP or remote access servers, providers have a secure mechanism by which they can upload batches of claims for billing. Providers submitting claims in batch mode receive immediate ICN assignment and claim adjudication. Within minutes, providers can inquire on submitted claims, determine if the claim was denied or paid, and determine the amount of payment. Providers have the same option to correct denied claims from the healthcare portal and resubmit the claim.

Assign Unique Control Number (Req. 4)

As valid, complete claims are loaded into the online OPEX folders, they are prepared for the SunGard FormWorks OCR process. Through the OCR process, each claim is indexed in the HPES TRIM electronic document management system (EDMS) and assigned a unique ICN to identify it in the system and on the provider's remittance advice after adjudication. The WV-iC system provides intelligent tracking for each claim and adjustment through assignment of this ICN. The ICN assignment process for the WV-iC system provides for intelligent tracking of claims from receipt to final disposition. Other document types—such as attachments, service authorization requests, and correspondence—receive their own unique control numbers.

The OCR function takes advantage of SunGard recognition software called FormWorks, which captures printed characters and handwritten text. Certain forms, such as the UB-04 and CMS-1500, are printed in red "drop out" ink, which enhances OCR processing. FormWorks includes editing against the WV-iC provider and member information, procedure, diagnosis, revenue code, and NDC files. This editing provides for improved accuracy of paper claims and prior approvals and helps prevent them from suspending. If the OCR component cannot read a form, it is sent to the Data Entry team to be verified and entered manually and then released into the WV-iC for entry into the Workflow Management System.

After a document is scanned, the image file output by SunGard is captured by HP TRIM, which is not limited in the document types it can accept. Authorized users of the system can pull up imaged documents as needed. Our system presents the user with a link to the associated documents. When the user clicks on the link, a web service calls the HP TRIM document management system to retrieve the appropriate document and present it for viewing or printing to the authorized user.

Perform Data Entry of Hard-Copy Claims (Req. 5)

Using the innovative OPEX scanner that will feed most claims and forms to be processed directly to the SunGard FormWorks system reduces the need for a significant amount of data entry. Our Claims Data Entry staff members will process forms and claims that are unable to be scanned. We have staffed this unit based on the volumes indicated in the Bidder's Library.

Pre-Screen Hard-Copy Claims (Req. 6)

After delivery to the mail room, mail is processed by the scanning clerks using the OPEX AS7200i high-volume production scanners. While typically the mail room data preparation clerks would sort mail by claim type, the use of the OPEX scanner eliminates a significant portion of this time-consuming manual process. The scanning clerks simply load the mail onto the mail extraction desk. The documents are then fed through a unique feeder that is capable of handling the widest range of document sizes, shapes, and thicknesses. After the documents are in the feeder, the scanning clerk uses a touch screen to indicate whether the document is an odd size, and the claims and attachments are directed to their appropriate claim folders. A second scanning clerk sits at a computer screen to assist with necessary further clarifications using hot keys to classify—for example, Universal Billing (UB) form with attachments from UB single or UB Crossover.

The OPEX AS7200i scanner, depicted in the following figure, virtually eliminates the additional preparation and postprocessing tasks associated with conventional document capture.

interChange System Checks

Action	System Checks
Verify the member is eligible for the services billed	Member file
Verify the provider's eligibility to perform the service billed	Provider file
Confirm that the services billed are covered during the date of service and that they do not conflict with any services previously billed	Reference file for diagnosis and edit and audit disposition
Verify that a prior authorization exists when required	Prior authorization file
Verify that other payers have been accounted for in the claim payment	TPL file

Claims in the WV-iC will process in real time, in a single pass, and can be expected to be in the claim engine for seconds, not minutes. Sequencing will occur in the processing, including member editing, provider, benefits, contracts, pricing, auditing, and disposition. Our user documentation will detail these processes. Business analysts will use the proper browser pages and the rules engines to configure the appropriate parameters—such as member-related pages, provider-related pages, BPA coverage, contract and reimbursement rules, audit rules, and disposition criteria. Each will be available, searchable, and reviewable within the appropriate configuration windows.

Propose Edit Criteria (Req. 15)

Claims suspense resolution will be a key component of the WV-iC claims business function. The claims business function will perform rigorous claims editing and auditing, based on BMS' policy and rules, to determine whether claims should be paid, suspended, or denied. The WV-iC's edit and audit process will be optimized for automated first-pass claims processing, including business intelligence for multiple same-day surgeries and duplicate and suspect duplicate checking, depending on BMS' specific criteria and requirements.

During duplicate auditing, the system reads the history that overlaps the dates of service of the current detail. The system performs the exact duplicate and the suspect duplicate audit for each history detail obtained. While the system uses numerous tables in provider, reference, member, and prior authorization for editing, users can customize audits online through a series of easily updateable audit criteria pages.

HPES will work with BMS to propose and define new editing or auditing criteria to include duplicate or suspect duplicate and criteria or procedures for adjudication of claims. We will work with BMS to implement customized editing as needed. Having worked with more than 20 state Medicaid programs, we often learn of new and innovative editing criteria being used by one of our states and will then bring this to BMS for possible inclusion in the WV-iC if approved.

Implement Approved Edit Criteria (Req. 16)

Claims will be subjected to system edits to verify that they comply with West Virginia Medicaid policies and medical criteria. Validity editing of claims will be part of the WV-iC. HPES will implement the approved edit criteria, and claims will be edited against provider, member, and reference data files as part of the claims processing function. The WV-iC will edit data elements on the claim for required presence, format, consistency, reasonability, and allowable values. Edits perform quality control checks in data fields for alphanumeric values, high or low range checks, data validity, and timely filing.

Propose and Process "Special" Claims Adjudication (Req. 17, 21)

We will work with BMS to verify the WV-iC is set up to incorporate BMS' existing edits and audits to include special adjudication rules or policies. This edit criteria will consider the current process to allow authorized users—with BMS' approval—to set criteria allowing claims to bypass the enhanced claims editing component based on various factors including dollar thresholds, member of provider-specific criteria, medical coding, and other as defined by BMS during DDI.

The WV-iC will have the capability to allow for processing of special claims through manual entry to include, for example, late billing, member retro-eligibility, adjustments, mass adjustments, and edit overrides in accordance with BMS instructions and for situations defined by BMS.

Review Suspended Claims and Override Claim Edits (Req. 18, 19)

The WV-iC offers many features and benefits that effectively support the claims processing business function. Claims will be systematically and, when appropriate, manually reviewed during claims adjudication per BMS specifications.

Suspended claims resolution involves the following activities:

- **Data correction—**For paper claims, incorrect data will be changed if the error resulted from a keying or scanning error. When corrected, the claim will continue through the adjudication process.
- **Manual pricing—**Price will be assigned by the Resolutions team based on the complexity of the service and using BMS-defined applicable pricing policy.
- **Forcing or overriding an error—**Claim edit will be overridden and forced to pay based on documented exception criteria and in accordance with BMS-approved procedures and guidelines.
- **Denying a claim—**Claim will be denied because the error cannot be corrected without additional information from the provider, and the error cannot be overridden per BMS rules.
- **Referring a claim—**Claim will be forwarded to another location for further review and adjudication determination.

Claims that fail the edits and audits that are not set to systematically deny will be suspended and routed to the appropriate system claim locations for manual review and further processing. These locations will determine whether the claims are referred to an HPES or a BMS Resolutions team member to resolve. Based on the results of claims editing, auditing, and pended resolution, a claim will be paid, denied, or suspended for further review and processing. Paid and denied claims will be forwarded to the financial function for processing in the weekly financial cycle. Claims suspended for further review and processing will go to claims resolution specialists, medical review, or to BMS for additional review.

Claims resolution in the WV-iC system will be primarily a paperless process performed online in real time. The claims resolution specialists will work with a split screen that displays the claims data that was entered into the claims processing system and an optical image of the claim that was submitted for processing. The Resolutions team will have access with point-and-click navigation to various data that may be needed to verify information on the claim. The WV-iC will be a rules-based system that allows claims to be suspended and systematically or manually reviewed based on criteria provided by BMS. Suspended claims will be systematically or manually released or overridden based on BMS guidelines. After claims have been reviewed by BMS or the HPES staff, they will be adjudicated in the next available daily cycle. We meet mandatory requirement 3.1.38—HPES will verify that adjudicated claims cannot be changed outside an approved adjustment process. After a claim is adjudicated and in a final status, the information will remain static and will be displayed in its entirety in the system.

Adjudicate Suspended Claims (Req. 20)

Claims that fail any of the edits and audits that are not set to systematically deny will be suspended and routed to the appropriate system claim locations for manual review and further processing. These location codes will be set up to allow the system to determine whether the claims are referred to an HPES or a BMS Resolutions team member to resolve. The location codes will be set up during DDI and implemented according to BMS-approved criteria. These location codes will allow the edits to go directly to BMS or HPES staff members for review and processing and provide a capability for the resolutions clerk to forward to a BMS or an HPES staff member should the need for further review be required.

Perform Keying and Problem Claim Resolution (Req. 22)

We have carefully reviewed the Bidder's Library and appropriately sized our Data Entry unit based on the information provided. This will allow us to perform keying and problem claim resolution services on short notice using the proposed system. This service will be provided within the same business day for priority items.

Price Claims in Accordance with BMS Policy (Req. 23)

HPES meets mandatory requirement 3.1.14—providing a system that will support multiple programs and plans including the addition of any other state agency, U.S. territory, or political subdivision. Payment rates are at the core of MMIS claims processing. The HPES interChange BPA function will accommodate the complexities and size of the West Virginia Medicaid Program. It will be a true multipayer benefit plan solution, featuring internal coordination of benefits between payers and benefit plans administered under the fiscal intermediary contract.

The process of adding new programs and rates will be table-driven, allowing BMS to expedite implementation of new programs or rates without experiencing the costs and time delays typically involved with a system development and installation project. The benefit plan functions of interChange have proven successful for Medicaid programs, including Pennsylvania, Oklahoma, Kansas, Florida, Georgia, and Wisconsin.

WV-iC rules management will allow trained authorized users to identify, create, refine, and maintain business rules that effectively capture and enforce medical policy. Within WV-iC, various business rules will govern each claim processed—billing rules from policy and contracts, coverage rules from benefit plans, and reimbursement rules that will determine how to price and pay the claim. The disposition of edits associated with business rules will determine whether to pay, suspend, or deny claims, according to BMS policy on how each service should be paid.

The WV-iC will have a robust claims pricing system that will be driven by user-updateable tables, such as fee schedules, provider-specific rate tables, and member cost-sharing tables—for example, patient liability, member spend-down, and copayment—and TPL tables. These tables will provide the WV-iC system with the data necessary for calculating the appropriate claim or detail payment for each service according to BMS rules and limitations applicable to each claim type, category of service, and type of provider. For example, pricing of inpatient hospital claims uses revenue code and DRG tables, whereas pricing drug claims uses a series of drug and dispensing fee tables.

The WV-iC will support the pricing of claims by many different reimbursement methodologies, including inpatient DRG, level-of-care per diem, Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) processing, FFS payment schedules, crossover pricing, and pharmacy formula pricing. Additional information that affects pricing may include modifiers, provider type and specialty, claim type, and member age. The BMS will benefit from the flexibility offered by interChange in applying these differing payment methodologies.

Medicaid reimbursement systems continue to evolve and are becoming increasingly complex. This complexity is driven by continued pursuit of Medicaid payment systems that better match program rates (payments) to member care needs and services delivered. Complexity also is driven by increased federal requirements placed on Medicaid programs.

Perform Manual Pricing (Req. 24)

The WV-iC will allow for online entry of manual pricing for claims as appropriate and will be done at the direction of, and with approval from, BMS. A manual price will be assigned by the Resolutions team based on the complexity of the service and using BMS-defined applicable pricing policy. The WV-iC retains user-entered manual prices and will have a pricing indicator of "MANUAL" when a manual price is assigned.

Maintain Exception Processing Audit Trail (Req. 25)

The WV-iC will price claims according to various methodologies to accommodate West Virginia's unique member populations and pricing policies. Additionally, the system will easily support BMS' current pricing methodologies and the implementation of future pricing methodologies with minimal system changes and impacts. Claims will be processed as directed by BMS on an exception basis. The proposed system will maintain a link to the coverage, billing, and reimbursement rules under which the claim was processed. The application also will capture the pricing indicator, rate type used to price the claim or detail, and the user ID of the person who adjudicated the claim. This information will be stored as a full audit trail for the methodology and resulting claims payment.

To preserve data integrity, the WV-iC will prevent users from deleting segments on the reference files. Rather than delete segments, users must end-date them, allowing historical data to remain in the database indefinitely for use by claims processing and the data to be viewed online for research purposes.

Refer Claims to BMS (Req. 26)

When referring a claim, the claim will be forwarded to another location for further review and adjudication determination. Claims will be referred to BMS for correction or approval according to policy determined by BMS using HPES' edit code logic and location codes. Claim scenarios identified by BMS will be pended in the MMIS using specific edit codes. When reviewed and approved by BMS, claims will be released for adjudication. Claims that fail the edits and audits that are not set to systematically deny will be suspended and routed to the appropriate system claim locations for manual review and further processing. These locations will determine whether the claims are referred to an HPES or a BMS Resolutions staff member to resolve.

Override Codes (Req. 27)

The WV-iC will contain many of the typically used MMIS claims processing reports. HPES will work with BMS to create and provide reports to monitor the use of override codes during the claims correction process in accordance with BMS-defined guidelines. Claim reports will be stored in HP TRIM, which will enable users to retrieve reports from their desktops in electronic formats, greatly reducing the time delay in receiving updated reports. Additionally, the electronic format of the report will let users run searches for critical information, print only the portion of the report they need, or export data to spreadsheet applications for analysis. The following table lists a representative sample of the reports, supporting the use of override or denial codes during claims correction processing that will be provided to BMS.

Representative Sample of Override Reports

Report	Description
Error Analysis by Forced Error Code	Lists the error code, description, and number of errors per claim type forced through the system; gives totals for the number of forced claims
Error Analysis by Denied Error Code	Supports the monitoring of daily edit denials by paper, electronic, and POS claims, and includes the clerk ID if manually processed
EOB Denial Analysis List	Lists for each claim the error code, description, and the EOB posted to the claim when it denied; displays the total number of denials for each error code and the number of denials per claim type
Edit/Audit Override Analysis	Contains the clerk ID who overrode the error, the claim type on which the error occurred, the error code and the number of claims that had that error code overridden, and the frequency of the overrides
Specially Handled and Processed Claims	Lists claims that were specially handled based on the region code in the ICN

Produce Recipient EOMB Documents (Req. 28)

Within the WV-iC, the existing quarterly claims Recipient Explanation of Member Benefit (EOMB) process will produce EOMBs using targeted filters or no filters. The filters will allow the definition of a random sample of the population or claims that meet configured criteria. Those filters can be defined to identify a target percentage—for example 3 percent—or a target number—for example, 1,000 members. This process will be set up during DDI according to BMS guidelines. The output of the process will be routed through our correspondence package, HP Exstream, and generate electronic or physical letters to be mailed to the members. The information generated through this process will be retained for reporting purposes and reside in our electronic document repository.

Provide Online Access to Claims History (Req. 29)

We meet mandatory requirement 3.1.37—the WV-iC will provide role-based security access for authorized users to help verify confidential access to MMIS data at the individual and group security levels. The role-based security access will enable various levels of security, as defined by BMS, to the MMIS. Access will be granted on a defined need basis, with business groups having profiles established within the security solution. As MMIS users are added, they will be authenticated and authorized according to the profile they are assigned. This role-based approach will limit the access to the specific business areas, the specific online user panels, and the specific features (add, update, or inquire) of the user panels, as needed, to maintain proper security.

Through the healthcare portal, providers can correct pended claims online and copy and resubmit. The portal will support the HIPAA-compliant search parameters to enable providers to search for their claims. Portal security verifies that a provider—or their designated representative—will only gain access to claims related to that provider. The WV-iC will provide flexible and convenient access to claim status information for BMS and provider community. The system will take full advantage of the Internet and provide instant access to claim adjudication results. Providers will know immediately if their claim paid or denied. interChange also will provide access to claim information through the AVRS and several HIPAA-compliant transactions. The following table shows the key WV-iC features supporting the claims status inquiries or notifications business function.

Claims Status Inquiries or Notifications Features and Benefits

Feature	Benefit
Multiple electronic methods for checking claim status	Provides flexible and convenient access to claims status information
Unsolicited 277 transaction for pended claims	Improves provider satisfaction and reduces calls to the call management center
Immediate claim status through the Internet on electronically submitted claims	Encourages electronic billing and reduces providers' administrative costs

WV-iC will offer many features and benefits that effectively support BMS' claims status inquiry business function. We discuss our approach to meeting the requirements for claims status inquiries and notifications in the following subsection.

Status Checks Through the Medicaid Portal

WV-iC and the healthcare portal will support the exchange of claim status information based on the needs of the individual user, using flexible, convenient, and secure technology. As mentioned previously, providers can verify the status of claims from the instant they are submitted by using the interactive claim submission and status verification capabilities. Providers who have implemented one of the many HIPAA-mandated claims-related transactions can use the healthcare portal and interChange to exchange one or more of the following transactions.

- HIPAA-compliant X12 276/277 healthcare claim status request or response transactions
- Unsolicited X12 277 healthcare claim status for pended claim status notifications
- HIPAA-compliant X12 835 healthcare claim payment or advice transactions

Using the X12 276/277 and unsolicited X12 277 transactions, providers will verify in real time the status of a single claim or several thousand claims. WV-iC also posts X12 835 transactions to the provider healthcare portal following each financial cycle.

Status Checks Using AVRS

Providers who do not have convenient access to a PC or the Internet will appreciate the user-friendly AVRS, which will offer providers access to pertinent healthcare information. Using a touch-tone telephone, providers can use the system to verify eligibility information, receive weekly check write and suspended claim status, submit claim status inquiries, and determine the status of a prior authorization. This system will provide prompt information to standard inquiries for providers.

The AVRS will have a menu-driven design so that callers can easily navigate through the prompts to obtain information. Shortcut key sequences will allow the caller to repeat prompts or messages, reuse information previously entered, and enter the current date. Claim status will be accessible regardless of whether the provider submitted the claim on paper or filed electronically. If necessary, the AVRS will transfer providers to the provider call center. At any time during the call, the provider can select the interChange transfer option and be transferred directly to a call center employee.

Provide Imaged or Hard-Copy Claim Documents (Req. 30)

Because HPES mail room staff members will electronically scan and image paper claims and claim-related documents, attachments, non-claim transaction documents such as paper checks and correspondence, and electronic transactions processed by the WV-iC, these items will be readily available electronically to BMS. Should BMS need a hard copy of the original claim, they will submit a request to the mail room supervisor and this copy will be obtained from our on-site or off-site storage facility—depending on how old the claim is—and provided to the BMS requester.

Claims Processing Summary

The base transfer system from Wisconsin is federally certified to meet CMS requirements. This base provides the foundation for WV-iC, on its implementation, to receive federal certification and continue CMS compliance. Transfer of a certified system reduces the risk associated with achieving certification of a new system and also reduces the time from commencement of operations to federal certification. HPES shares BMS' goal of efficient, accurate claims processing that maximizes the use of time and program dollars. To achieve this goal, we will provide BMS with a federally certified transfer MMIS delivering improved features for efficient claims processing. We will use clinical logic and input from BMS and our experienced claims processing team to determine the criteria for the most effective and appropriate claims processing. Additionally, BMS will benefit from our flexible, table-driven system that will enable us to easily modify the interChange as edit and audit criteria change. These tables are accessible and updateable through the flexible browser-based application.

We meet mandatory requirements 3.1.19 and 3.1.20. HPES agrees to incorporate applicable current and federally approved coding standards specified in the RFP, including ICD-10, HIPAA v5010, NCPDP Claims Processing Standards D.0, the Patient Protection and Access to Care Act (PPACA), and the Health Information Technology for Economic and Clinical Health Act (HITECH) to verify that the MMIS is current in its ability to accept and appropriately employ current standards and requirements. As new standards and requirements occur—such as when new federal and state regulations are promulgated—enhancements will be handled through the approved change order process outlined in our response to the "3.2.2 Project Management" section.

of the receipt of BMS requests. WV-iC will allow for tracking and payment of specific transactions with detailed remittance requirements, such as claims, positive adjustments, capitation transactions, and more generic transactions, such as lump sum payouts. The WV-iC financial cycles will result in the generation of payments to providers for payable balances.

Produce Remittance Advices (Req. 3)

WV-iC will produce and reproduce remittance advices, in hard copy or standardized electronic format, in nontechnical language that is understandable. Provider remittance advices will be produced in a comprehensive and user-friendly document that provides weekly and year-to-date provider earnings information on paid, adjusted, and denied claims, as well as claims in process and pending. The remittance advices also will contain error codes and TPL information, where appropriate, and give a summary of the provider's year-to-date earnings information.

Provider payments will be generated with a provider remittance advice in paper check format or as electronic funds transfers (EFTs) as requested by the provider. WV-iC will provide the flexibility to suppress the generation of zero-pay checks but still generate the associated remittance advice. The system will generate a remittance advice to every provider who has had claims or financial activity during the week, regardless of the payment amount. The remittance advice will display the status of the claims submitted that may have been pended or denied. It also will include EOB codes and their full translations to inform the provider of the reason for the claim denial or suspension.

Interactive Remittance Advices

WV-iC transforms how providers reconcile and resolve billing issues. Through the interactive web-based remittance advice capability, the reconciliation process, which historically took at least one week, can be accomplished in less than one day.

The system also will generate a remittance advice if a provider has an outstanding accounts receivable or accounts payable, until such account is fully satisfied by claim activity or the issuance of a check. WV-iC will report error codes for each claim header and detail on the remittance advice. For HIPAA-compliant electronic 835 transactions, national adjustment reason codes and healthcare remark codes will be used to convey this information. The codes that apply to the claim, adjustment, denial, or financial transaction will be reported in the corresponding area of the remittance advices. On paper remittance advices—as allowed by HIPAA standards—the detailed message text of each applicable error code, including suggested corrective action, can be printed for the provider's convenience. This detailed, thorough error reporting will help providers understand and correct billing errors in one resubmission of the claim.

HPES will provide clear, concise communication to billers to reduce questions and the need for resubmissions. HPES has transformed how providers reconcile and resolve using our interactive, web-based remittance advice capability. The reconciliation process, which historically took at least one week, can be accomplished in less than a day. Additionally, BMS will have access to the RA Summary Inquiry page, which is used to search the remittance advice for information on a given provider number and location code, remittance advice number, tax ID, and other optional search criteria. The WV-iC financial reporting system will make the receipt of payments and application for the provider quick and easy while BMS will have the information at its fingertips after each payment cycle.

Process Capitation Payments (Req. 4)

WV-iC will calculate and generate capitation payments to MCOs and other providers on a schedule defined by BMS. The system will prorate capitation payments to the days the member is enrolled with the managed care provider in the given payment period, or the system will pay a flat monthly rate based on the payment requirement for the particular managed care program. The system will provide the ability to make capitation payments at provider-specific rates based on member demographics, including eligibility program, place of residence, age, gender, and risk factors. The MMIS will base the capitation rates on these factors and automatically calculate and pay the appropriate provider of the managed care benefit plan based on the member's choice of a provider.

WV-iC will store the capitated rates for the respective managed care programs in an easily maintainable and user-friendly browser environment. Meaningful displays of MCO capitation rates will provide quick, easy access to current and historical rate information.

Process FFS Payments (Req. 5)

WV-iC will process FFS payments based on the payment schedule defined by BMS using the appropriate HIPAA transactions. We provide a more detailed explanation of our proposed provider payment process in our earlier response to Requirement 3.

Produce Provider 1099s (Req. 6)

As a fiscal intermediary for many state Medicaid programs, HPES has a wealth of experience in Federal Form 1099 processing, including issuance to providers, submission of data to federal and state tax authorities, and issuance of special

forms such as "B" notices to providers for purposes of correcting mismatched employer identification numbers. Along with the regular weekly and monthly financial processing, annually HPES will process 1099 information and mail to providers meeting the IRS-established criteria by January 31, following the end of the preceding calendar year. Payments will be reported as medical and healthcare on the Form 1099 MISC. Earnings will be reported by tax ID to the IRS, the West Virginia Department of Health and Hospitals, and any other State tax authorities as required by the established deadline.

Using a secure file transfer protocol, 1099 files will be transmitted to the IRS and the BMS-requested West Virginia tax authority. This comprehensive 1099 financial process validates that providers will receive their 1099 information promptly and accurately and BMS tax requirements are met.

Perform Adjustments (Req. 7)

The WV-iC claims adjustment process will be easily accessible to the provider community and minimizes negative financial and administrative impacts to BMS and the providers. The MMIS will provide an effective and efficient solution for claims adjustments. Through Internet access, providers will have user-friendly access to initiate adjustment requests that will be immediately processed and paid or denied.

Adjustments that WV-iC processes will be accurately reflected in the files that are accessed during the reversal and reprocessing of a claim, including the provider master, the member maintenance, the prior authorization, and the financial tables. The MMIS also will clearly reflect adjustment transactions on the provider's remittance advice, which helps the provider to reconcile records. The WV-iC reporting function is an important component of the adjustment processing function. It also is designed to meet BMS and federal reporting requirements**.**

The West Virginia adjustment function offers the following:

- Online capability for adjustment processing for providers
- Cross-referencing of the original and adjusted claim for easy referencing
- Online web page for mass adjustment requests by different selection criteria, such as per diem rates, procedure codes, and dates of service
- Ability to review financial effect of gross adjustments before release in the system—when released, adjustments adjudicate instantaneously

WV-iC will process claim adjustments through the claims processing subsystem. Adjustments are allowed on claims that were approved for payment, regardless of whether there was actual reimbursement issued because of payment reductions for such factors as TPL and spend-down.

The original and adjustment claims will process in the same cycle and display on the same remittance advice. WV-iC will display the original and adjusted claims on the provider's remittance advice as offsetting transactions. The original claim appears as a debit (negative) transaction and the adjustment appears as a credit (positive) transaction. Additional payments due or receivable amounts resulting from the adjustment are applied to the current check write. This approach of processing and reporting adjustments makes it easier for the provider to determine the net result of the adjustment and make the necessary account reconciliation. The WV-iC will maintain an audit trail of the previous processing along with the adjustment processing for future reference.

Adjustments are allowed on the most recent version of the claim and void the most current claim or adjustment and then reprocess the adjustment as a replacement of the original claim or adjustment. The adjustment contains the ICN of the original claim as a link to the claim that is being adjusted.

As with other claims, claim adjustments will be data-corrected in real time. Online changes to adjustment claims will be part of the WV-iC data correction function. During data correction, sometimes referred to as pend resolution, authorized users can make online corrections or changes to the adjustment claim record. The ability to process suspended adjustments online, coupled with multiple daily claim cycles, will give rapid turnaround on suspended adjustments, resulting in increased service to providers.

Gross Adjustments

WV-iC will provide for processing of user-initiated gross adjustments (Adds/Pays) by authorized users. The adjustment processing function is flexible in supporting processing of individual or gross adjustments of claims. Gross adjustments include systematically selected claims for repricing because of retroactive pricing changes, including capitation rate changes, spend-down changes, member or provider eligibility changes, and other changes that require reprocessing of multiple claims. The targeted claims are selected from paid claim history, voided, and reprocessed using the new pricing rate or criteria.

The MMIS will display claims meeting the specified criteria. Variables that can be selected include time period, age, sex, claim type, DRG, diagnosis, ESC (error code), NDC, program, provider ID, member ID, region code, revenue, procedure, modifier, and provider type or specialty. The user can select or deselect any of the claims, release the selected claims for continued adjustment processing, or cancel the adjustment. This capability gives added flexibility in performing gross adjustments.

If the selected claims are released for processing, the previous payments are taken back, and the adjusted claims are paid. Both claims are displayed in the provider's remittance advice, which shows the original and adjusted claims as offsetting transactions. Each adjusted claim has an adjustment reason code and a description of the reason code. The retroactive rate adjustment capability is part of the mass adjustment processing function. This function automatically identifies claims affected by the rate adjustment, creates claim adjustments, and reprocesses the claims. As with any other adjustment, a link is maintained between the original and adjustment claims.

Update Claim History and Online Financial Files (Req. 8)

WV-iC will have the capability to update claim history and online financial files with the check number, date of payment, and amount paid after the claims payment cycle. After the claims history and online financial files are updated with the check number, date of payment, and amount paid, the data is fully accessible to authorized WV-iC users through the WV-iC web-based user interface. This information also will be easily accessible and readily available to providers through the healthcare portal.

Process Withhold or Recoup Payment (Req. 9)

WV-iC will include a process to withhold or recoup a fixed dollar amount or a percentage of payments for MCOs or providers from current payments. WV-iC will have a fully functioning recoupment system that allows authorized users to set up and track a recoupment case using the web-based user interface, plus review regularly scheduled reports. There is an associated WV-iC panel where users can log comments about the case. The system's audit trail capabilities will track when changes are made and the ID of the user who keyed the change.

HPES provides the recoupment process in our various Medicaid contracts, each according to the individual state's business rules, promoting a flexible solution for each state. Recoupments are often generated through adjustments to a claims payment. In the adjustment process, the amounts, counts, and units on the original claim are reversed, creating a debit (negative) transaction. The adjusted claim creates the corresponding credit (positive) transaction. WV-iC will provide the capability to set up the recoupment to take back all or a portion of the money owed by the provider across a period of weeks. With BMS' approval, this is set up as a set dollar amount or set percentage amount each week, thus lessening the effect on the provider cash flow yet validating that the money owed is fully recouped.

Provide Expenditure Data (Req. 10)

WV-iC will provide expenditure data, in the format and media specified by BMS to designated entities. Accurate claims processing and control of budget expenditures depend on flexible and robust system controls. These controls must support various programs that function interdependently and independently. The addition of new services and new programs within the Medicaid Program and within other state divisions requires a system that can differentiate among programs and apply program policy appropriately. The HPES solution brings a CMS-certified system that provides control in each aspect of claims processing and reporting. BMS executives, program managers, and analysts need quick and easy access to merge and manipulate Medicaid Program data on demand. With BMS' budget being one of the larger expenditures in West Virginia's budget, the State must have advanced reporting and analytical tools for forecasting, managing expenditures, and verifying those expenditures are appropriate. We can help BMS maximize program resources. West Virginia can rely on our WV-iC capabilities, staff, and business operational experience and leadership to implement the most effective Medicaid Program.

Examples of the predefined reports our WV-iC solution offers include the following:

- Expenditures by Category of Service (COS)
- Participation by aid category
- Participation by COS
- Payment by COS
- Payment by provider type
- Place of service analysis

Accept Data Format and Media Specified by BMS (Req. 11)

WV-iC will accept data in the format and media specified by BMS from the designated entities. The HPES team will provide support as required or requested by BMS. HPES will work with BMS to develop file layouts for other reference files as required.

In other states, we receive and process batch updates from other outside entities identified by BMS. For example, we process batch updates and data match updates of member third-party information from data received in an interface feed.

Monitor Status of Accounts Receivable (Req. 12)

The WV-iC and our experienced Financial Operations team will monitor the status of each account receivable and report at least weekly, monthly, and quarterly to BMS in aggregate or individual accounts—on paper and online. The WV-iC provides reports of open accounts receivable and the ability to obtain search results from accounts receivable web-based pages. The WV-iC solution will provide a comprehensive online financial inquiry capability, providing current week, month-to-date, and calendar year-to-date summary information. This information will be available to authorized users through the secure browser-based page, incorporating pull-down menus and point-and-click navigation.

Information may include the following:

- Category of eligibility
- Provider type
- State agency
- Date of service
- Initial receipt or processing date
- Vendor
- Amount of payment

In each financial cycle, WV-iC will check for outstanding provider accounts receivable and deduct the appropriate amounts. HPES will maintain accounts receivable—gross-level and claim-generated transactions—and will process payments against the accounts receivable according to State-approved procedures. WV-iC will fully support this requirement with its integrated accounts receivable process.

The system will automatically establish a provider accounts receivable when the net reimbursement of an adjustment transaction is less than zero. Additionally, accounts receivable records will be manually established through the Accounts Receivable Setup/Maintenance page for providers, members, and other entities, such as counties. This page establishes the parameters necessary to tell the system how money owed the State should be collected, including the following:

- Whether through manual or automatic recoupment
- Maximum dollar or percentage to be recouped from the provider each payment cycle
- Applicable payer and fund code

Accounts receivable balances are reduced automatically when cash receipts are applied or claims payments are recouped. Because WV-iC is a fully integrated MMIS, transactions—such as claims, adjustments, payments, receivables, cash receipts, recoupments, and voids—are linked to related records in the database. The WV-iC MMIS will allow for manual and automatic recoupment of funds using the Accounts Receivable Information and Maintenance pages, which display and maintain the information for accounts receivable in the system.

Recoupments in WV-iC can be in the form of a flat dollar amount or a set percentage of the provider's payment for each financial cycle. The frequency of the recoupment also is flexible and can be set so that the deduction is taken weekly, monthly, quarterly, or annually, as well as during every financial cycle until the accounts receivable are fully satisfied. Recoupments reduce the dollar amount distributed to providers for payments to be made from such transactions as claims and positive adjustments paid in the particular financial cycle. The total claims paid and the recouped dollar amounts are reported appropriately on the remittance advice. This information also is tracked in WV-iC by BMS' accounting codes, allowing us to produce interfaces summarized at the level requested by BMS.

The WV-iC financial business process will automatically update and maintain payment dates and dollar amounts on the provider tables as payments, and as other financial activities occur, such as recoupments and adjustments, the totals for these types of transactions are reflected within the current calendar year.

Follow State and Federal Guidelines (Req. 13)

HPES will follow and monitor compliance with written procedures to meet State and federal guidelines for collecting outstanding accounts receivable. The WV-iC solution promotes a standard and consistent application method for collecting outstanding accounts receivables that are consistent with West Virginia Medicaid policies, rules, and procedures. BMS can be confident that our processes and procedures supported by HPES' Financial team are based on sound, evidence-based information that meet State and federal guidelines.

Provide Online Access to Financial Information (Req. 14)

HPES will provide flexible and convenient online access to WV-iC claim status and financial information to BMS and the provider community according to BMS specifications. As described in MITA, consumers continue to demand that information be

available at their fingertips. The web-enabled architecture of the system takes full advantage of the Internet and provides instant access to claim adjudication results. Regardless of how the information is requested—using the web, through a kiosk, or directly through the online application—WV-iC supports the industry-standard transactions that can answer the inquiry.

BMS will have convenient, online, secured access to claims status and historical information. BMS will have the option of accessing one of many standard claim status reports, or it can use the system's ad hoc claim status inquiry capability that includes multiple criteria for selecting and reviewing claims. Users can retrieve reports from their desktops in electronic formats, greatly reducing the time delay in receiving updated reports. Additionally, the electronic format of the report lets users run searches for critical information, print only the portion of the report they need, or export data to spreadsheet applications for analysis.

Enter Non-Claim-Specific Financial Transactions Received from BMS (Req. 15)

WV-iC will allow entry of non-claim-specific financial transactions received from BMS. The WV-iC solution maintains the accounts receivable business function for entering and processing several non-claim-specific financial transactions such as emergency provider payments, liens, and recoupments with unparalleled expertise. An example of non-claim-specific financial transactions processes are described in the following subsections.

Emergency Provider Payments

WV-iC will process BMS requests for provider payouts (manual checks) with the capability to set a start date for recoupment and a rate of recoupment—for example, total, specified amount per payment cycle, or specified percentage per payment cycle—to recover the paid amount. The system will have the capability to advance pay a provider through an expenditure (payout). When this is done, an accounts receivable also is set up to recover the advance later. Cash refunds from a provider will be received to clear an open accounts receivable. The cash control number (CCN) and batch number of the returned check link the refund to the original transaction in the system.

Liens

WV-iC will maintain lien and assignment information to be used in directing or splitting payments to the provider and lien holder. The money for liens will be recouped by a percentage of the payment amount or a set payment rate. The flexible design of WV-iC will process liens against providers at BMS' request, including splitting provider checks where necessary.

Recoupments

WV-iC will allow for manual and automatic recoupment of funds using the Accounts Receivable Information and Maintenance panels, which display and maintain the information for accounts receivable in the system. Using the Accounts Receivable Setup and Maintenance page, the user will enter the parameters for the recoupment, including the effective date. Authorized users also will have access to terminate recoupments through the user interface panels. WV-iC will provide reports of open accounts receivable and the ability to get search results from accounts receivable WV-iC panels. The WV-iC financial business process will automatically update and maintain payment dates and dollar amounts on the provider tables as payments and other financial activities occur, such as recoupments and adjustments and the totals for these types of transactions are reflected within the current calendar year.

Support Reconciliation Process (Req. 16)

WV-iC will support the reconciliation process by researching and resolving discrepancies. Much like balancing a personal checkbook, the HPES Financial Operations team will use experienced staff members and various WV-iC financial reports to account for issued items and validate the book balance to the bank balance after every payment cycle.

Support Recoupment/Refund Functionality (Req. 17)

WV-iC will support recoupment and refund functions. HPES provides a recoveries process in our various Medicaid contracts, each according to the individual state's business rules. WV-iC will accept claim and non-claim-specific adjustments, automated adjustments from accounts receivable and TPL case tracking, no-history adjustments, recoupment, mass adjustments, and cash transactions (refunds). WV-iC also will accept retroactive adjustments to account for retroactive changes to patient spend-down, TPL retroactive changes, and retroactive changes to medical coverage codes (groups). The MMIS also will accept program integrity automated adjustments.

WV-iC will allow the adjustment of claims history to reflect a partial recovery of payment because of TPL. During the claim adjustment process, the refund amount will be applied to the claim and the original claim is systematically adjusted to zero. The system then creates an accounts receivable for the provider, where the TPL payment is applied. The net payment to the provider is zero. This action is accomplished in a similar manner as internal adjustments and is logged in the claim history.

closely coordinate to meet future CMS or BMS-specific data security requirements. This approach lets users access data required to perform their job, while restricting access for which they are unauthorized.

Maintain Complete, Accurate and Balanced Data and Reports (Req. 1, 7, 10)

The RFP calls for the replacement system to provide comprehensive reporting and ad hoc access to the MMIS data. Particularly, the RFP requires that we maintain payment, claims history, and associated reference data for each claim type processed by the MMIS. The WV-iC meets these requirements through the BIAR component, which delivers the following MMIS reporting capabilities:

- Ad hoc access to MMIS data, including claims, payment, and reference data for each claim type
- MAR, including 26 online, parameter-driven, flexible reports
- Dashboard reporting of MMIS key performance indicators

The BIAR solution includes 25 seats of SAP BusinessObjects Premium query and reporting COTS tool. SAP BusinessObjects is a market leader in the business intelligence market, and the HPES team has worked with this software for more than 12 years, successfully managing more than 2,500 seats of this software. Our WV-iC MMIS BIAR solution provides reporting empowerment directly to the desktop of the users while setting the foundation as an advanced DSS/DW solution for BMS for years to come. The predefined reports included in the WV-iC MMIS BIAR solution will be a catalyst for the user community to quickly gain value from the reporting solution, while the breadth and flexibility of the solution provides the growth needs required to make the offering relevant throughout the life of the operational contract. Please see proposal section "3.2.10 Vendor Proposed Services" for a description of the additional services of the BIAR offering.

To provide, maintain, and update the data model to support the MAR extract functions for the BIAR solution, HPES will update the underlying MAR datamart tables that support the monthly MAR cycles. We will then extract, update, and store the MAR summary data monthly. The major inputs to the MAR function are data from the claims processing functions and the financial, member, reference, and provider areas. The major outputs are the financial, statistical, and summary reports; data required by federal regulations; and other reports and data that assist BMS in program management and administration.

With consistent CMS requirements for MAR reports across the states for Medicaid program reporting, our transfer interChange MMIS will require minimal modifications to accommodate the specific requirements for the West Virginia data model. These changes will include updating the summary process to reflect differences in attribute names or data types and sizes. New and expanded uses for the state Medicaid program data are continually being created and implemented at the federal level. It is imperative that BMS deliver accurate and timely MMIS information to CMS for these purposes.

Summarized MAR database tables are used to store needed MAR data. The system presents MAR data by variables such as program code, category of service provider type and specialty, member aid category, and claim type. The system supports users in tracking summarized payment data, claims history data, and supporting reference data for each claim type.

To promote reliable and accurate MAR data for BMS users, we balance MAR to its source data in the MAR datamart, which reconciles it to its source data, Claims/Financial, as seen in the following figure.

MAR QA Data Flow

We will deliver the balancing report to BMS with each MAR production run, which also will be maintained in our HP TRIM DMS) for future reference. To help supply BMS with timely, accurate, and complete data for reporting and analysis, a quality assurance assessment of the monthly summary process takes place before the data is released for users. Quality assurance procedures will confirm that the MAR monthly summary process results and output are reconciled to output from the financial and claims processing business functions.

Through the balancing and reconciliation report processes we describe in our previous requirement response, HPES confirms the accuracy of reports before delivery to BMS. For discrepancies found, our team will thoroughly research the report and data source to determine the cause of the reporting difference. We will notify the BMS designee of the discrepancy and the corrective action taken to remedy the issue. Reports will be finalized and approved before delivery to BMS.

Meet BMS and CMS Requirements (Req. 2-4, 11, 12)

HPES will develop, implement, and operate our MAR solution according to BMS rules and federal guidelines and regulations for program management reports. The MAR parameter reports enable the user to quickly focus on the subset of data needed to support their work. Users can run electronic searches using various parameters, including provider information for some reports, with resulting data returned in seconds. Additionally, users can export data to other software for analysis or print only a few pages they need rather than waiting for the delivery of paper reports. By using the point-and-click online access to MAR data in the WV-iC, program data is accessible at the desktop and allows the user to see the requested report information and produce reports on the user-selected media.

Through the WV-iC, the online MAR reports are organized into the following categories: Payments, Operations, Provider, and Member. The report results can be as broad or as narrow as the user defines through search fields, including COS, medical status code, sub-COS, and time period. By using the parameters, the user quickly navigates to the subset of data requested—saving time and getting focused results.

Data on the MAR online panel is summarized by month. For paid claims, it is the month that the check issue date falls in. For denied claims, it is the date of the financial cycle in which the claim was finalized. Our MAR solution meets the routine MAR report requests through the inclusion of our online prompted MAR reports. We will transfer to West Virginia these MAR reports that go beyond the base requirement. These reports include timely claim-filing information, payment by program, and provider error submission reports. These best practice MAR reports are a value-add that we bring to BMS based on the experience we have acquired through our many implementations and operational support experiences.

Our solution fully supports the federal reporting guidelines and regulations, with support for CMS-372 and CMS-372S Annual Reports on Home and Community-Based Waiver Reports, CMS-37 and CMS-64 quarterly estimates and expenditure reports, MSIS, and the CMS-416 report. From our work with state programs around the country, it is our understanding the CMS-2082 reports are no longer used with CMS. The MSIS files have assumed the functional capability of the 2082 reports, and our MAR solution produces these files. West Virginia is required to deliver the MSIS files to CMS that report services provided, eligible members, and expenditures incurred during the federal fiscal quarter. We produce the five CMS files in the required format and verify the accuracy of the files, which include ELIGIBLE, CLAIMIP, CLAIMLT, CLAIMOT, and CLAIMRX files. After the output is finalized, the files are sent to CMS. The BIAR solution generates the CMS-required MSIS files in accordance with current CMS directives. As the only nationwide information source for Medicaid eligibility and claims information, accurate information feeds to the MSIS database are crucial.

BMS also will find additional program benefits from using MAR reports, including projecting program costs based on past expenditures, comparing and analyzing current and previous period cash flow, determining cost benefit by analyzing program expenditures, tracking and reporting of specific program track utilization, and tracking and reporting service usage by aid category, service group, or category of service.

We will work with BMS during report design to determine the "best delivery method" based on the type of requested report and BMS' preferences. Our WV-iC online reports provide flexibility for the user to view the report data and then print only what is necessary—reducing costs related to paper and printing. Standard reports are typically generated and sent to HP TRIM, our proposed report storage and retrieval tool. Whatever the choice, our role is to help determine if the report works best for BMS using a batch report to HP TRIM or an online report. Data for the CMS-64 report will be obtained systematically through WV-iC to provide complete and accurate financial reporting. HPES will provide the required administrative data needed for CMS 64 reports in an agreed-on format and delivery method.

Modify MAR Reports (Req. 5, 6)

HPES will define and recommend modifications to data arrangement and coding schemes—such as specialty codes, district codes, or accounting codes—as needed and when applicable to meet changing information needs of the Medicaid Program, help support compliance with changing requirements, or enhance the reporting. To maintain reporting compliance with CMS, our team will keep abreast of State and federal changes to CMS guidelines that may affect how a particular category of service is defined and what types of claims report to a particular category of service. We will work with BMS to understand specific changing State and BMS requirements.

The federally required information and files include the CMS 64, MSIS, and 372 Waiver reporting. The MAR solution has been federally certified to meet the requirements of the State Medicaid Manual (SMM) Parts 7 and 11. Because of the unique and complex nature of MAR federal reporting, many data sources are consolidated to produce these reports and files, and are therefore run in a batch summary process on the server, with the output being text-based reports stored in HP TRIM. The

Feature	Benefit
	future processing
Ability to identify and generate invoices on drugs eligible for rebate	Identifies and generates invoices for rebate drugs, enabling BMS to maximize collections and realize greater overall savings for the pharmacy program
Ability to exclude PHS (340B providers) from quarterly invoice	Verifies 340B providers quarterly and excludes them from the invoice; decreases disputes because manufacturers look for 340B providers in the quarterly data
Ability to request outstanding accounts receivable data online	Provides data online at the NDC level and invoice level and provides reports to manage outstanding accounts receivable
Ability to calculate interest online	Assesses interest according to CMS guidelines while maintaining interest from the invoice balance
Ability to view and maintain conversion information for specific NDCs	Allows for a conversion to be put in place, using the Unit Conversion web page, so that the units are converted to the invoice correctly, minimizing disputes and maximizing collections
Ability to create separate invoices and reporting for the federal and state rebate programs	Allows BMS to maximize rebate collections through federal and state programs

Besides the state-of-the-art drug rebate features, HPES is working to revise and update the invoice process and associated reports to accommodate the new data elements required by the ACA. These updates will be integrated into the WV-iC drug rebate solution.

Generate and Send Out Drug Rebate Invoices (Req. 1)

HPES will receive and load the quarterly CMS rate and labeler files into WV-iC. The rate file contains NDC-level Unit Rebate Amount (URA) pricing data and unit of measure, Drug Efficacy Study Implementation (DESI), manufacturer contact information, and effective and termination dates. The WV-iC system will merge claims data with the data on the rate file to create quarterly invoices and reports. Because drug rebate features are integrated and not being imported from a different system, the data will contain no delays or discrepancies. The data information that was used to process and pay the claim is used to create the rebate invoice.

The system will calculate quarterly rebate amounts due based on the number of units per NDC and the CMS list of quarterly unit rebate amounts and supplemental unit rebate amounts supplied by GHS. NDC data derived from claims is combined with the CMS file and the supplemental rebate file to generate the drug rebate quarterly invoices. HPES will generate and mail invoices for rebates and rebate adjustments to manufacturers quarterly within 60 days of the end of the quarter.

Following State and federal regulations, HPES will exclude specified classes of drugs from the rebate process, enabling BMS to maximize collections and provide greater overall savings to the pharmacy programs. HPES will develop, maintain, and update a conversion table based on HCPCS/CPT code conversions to NDCs as determined by BMS for invoicing certain injectable drug products. The WV-iC rebate function will be integrated with claims processing to negate delays or discrepancies between rebate extracts and claims information. When claims are adjusted in the claim subsystem, this information is systematically brought into the rebate system.

Invoice generation is a batch process that edits and merges claim and rebate rate data to produce invoices and update accounts receivable records. On completion of the final invoice print status, the invoice data are saved to a rebate invoice table on the database. Additional information tracked and maintained for invoices includes the year or quarter of the invoice mailing, invoice status (trial or print), invoice date, BMS-designated threshold amounts, interest calculation status, and invoice postmark date.

HPES' drug rebate invoices meet CMS-required data elements and layout guidelines and are presented in a user-friendly layout for clarity and ease of processing. For BMS, HPES will receive the CMS rate file information electronically from the CMS Medicaid Drug Rebate system. The system will create separate invoices and cover letters for the federal rebate program, State rebate programs, and supplemental rebate programs. To maximize rebate monies collected, HPES has designed and produced invoices to be as user-friendly for the manufacturer while conforming to CMS requirements for format and content. HPES is revising invoices and associated reports to accommodate new date elements required by the ACA.

The WV-iC will enable manufacturers to receive electronic invoices to minimize the turnaround time for drug rebate collections by reducing the workload required to handle paper invoices. The Drug Rebate team will post manufacturer invoicing media preferences to the system. Manufacturers that do not specify a desired media format will receive invoices on paper, besides receiving regular reminders of their media format options and the benefits of the alternate options. HPES will generate paper and electronic invoices in the CMS-mandated format.

Each invoice has a cover letter with pertinent information, such as check mailing address, to help the manufacturer process the invoice and remit rebate payments quickly and efficiently. Cover letters can be customized each quarter to call manufacturers' attention to changes or specifics about the quarter. An invoice number is assigned to each invoice. The invoice number comprises the labeler code, quarter, and year of the invoice period. The invoice number will enable manufacturers to easily identify invoices and enable the rebate specialist to access manufacturer invoice information more efficiently. The drug rebate subsystem automatically generates manufacturer mailing labels. It also will generate mailing labels on request from the labeler database of addresses. Several summary reports will be available to the rebate staff and BMS for program management, reporting, and verification of the invoice process.

Receive and Process Rebate Checks (Req. 2)

HPES will apply a timely update of payment and adjustments to the rebate system. Because of the user-friendly design of the invoice payment browser-based windows, users can take advantage of the point-and-click functional capability to disposition payments and access information in the system. After HPES receives the payment information, including the Reconciliation of State Invoices (ROSI) or Prior Quarter Adjustment Statements (PQAS), the drug rebate analyst will begin the dispositioning process, which will include prior period adjustments. WV-iC drop-down menus support fast yet accurate dispositioning of the payment.

The Drug Rebate team will post payment to the NDC level of the invoice and mark an NDC as being in dispute and include the reason the manufacturer is disputing the payment. If the manufacturer decides to dispute an NDC but makes a payment on some portion of the rebate due for that NDC, the rebate analyst can post that partial payment. The account receivable for that invoice will remain open until the dispute is resolved. At the time of resolution, the rebate analyst can mark the dispute as resolved and close the account receivable. The WV-iC also will allow the rebate analyst to reconcile NDC-invoiced amounts.

After a check is applied and dispositioned, the invoice browser-based windows reflect the correct invoice and dispute information. The interChange system minimizes redundant input and improves productivity while posting drug rebate payments. Authorized users can associate and post specific payment amounts and overpayments on a check to the appropriate drug rebate invoice period, claim, and program. For overpayments, HPES can initiate a request for refund, issue a refund check, or credit to the manufacturer.

To verify that drug rebate receipts are properly posted, HPES has developed quality control tools and procedures within our drug rebate teams and the interChange system. These features include using secure browser-based windows, implementing automated audits, issuing a CCN for each check, dispositioning from the CCN, and keeping the account receivable open until the check is fully dispositioned. These checks and balances improve the quality of our services.

Work Labeler Disputes (Req. 3)

Dispute information from the manufacturer is documented on the ROSI or PQAS forms. HPES will accommodate paper and electronic dispute communication in compliance with HIPAA confidentiality and security policies. Disputes will be entered and accounted for in the drug rebate dispute tracking system. The system automatically creates dispute information when payment is dispositioned to the NDC-level detail by using a dispute reason code. The analyst's record includes distinct dispute codes for each NDC, based on CMS guidelines, to indicate the reason the manufacturer disputed the NDC. The WV-iC system will enable users to inquire or add dispute information from various browser-based panels, eliminating the need to enter data multiple times and streamline the analysis of the dispute-related data.

The WV-iC drug rebate subsystem will provide a method of extracting claims for a disputed NDC. The drug rebate claims history files are created quarterly during the invoice cycle. When the rebate specialist enters an NDC and invoice quarter on the Drug Rebate Claim Detail Request panel, a batch process extracts the request and uses that information to search the drug rebate history files for the requested NDCs and quarters and generate the drug rebate claim detail reports.

The proposed interChange drug rebate system will produce drug product utilization reports such as the drug rebate claim utilization for labeler report. Manufacturers use the report to identify billing discrepancies and resolve disputes. Claim utilization can be transmitted electronically to drug manufacturers. The drug product utilization reports can be exported to an Excel file, which allows the rebate analyst to quickly and easily provide this information to the manufacturer.

Perform Dispute Resolution (Req. 4)

On receipt of a manufacturer's dispute information, the rebate analyst will enter dispute information on the Dispute Detail Resolution panel, which classifies the dispute based on the list of CMS-defined and required reason codes that drug manufacturers must use when disputing invoiced products. The drug rebate resolution statement report is generated weekly through a batch process. This report notifies the manufacturer that the dispute for an invoice period has been closed. The report will provide the manufacturer with NDC detail data of the research and the dispute determination for the specific invoice period. Drug rebate analysts can easily identify claims related to disputes by looking at the Related Claims Search panel, which allows the user to view claims related to an NDC, invoice period, and rebate program. The rebate analyst will contact providers to verify NDC utilization discrepancies identified in the dispute resolution process.

After utilization discrepancies have been identified using review of the claim level detail, adjustments to the claims data will be corrected in the system. Adjustments and recoupments will be captured and applied to the provider's payment if based on the NDC units. After the dispute resolution process is complete and adjustments made, the system will automatically recalculate the use for each disputed NDC. Generating the recapitulation report will summarize the changes made to the invoice.

Maintain Drug Rebate Data (Req. 5)

The HPES interChange drug rebate subsystem maintains information on drug rebate manufacturers in an online drug rebate labeler file. This information includes ROSI/PQAS, manufacturer technical and operational contacts, manufacturer addresses and participation, and effective and termination dates for each manufacturer. This and other appropriate manufacturer information will be updated according to information received from CMS, BMS, or the manufacturers.

CMS sends labeler information electronically each quarter. This file is downloaded by designated personnel from CMS' Medicaid Drug Rebate system (DDR) and is used to update the labeler information before invoicing. CMS sends ongoing releases to the drug rebate staff containing labeler and NDC coverage updates. The proposed WV-iC drug rebate subsystem will be able to perform batch and online updates to manufacturer data and identify the source of the update. Addresses and other rebate-related information are captured from the quarterly CMS electronic file. This information can be updated manually by HPES with BMS approval.

Manufacturer rebate data will be updated within 24 hours of receipt of rebate-related information from CMS, BMS, or manufacturers. To support the production and submission of accurate invoices, the system also updates manufacturer information with the quarterly CMS data file. The drug rebate labeler address update report provides a means to identify discrepancies to the address update process that must be resolved with CMS or the manufacturer.

Perform Direct Data Entry (Req. 6)

The HPES team will work to incorporate the historical data provided by BMS sources into the WV-iC drug rebate solution. Given that the rebate data since 1991 has been provided in the past by multiple vendors—First Health, ACS, and Molina—HPES will develop system requirements to account for past rebate information into the WV-iC system to provide a full integrated system for review of past claims. WV-iC also can account for the challenges of identifying and displaying different rebate program types in the past systems such as federal, supplemental physician-administered, ADAP, and MCO rebate data. HPES has the knowledge and experience to accommodate this type of data management when the integrity of the past data has been upheld and systematically available.

Reconcile Data Sources (Req. 7)

A benefit of the interChange system is the full integration of claims payment and processing within the same system. Data sources to be reconciled include drug reference data file, provider data, CMS drug rebate files, supplemental drug rebate files, and claims data.

Information from the data sources will be integrated directly into the processing of claims requiring NDCs that qualify for drug rebate invoicing. In turn, this front-end processing directly coincides with the efficient extraction of claims appropriate for drug rebate invoicing. The reconciled data from numerous data sources verifies that drug rebate invoices will be accurate and lessens the magnitude of disputes from the manufacturer.

Maintain and Update Manufacturer Data (Req. 8)

WV-iC drug rebate subsystem functions will provide the ability to accept and maintain CMS' current list of manufacturers with drug rebate agreements. Information is maintained on drug rebate manufacturers in the Drug Rebate Labeler panel. This easily updatable information includes: manufacturer ID and labeler codes, manufacturer contacts, manufacturer addresses and participation, email address, enrollment, effective, and termination dates, and also indicates the collection and invoicing media

for each manufacturer. The following specific reports are produced at the invoice cycle for monitoring labeler address information:

- **Drug rebate address update—**Identifies discrepancies to the address update process that need to be resolved with CMS or the labeler
- **Drug rebate participation by labeler code—**Can be used to determine a product's rebate status, provides a listing of participating labelers by program with effective and end dates, breaks by rebate program (such as federal or federal supplemental), and is sorted by labeler code

The manufacturer's collection media will be classified as cash, check, or electronic funds transfer. Invoicing media can be categorized as diskette, FTP, or paper for tracking. Manufacturers that fail to specify a desired media format will receive invoices on paper, besides receiving regular reminders of their media format options and the benefits of the alternate options. The WV-iC drug rebate solution will allow for the maintenance of multiple effective date spans by program. Labeler participation information is easily viewable from reference and claims screens. Additionally, State-only program rebate agreements can be stored electronically and viewable from the labeler windows.

The HPES drug rebate staff will update the CMS manufacturer rebate data within 24 hours of the receipt of the CMS release or file. BMS, manufacturers, CMS news bulletin releases, State-driven or federal directives, manufacturer contact addresses, and new or updated product information also will be entered into the drug rebate system quickly. To support production and submission of accurate invoices, the system also updates manufacturer information with the quarterly CMS data file. The drug rebate labeler address update report provides a means to identify discrepancies to the address update process that need to be resolved with CMS or the manufacturer. Labeler addresses also can be manually updated by authorized personnel and not overwritten by CMS file information, if not correct.

Generate Invoice Cover Letters, Collection Letters, and Follow-Up Collection Letters (Req. 9)

The WV-iC drug rebate solution will automatically generate invoice cover letters with the quarterly invoice process and create a delinquent payments report monthly. The report lists manufacturers that have delinquent rebate amounts due. Manufacturers will appear on the report when no payment has been received 38 days after invoice has been sent or no activity has occurred for a period of six months for a specific manufacturer or quarter.

The WV-iC will maintain an electronic data file of disputes. The system will generate a monthly dispute status report—drug rebate dispute summary by invoice period—that provides an account of dispute information for each invoice period. The drug rebate specialist monitors balances due on unpaid invoices and disputes and generates follow-up letters to manufacturers that have not responded to the invoice.

Invoice collection reminder letters will be created and sent out monthly. The drug rebate invoice 38-day reminder letter is sent out 38 days after the mailing date of the most recent quarter's invoicing cycle. Letters are sent to labelers who have not made a payment on that quarter's invoice. Drug rebate collection follow-up letters also sends out 68- and 98-day letters.

Maintain Activity Audit Trail (Req. 10)

Communication with drug manufacturers is tracked in the interChange drug rebate subsystem in a comments field, which can be entered at the invoice or NDC level. The drug rebate call management and tracking capability allows the analyst to record the date of contact with the drug manufacturer, the type of contact (such as telephone, fax, or email), and the type of resolution. interChange automatically stamps the record each time it is updated, providing an audit trail of the correspondence.

HPES has developed system enhancements, tracking tools, and reports to maintain an audit trail of modifications or correspondence in the interChange drug rebate subsystem. Examples of the reports used to audit invoice, payment, and adjustments include drug rebate accounts receivable by labeler and drug rebate accounts receivable by period, and drug rebate amounts billed and adjusted and collected.

For immediate review of an NDC, modification panels have been created to view previous changes by clicking the "Audit" button. Invoice records at the NDC level include a status that lets the user know whether the record is the original or has been adjusted, written off, or disputed.

Generate Manufacturer Mailing Labels (Req. 11)

The drug rebate subsystem automatically generates manufacturer mailing labels. The WV-iC also will generate mailing labels on request from the labeler database of addresses.

Provide HIPAA-Compliant Access (Req. 12)

HPES will provide a secure online HIPAA-compliant web portal for manufacturers to access their invoices, claim-level detail, and accounts receivable information. After the drug rebate cycle runs, the invoices will be produced and loaded onto the website and other rebate-related data. The secure portal eliminates the time-consuming paper invoice process and creates an effective and efficient means for exchange of data and documentation with the manufacturers. This will benefit BMS by making the invoice process more efficient, decreasing cost and time constraints, and maximizing the collection of drug rebate monies.

The drug rebate portal is being successfully used in other HPES states and is receiving high accolades from the manufacturer community for the increase in productivity and timely access to claims-related data. We will comply with pending HIPAA and security requirements enacted by the HITECH Act. After CMS has finalized these requirements, our standards will evolve to comply with HIPAA.

Contact Management

HPES' Contact Management system is a powerful tool that supports the following:

- Contact logging and tracking
- Managing knowledge content
- Escalation
- Reporting
- Searching historical data
- Electronic document management

The HPES team brings to West Virginia more than 40 years experience in successfully providing contact management services to our clients. Our experience has allowed us to develop contact management best practices that are part of our solution. The HPES solution offers an online, browser-based CTMS, which serves as the secure, centralized repository to electronically manage contacts, whether received through telephone, email, web portal, AVRS, mail, fax. Using the CTMS tool, information about the contact will be recorded to include the provider or member identification, type of issue, date and time of contact, description of the issue, the name of the call center CSR logging the call, resolution, and date closed.

Log and Track Information Requests (Req. 1)

CTMS is a fully integrated solution for logging and tracking, and measuring statistics for inquires. Using CTMS, the HPES team can provide detailed contact and call reports that will include the following:

- Provider or Member Identification
- Name and number of caller
- Caller type
- Manner of contact, other than call
- Description of inquiry
- Status of call
- Response provided using reason codes

Each of these components allows us to track and provide clear, direct answers to inquiries quickly. An integrated Enterprise Knowledge Management System (EKMS) allows CSRs to access reference material and frequently asked questions (FAQs) regarding policy, programs and procedures. EKMS facilitates consistent and accurate information from the call center.

The power of our WV-iC solution allows the efficient handling of the contacts and calls by requiring minimal data fields for search criteria. For example, if a provider calls in regards to a claim denial, only key information including the ICN for the claim questioned would be required. The HPES specialist can use this information to determine why the claim denied without having to key the reason for the denial in the free-form notes panel.

CTMS serves as a centralized repository where contacts, or information requests, can be electronically logged. As described above, information is recorded including the provider or member identification, name of contact, description of the question or issue, method of contact, resolution and status. A unique contact tracking number (CTN) is assigned to every event to enable logging and tracking of the information requests. The same components used to document a contact can be used to query CTMS to view a clear audit trail of a contact. Authorized users of CTMS can query for previous contacts by using the contact tracking search panel shown below. This feature is especially useful with contacts that must be transferred to other agents, or BMS, for input.

Customer Service Support Call Center

The WV-iC call center will set the tone for the perceptions of the program. A positive experience can make even a difficult situation acceptable. Our HPES team provides an effective call center services team, blending lessons learned, innovative technology, and extensive industry knowledge to provide exemplary customer service. The following provides detail into how our HPES team meets and exceeds the requirements for providing call center services.

HPES is the leader in U.S. government healthcare administration—trusted by 19 states that choose to outsource the fiscal intermediary services.

The HPES team understands BMS' need for a dynamic call center that assists various types of callers, including providers, members, and pharmacies. Additionally, the HPES team recognizes the need for support call center services for BMS MMIS users. We have designed a call center where customer service representatives (CSR) will be trained to handle calls from these various entities. The provider, member and pharmacy call centers are staffed by CSRs Monday – Friday, from 8 a.m. to 5 p.m. Eastern Time except for state holidays. The MMIS technical support call center is staffed by CSRs Monday – Friday, from 8 a.m. to 5 p.m.

Our call center solution is driven by rules programmed into the Avaya telephone system (ACD/PBX) and the Automated Voice Response System (AVRS). Access to the self-service features in the AVRS will be available to providers, members, and pharmacies through toll-free services. If additional assistance is desired, users can opt out to a CSR during business hours using skills-based routing. Skills sets are matched to CSRs based on the primary reasons calls are made, and CSRs are specifically trained for these skills. With the use of scripts and an enterprise knowledge management system, consistent and accurate information will be provided to the caller.

The following tools are used in our proposed call center solution, for BMS, to promote efficient contact handling:

- **Computer Telephony Integration (CTI)—**Otherwise known as screen pop technology, CTI takes the NPI entered by the provider in the AVRS and integrates it with the WV-iC. With this integration, the CSR is presented a "screen pop" with the provider's information before the provider and the customer service representative are connected on the telephone. CTI technology reduces the time the provider has to wait on the telephone for the CSR to re-enter the provider's NPI.
- **CTMS—**Used by the CSRs to track contacts including calls, emails, and correspondence. CTMS provides the CSR with historical contact information so the provider does not have to restate previous contacts and also uses the routing mechanism to escalate issues within HPES and BMS. CTMS also provides reports that are used for trending contact data, such as most often asked questions and responses.
- **Enterprise Knowledge Management System (EKMS)—**Online tool that allows CSRs easy access to reference and frequently asked questions (FAQs) about policy, programs, and procedures. This tool promotes consistent and accurate information from the call center.
- **CMS and NICE Quality Management—**Call recording and CSR quality monitoring and reporting tools are built into Avaya telephony product.

As BMS' plans evolve, HPES will assess the needs and resources required to support callers, based on our extensive, multistate experience. Our experience will assist in building the highest-quality call center. Our recruiting process selects, trains, and retains the best customer service professionals in the industry. We offer a highly skilled, technology-savvy support staff that delivers the right solutions with a high degree of reliability.

Staff and Maintain a Call Center (Req. 1, 2, 3, 4, 12)

Our centrally located call center will be staffed with trained CSRs who will be available through toll-free lines. We will use the same telephone system with separate, dedicated toll-free numbers for providers (in- and out-of-state), members, health plans, and other stakeholders, as defined by BMS. HPES will obtain and maintain toll-free lines for the call center. If available and to minimize disruption to providers, the HPES team will assume responsibility for toll-free lines in use and redirect them to our call center.

Our vast experience delivering call center services in more than 20 states during the past four decades allows us to gauge the appropriate level of staffing needed to meet BMS' requirements. We commit to providing required staff and enough of telephone lines to handle the call volume. The HPES team has a defined staffing process to facilitate the hiring of qualified staff throughout the account. We have found that working closely with BMS along with the outgoing vendor allows the opportunity to identify local Medicaid knowledgeable staff interested in continuing in their roles of supporting the Medicaid program. In these cases, the HPES team will work with BMS and the outgoing vendor to verify that appropriate support of the existing MMIS can be maintained while best positioning the new MMIS staff to meet future challenges. We understand that peak staffing for the call center, throughout the span of operations, can sometimes change based on many variables, including ramp-up, ramp-down, productivity improvements, anticipated changes in volumes, and other activities that can occur during the life of the contract.

Inquiries into the call center will be documented using the online, browser-based CTMS that is a part of WV-iC. The CTMS is a robust system that allows the capture of forms, written mail, email, web-based, fax, and telephone. Using the CTMS tool, information related to the contact will be recorded to include the provider or member identification, type of issue, date and time of contact, description of the issue, the name of the customer service call center representative logging the call, resolution, and date closed.

Each contact is assigned a CTN, which can be used in future searches. The same components used to document a contact can be used to query CTMS to view a clear audit trail of a contact. This feature is especially useful with contacts that must be transferred to other CSRs, or BMS, for input.

Respond to Member and Provider Inquires (Req. 5, 8)

The WV-iC AVRS automatically answers member inquiry calls 24 x 7, except for agreed-on scheduled maintenance downtime. When additional information is needed, members can speak with a call center CSR during regular business hours regarding a denied claim. There is no limitation on the number of calls a provider can make into the AVRS or the call center for assistance.

Accept Provider Faxes (Req. 6)

A toll-free telephone line will be established to receive and respond to provider faxes, including PA requests and claims, as directed by BMS. A workflow process will be established to route faxes to appropriate business units for resolution.

Call Center Reporting and Quality Control (Req. 7, 13)

Avaya's CMS and NICE Quality Management are reporting tools available in the WV-iC call center. Avaya's CMS integrates with the ACD and collects data to provide real-time reports for monitoring call center performance. Avaya's CMS also has more than 100 historical reports to provide statistics on call center and CSR performance. Reports in Avaya's CMS can be exported to standard spreadsheet or database programs such as Microsoft Excel or Microsoft Access to be used to develop CSR and operational dashboards. Additional features include administration of CSR skill assignments, queues, and resource utilization.

The call center manager, supervisors, and other designated personnel—including authorized BMS staff members—can monitor call metrics such as call abandon rate, call length, hold time, ring busy time, peak hour statistics, and speed of answer. We also will track real-time call volumes, active queues, numbers of calls offered, answered, and many other categories. Hundreds of historical reports are available for analysis of call center activity on an interval (half-hour) basis or daily, weekly, or monthly.

Call center leadership can monitor, record, and audit calls for quality control, customer service, program integrity, and training purposes. As the outside-facing entity working for BMS, it is important that HPES support the highest levels of customer service. This is something we take seriously. Call center leadership will develop criteria on which to audit call for the respective call center CSRs and will provide results of call audits to BMS on request.

Provider Voice Messaging System and Scripts (Req. 9-11)

HPES understands the need to create a messaging system for after-hours calls and during queue hold times. This is a valuable outreach tool to educate callers about available self-service options, policy updates, and training opportunities. The HPES team

Provide, Operate and Maintain an AVRS (Req. 1)

HPES proposes the BPO Platform's Genesys Voice Platform for providing, operating, and maintaining a touch-tone, telephone-based toll-free AVRS capability for authorized user inquiry functions. The Genesys system is located at the Plano, Texas, and Auburn Hills, Mich., service management centers and integrated with the Avaya Communications Manager Telephone system. The Genesys system is capable of growth through hardware and software enhancements and is integrated with the Avaya ACD. Using this system for West Virginia only requires development of the call flows, voice prompts, and integration to the WV-iC system and other systems.

The AVRS allows authorized users to complete automated inquiries and requires secure access. For example, providers can retrieve eligibility information regarding a member by entering required information such as the NPI, Provider Identification Number (PIN), and enrollee identification number, among others. The eligibility data is extracted from WV-iC and spoken back to the caller.

We meet mandatory requirement 3.1.37. We will work with BMS to determine the appropriate role-based access for authorized AVRS users, including: providers, members, MMIS users, health plans and other stakeholders. HPES understands and complies with requirements to provide access to PHI and personally identifiable information (PII) on a "need to know" basis for job-related functions only.

Our AVRS meets X12 transaction standards, along with HIPAA-compliant security measures for electronic eligibility transactions protecting confidential information. For example, the AVRS can speak back pertinent information, including the following:

- Benefit plan enrollment
- Commercial health insurance and TPL coverage
- Managed care enrollment
- Medicare coverage
- Prior authorization
- Provider lock-in

If the member is not enrolled in a benefit plan, the caller will be informed of the ineligibility. We will work with BMS to define the call flow requirements and voice prompts.

The AVRS has a menu-driven design so that callers can easily navigate through the prompts to obtain information. Shortcut key sequences allow the caller to repeat prompts or messages, to reuse information previously entered, and to enter the current date. The AVRS has barge-in capability, which allows the caller to interrupt any AVRS prompt or message, enter information, or request to speak with a friendly provider representative during business hours.

Maintain Performance Standards (Req. 2)

HPES will maintain sufficient AVRS access lines to maintain availability 100 percent of the time 24 hours per day, seven days a week, except for the agreed on downtimes. Besides the service-level agreements (SLAs) in Appendix G, our team will maintain two levels of customer service support: callers will be connected with the AVRS within three rings at least 99 percent of the total daily call volume; and calls will not be dropped more than one percent of the total daily call volume.

To track the AVRS standards, we will use the Avaya Call Management System (CMS) to report call volumes and statistics. Reports in Avaya's CMS can be exported to standard spreadsheet or database programs such as Microsoft Excel or Microsoft Access to be used to develop agent and operational dashboards. HPES will use these reports to monitor our AVRS performance to the key performance indicators (KPIs) documented in the RFP.

We will submit our AVRS performance report card on applicable KPIs monthly, delivering no later than the 10th of the following month. If desired by BMS, the supporting Avaya CMS reports will be available for review. If a KPI for the AVRS functions is not met, we will provide a detailed Corrective Action Report to BMS with the information outlined in the RFP. After BMS' review, we will initiate the proposed corrective action only if approved by BMS.

At a future time as outlined in the RFP, we will work with BMS to review the AVRS KPIs to determine if revision is necessary to produce effective tracking and reporting.

Provide Real-Time Access to Prior Authorization Status Inquiries (Req. 3)

Our WV-iC solution will provide real-time access to the status of prior authorizations inquired through the AVRS. After the prior authorization decision is generated, the WV-iC database is updated with the information. Because the WV-iC is a true relational database, the AVRS process simply accesses the prior authorization tables to determine the status of the inquired prior authorization.

- Shared investment in ongoing development of the portal across a broad base of healthcare communities that contribute to the road map and evolution of the product
- Reduced maintenance because HPES maintains healthcare portal technology as a product. HPES delivers regular releases, reducing the need for expensive custom development
- Full and ongoing automated and regression testing used to maintain stability, minimize defects, and maintain performance against multiple configurations to each new release
- Consolidates multiple workflows and systems through a single easy-to-use user interface for providers
- Encourages electronic submissions, leading to cost savings in the reduction of paper and material requiring manual processing
- Enhanced provider web portal with enrollment wizards to facilitate self-service enrollment
- Encourages self-service empowering providers and increasing satisfaction
- Support error-free submissions with data field masks, customer-side edits, and prepopulated fields

Additionally, information on portal capabilities can be found in our response to the options services referencing the "Enhanced Member Web Portal" area in RFP section "3.2.11 BMS Optional Services."

Portal Framework

HPES offers West Virginia a robust .NET platform that has been designed to provide as standard a set of underlying capabilities critical to adoption. This platform will allow BMS to grow into the future—with smooth adoption and integration of the portal's enhanced features such as managed care, electronic health records, and e-prescribing—with a platform that has following the fundamentals embedded throughout:

- Secure, Regulations Compliant Platform; Safeguarding protected health information (PHI) and personally identifiable information (PII); including HIPAA, NCPDP, ICD-9, ICD-10 Compliant, ADA Section 508-compliant (including TTY/TDD support)
- Highly Configurable: Localization, branding (Look and Feel), componentized; designed for intuitive ease-of-use with multiple navigation paths
- A 24 x 7 primary communications channel for alerts, messaging, and delivery of information; multilanguage

Navigation and Support

HPES worked with many groups of healthcare professionals to assemble the requirements for the provider, member, and trading partner stakeholders. Physicians, nurses, pharmacists, and other portal users were consulted for information and input into the creation of these systems. The portal was in part developed by doctors for doctors.

With a focus on usability and multiple navigational paths, the healthcare portal has several features that assist in workflow navigation. This includes a navigation bar; breadcrumb trail; comprehensive search; results; member focus; and contextual help. The following figure illustrates some of these features.

Member and Provider Inquiry

The healthcare portal allows enrolled providers to generate secure electronic messaging to provider services staff. Typically this messaging is directed to the provider call center; however we can work with BMS to determine how and when this correspondence should be forwarded to BMS. The healthcare portal provides Contact Us access on every page where the provider can access contact mail addresses, telephone numbers, and email addresses or submit an inquiry directly through the portal.

ePrescribing

HPES will provide payer enablement as part of the pharmacy POS system, which will be certified for ePrescribing with Surescripts. HPES plans to integrate West Virginia's existing provider-facing solution, WVeScript, with the proposed healthcare portal.

Provider Enrollment

Our WV-iC MMIS provider enrollment capabilities will reduce paper enrollment processing times between 50 and 75 percent.

The healthcare portal offers a secure and easy-to-use place for enrollment, re-enrollment, and update requests, including requests to disenroll. Some of the online benefits include an easy-to-use enrollment wizard from initiation through to disclosures and online submission; replacing paper-intensive, manually driven steps with automated highly efficient transactional workflows; save and resume an enrollment later; and check on enrollment status. To evolve BMS' provider management system along the MITA maturity path, we have made the online enrollment through the healthcare portal a simple, secure, and highly efficient process. Likewise, we have automated much of the processes involved with moving a paper application through the enrollment workflow process.

We project that the use of the healthcare portal for e-applications will streamline data entry and processing of paper applications should improve enrollment time frames by 50 percent to 75 percent. This would be a sentinel achievement in BMS' move toward higher MITA maturity levels. It should be possible for a professional application originating in the healthcare portal with clean credentials to be finalized within three business days.

Prior Authorization Features

The healthcare portal provides online access to prior authorization entry, submissions, and real-time inquiry. These web screens have proven exceptionally provider-friendly and intuitive for our healthcare clients using HPES' provider-facing portals. Making the web portal an easy and efficient channel for prior approval submission minimizes frustration for the provider community, reduces the number of calls to BMS voicing aggravation about difficult manual prior approval submission, and saves the provider valuable time in submitting and receiving approval for the prior approvals that are needed to facilitate delivery of the needed service to the member.

Benefits of our prior authorization business process include the following:

- Automates the authorize service process completely
- Authorizations can be auto-approved, pended, or denied
- Automated generation of approval or denial notices or requests
- Link multiple providers to a service authorization
- Online real-time functions for the entry, routing and processing of prior authorization requests

The following figure provides a view of a provider's prior authorization search results through the secure healthcare portal.

Develop and Maintain Help Screens (Req. 5)

Full online help is available, including standard help menus and contextualized help for the page the provider is viewing. Additionally configurable mouse-over text is available for each entry field header that allows for additional immediate assistance in interpreting next steps. HPES will work with BMS to review and customize the online help content to provide clear instructions in completing processes such as enrollment and PA submission, along with assistance to your provider community.

Provide Links to BMS-Designated Stakeholders (Req. 6)

BMS will be provided links to State agencies and other BMS-designated external entities by HPES. We also will work with BMS to distribute information from specified external entities through the healthcare portal. The healthcare portal easily supports the ongoing publication of such information.

Ensure Compliance with State and Federal Regulations (Req. 7)

The healthcare portal will be designed, developed, implemented and operated in accordance with State and Federal regulations and guidelines related to security, accessibility, confidentiality, and auditing.

Provide Secure "Once Only" Web Survey Responses (Req. 10)

We propose conducting surveys electronically through the new healthcare portal using Survey Monkey. Conducting surveys electronically supports a most effective means to compile results and make them easily and quickly available to our HP Provider Services staff and BMS.

Survey Monkey is flexible in that it can reach a targeted audience of providers or the entire provider community and is an easy-to-use and cost-effective method for conducting surveys. Surveys will be made available through the West Virginia provider portal. Online surveys allow BMS and our HPES team to quickly and easily assess operational and program performance of the West Virginia Medicaid program.

Technical

As the WV-iC moves into the Fiscal Agent Operations Phase, HPES will diligently monitor our performance. HPES is a fiscal agent in 22 states and brings our mature operations experience to West Virginia. The HPES team will proactively monitor systems availability and operations, which includes comparing and evaluating actual system performance to system specifications and initiate resolution of anomalies. We will build our high-performance team to appropriately support and monitor the WC-iC as we have done successfully and satisfactorily in our other states. Cross-training and knowledge-sharing occur continuously within the teams. This avoids single points of failure and reduces the risk of service disruption when key personnel are unavailable. We also stagger teams and team members to provide an effective 24 x 7 support rotation where applicable. We schedule employees within each critical support team on a production-support rotation in which different members of the team would be on call at different times.

System Availability

System Availability, Failover, and Reliability (Req. 1)

HPES will adhere to defined performance standards to meet system availability, failover, and reliability requirements of the SLAs as defined in Appendix G. This includes using the KPIs defined within each SLA that provide monthly reports of our performance compliance based on the KPIs and, if necessary, provide BMS a written Corrective Action Report when a KPI is not met. Throughout the life of the contract, we will work with BMS to annually evaluate and change KPIs as needed.

Additionally, the HPES solution includes numerous capabilities that enable failover at our primary and backup data center. Our approach verifies critical system availability 24 x 7, except for scheduled downtime. Our recovery time objective (RTO) is 24 hours to completely transfer production operations to the backup system, redirect associated network traffic, and return to regular production volumes.

Provide Authorized Users Access (Req. 2)

Because we understand the vital role WV-iC plays in delivering Medicaid services to West Virginia residents, HPES knows appropriate access to WV-iC is paramount. We will implement a comprehensive security management function across the applications to provide authorized, role-based, and appropriate access to system and applications. The HPES team will promote system component access to users authorized by BMS to include BMS staff members, providers, and members. Appendix E Business and Technical Requirements M.E. 21 required enrollment brokers to have direct user-access to the MMIS. This requirement is met through our role-based user access and security profiles. User ID and passwords are used to

identify the users and control access rights and authenticate whether the user has access to a PC, a network, or an application. At the application level, the ID and password are used to identify the user and authenticate what data the user can access and what level of access is granted, such as read-only, or if the user can change or delete data.

We will meet access performance standards 100 percent of the time 24 hours a day, seven days a week for web portal, AVRS, and pharmacy POS–except during negotiated downtime for system maintenance during off-peak hours.

Operate Technical Support Desk (Req. 3)

HPES will share our Information Technology Infrastructure Library (ITIL) expertise and capabilities to deliver a technical support desk to BMS. The IT services industry considers the ITIL framework a best practice. It promotes that services, processes, tools, and support activities be integrated so that services can be reliably provided while delivering higher value to the business. HPES has built our best practice processes during 40-plus years of integrating large-scale customer IT environments. The HPES team will perform first-level support though our web portal, email, and telephone and be available at least for 100 percent of the time during BMS working hours.

Submit System Maintenance Schedule (Req. 4)

HPES will routinely perform system maintenance on WV-iC during times least disruptive to system users. HPES will work with BMS to develop an approved system maintenance schedule at least 30 days before the event.

Schedule Maintenance Window (Req. 5)

To minimize service disruptions, HPES will schedule and complete maintenance between the hours of 1 a.m. and 6 a.m. If event maintenance cannot be performed during that window, HPES will seek approval from BMS or provide justification to request a different time frame.

Make a Daily System Availability Schedule (Req. 6)

HPES carefully monitors system availability and follows a predefined availability schedule that takes into consideration scheduled maintenance. We will distribute the system availability schedule to MMIS users and staff members through email. As the schedule changes, updates also will be distributed.

Provide a Failover Environment (Req. 7)

The HPES solution includes numerous capabilities that enable failover at our primary and backup data center. A dedicated failover environment at our backup data center in Colorado Springs provides the ultimate recovery to support continuous flow of operations so business is not affected by natural disaster or random events such as loss of power at the primary site. The HPES solution also includes high-availability features such as Tier 3 data centers, multipath network links, redundant compute and storage components, application clustering, and virtualization. The primary and backup data centers are linked with redundant, high-speed MPLS network circuits that enable continuous replication of data using storage area network (SAN) and application-based replication technologies. For example, HPES uses Oracle Database Enterprise Edition with Data Guard to keep both data center's databases synchronized. This is a allows near real time, asynchronous updates of transactions to the backup data centers failover environment for 24 hour a day, seven day a week access to data. This approach verifies that critical systems are available 24 hours per day, seven days a week, except for scheduled downtime. Our recovery time objective (RTO) is 24 hours to completely transfer production operations to the backup system, redirect associated network traffic, and return to regular production volumes.

Security and Privacy

Security, privacy, and confidentially are critical elements of the MMIS Re-procurement Project's success. The HPES team will preserve the security, confidentiality, privacy, availability, and integrity for the sensitive information we will manage for BMS. HPES brings our best practices and expertise from around the globe to deliver the right security and policies, requirements, control standards, and implementation procedures for BMS.

BMS will experience an outstanding level of security and confidentiality service. HIPAA readiness is fully integrated in the system. We use our security, privacy, and confidentiality plan—which will serve as a living document for the life of the project—to support every facet of the MMIS program. HPES will develop a comprehensive set of policies, procedures, and standards for WV-iC that will be documented in the HPES West Virginia MMIS Security, Privacy, and Confidentiality Plan. Please see the "Comprehensive, Initial Security, Privacy, and Confidentiality Plan" subsection of our response to RFP section "3.2.6 Phase 1: MMIS Replacement DDI & CMS Certification Planning" for our detailed responses to security and privacy. In this section, we address the Appendix F Security and Privacy requirements that the HPES team will meet during the Operations Phase.

Each user will have a unique ID for accessing the system. The individual user will be allowed to access applications on the system only after entry of a password with the correct user ID. User IDs are set up with role-based security, with the ability to assign multiple roles to a user ID, which means users are limited to the functions they are allowed to perform. Our solution meets Appendix D Requirement SP1.3 to support a user security profile to control user access rights to appropriate levels of functions. For example, some providers may have inquiry access only while others will have the update capability necessary to submit claims. Stakeholders are not provided access to a system they are not required to use. The logon process provides a list of applications that are available. The only applications that are listed on this screen are those the stakeholder has been granted access to use.

Provide Secure Email (Req. 8)

Email has become a cornerstone of electronic communication that delivers a range of operational benefits and efficiencies. We use a careful selection process to make sure the COTS products—including email—and hardware specific to our security solution integrate with the overall architecture and solution. The following table includes the secure email products HPES will use to manage daily email demands, and those that require security encryption.

Email Software Products

Purpose	Vendor	COTS or Hardware
Account-Based Email Gateway	Microsoft	Account (or healthcare-based) exchange email gateway (to help route account based email by server for DLP)
Secure Encrypted Email	HP	Secure/Multipurpose Internet Mail Extensions (S/MIME)

Provide New MMIS User Access (Req. 9)

HPES will implement a comprehensive security management function across each application to provide authorized, role-based user access to systems and applications. HPES' solution proposes implementing robust identity management controls—including password management controls— designed to prevent wrongful use, access, and disclosure of sensitive information. This extends to providing appropriate role-based MMIS access to new, authorized users.

We will follow established HPES procedures that include conducting required security checks and protocols for new staff members. Access is granted using a security request form approved and sent to a security team for execution. HPES will develop security request form procedures that provide detailed explanations for the access types listed on the form. Security access will be provided within one workday of employment or notification. Users receive their IDs after HPES receives appropriate authorization.

Terminate BMS User Access (Req. 10)

HPES will use our user access procedures and security request form to revoke access of terminated BMS users. The form will be approved by an individual listed on an authorized submitter list and sent to a security team for execution. To protect the integrity of MMIS confidential data, HPES will swiftly terminate access for terminated BMS users by the end of their last business day and within one hour of notification by BMS.

Identify Email and Internet Spam and Scams (Req. 11)

Antivirus and anti-spam software and support will filter infected or "junk" email from the email server before posting to the email users. The HPES team uses proven McAfee Endpoint Antivirus software for virus detection and control. The software is configured to notify recipients on detection of an infected email. Our support teams will use features in McAfee to allow administrators to authorize or block website access, promoting compliance.

Detect and Prevent Hacking and Intrusion (Req. 12)

HPES best practices dictate a multilevel security regime that provides high-speed firewall and intrusion detection capabilities within each security zone. The policies governing the type of traffic that passes between the networks through the firewalls are normally strict to increase performance and decrease the possibility of misconfiguration—which could inadvertently leave an avenue for hackers and unauthorized users.

Intrusion detection sensors complement the firewalls at various points in each security zone by looking for specific profiles that indicate suspicious activity. They can alert or respond to such events. In this way, Internet server farms are secured from intranet and extranet server farms, external access gateways, and internal networks.

HPES has developed a framework that enables the solution to stay platform-neutral and use web services. The security component broadly encompasses various subcomponents, each playing a role in controlling access to resources and keeping the system safe from fraudulent or malicious intrusion. The standard in SOA-related security is Web Services Security (WS-Security). This standard defines application-to-application security that can pass sensitive portions of the message through intermediate applications without decrypting the message. The security subcomponents include identity management, access control, encryption, public key infrastructure, digital signatures, and threat protection.

The files in WV-iC UNIX systems are protected by native UNIX utilities, including Pluggable Authentication modules (PAM), Access Control Lists (ACL), and files and directory permissions. These utilities deny access to unauthorized personnel and inappropriate modification or deletion of files, and corruption and mutilation of files is prevented. The environment also deploys host intrusion detection and processes for reacting to potentially malicious activity.

Files in WV-iC Microsoft Windows systems are protected by a combination of native Windows tools, including Active Directory authentication, file and directory permissions, and McAfee anti-virus software. These utilities deny access to unauthorized personnel. Attempts to gain access are logged and monitored, and inappropriate modification or deletion of files or corruption and mutilation of files is prevented. The environment also deploys host intrusion detection and processes for reacting to potentially malicious activity.

HPES recognizes the importance of protecting the data entrusted to us by BMS. One of the many layers of protection is preventing unwanted users and traffic on the network. This layer of security includes such actions as network and host intrusion detection and intrusion prevention, service and protocol filtering at points such as a firewall, and following standard practices to harden servers. Intrusion detection will continue to be employed on the host servers that store PHI. The software will be configured to detect and protect from malicious activity. Network hardware also will have software that will be configured to monitor the content and flow of network traffic. If potentially malicious traffic is detected, operations will be alerted and, when possible, the traffic will be automatically blocked.

The hosts and network firewalls will be configured to close ports that are not needed, limiting traffic into the network from these ports. Traffic from open ports will be monitored and will not allow traffic to pass into the network unless it is explicitly allowed. This will be done by defining valid source and destination Internet protocol addresses in the internal firewall configuration. Filtering will be done on the host systems to enforce policies to block traffic that is not allowed. Blocked traffic is specifically defined as traffic not explicitly allowed by security policy.

BMS and HPES facilities and surrounding grounds are the first line of defense for protecting information, assets, and staff. The facilities are designed to limit access to only authorized personnel. Entrances that are not manned are locked to prevent unauthorized access. Our physical facility access protocols will include the following security measures, guarding against intrusion and unauthorized use of system resources:

- Security badge entry cards and unique PINS
- Cameras at access points
- Mechanical audit logs and monitoring stations
- Fire suppression and flood warning systems, fuel, and battery backups
- HVAC control access
- Network drop access
- Policies for background and security clearance
- Escorts
- Hours of access

Report Hacking and Intrusion (Req. 13)

Under HIPAA, 45 code of Federal Regulations (CFR) 164.308(a)(6)(ii), 45 CFR 164.530(f), and section 13402 of the HITECH Act, each employee at the West Virginia account will be trained as required to prevent, protect, and report security incidents—including hacking and intrusion.

The HP Global Security Group (GSG) leads in the investigation of incidents to determine if unauthorized access occurred. If unauthorized access to customer personal data occurred, the HP Privacy Office is consulted. Our policy is to report customer data breaches to our customers and law enforcement officials based on the requirements in the specific customer contract, relevant security breach laws, and regulations. We have cross-functional, multidisciplinary escalation processes to proactively manage security incidents. As stated in Appendix D Requirement SP3.4, HPES will provide security incident reporting and mitigation mechanisms, such as the following:

- Generate warning or report on system activity based on security parameters

- Terminate access or generate report when a potential security violation is detected
- Preserve and report specified audit data when a potential security violation is detected

Our post-breach review procedure includes the analysis of system and procedure weaknesses to make sure that appropriate remedial and longer-term cause elimination efforts are taken.

A successful breach notification plan encompasses more than just a method for promptly notifying the victims of a security breach event. HPES will implement full audit trails of system activity so that when a security breach occurs, the mechanism and extent of the breach can be determined. We will help BMS minimize the potential effect of threats by addressing the technical, environmental, and personnel aspects holistically with a common, guiding principle.

The WV-iC will be designed to provide an audit trail for each transaction identifying who made the change, what change was made, the date or time stamp of the change, and why the change was made. It will be able to provide a record of the data before the time the change was made. Audit trail functions have received full federal certification as part of the base interChange MMIS that has been retroactively certified by CMS.

HPES requires an audit trail of security relevant events be maintained. Such events include the following:

- Network access attempts
- Database start-up and shutdown
- Creation, alteration, and deletion of user accounts
- Unsuccessful attempts to connect to the database
- Activity performed by users with elevated privileges

Additionally, audit trails must be periodically reviewed based on the criticality and sensitivity of the database and database content. Audit trails must be protected against unauthorized disclosure, alteration, or destruction.

Prevent Adware or Spyware (Req. 14)

HPES proposes using industry products to proactively intercept adware or spyware. Network hardware also will have software that will be configured to monitor the content and flow of network traffic such as Symantec Endpoint AntiVirus. If potentially malicious traffic is detected, operations will be alerted, and, when possible, the traffic will be automatically blocked.

Update Virus Blocking Software (Req. 15)

The new MMIS is designed to guard against virus infections. HPES will aggressively monitor WV-iC to track new threats and communicate across the support team, remotely and mechanically apply patches to infrastructure components, and report on noncompliant equipment. Our team will support procedures for guarding, monitoring, and detecting malicious software and will deploy the AntiVirus software listed in the following table. This meets Appendix D Requirement SP3.3.

AntiVirus Software

Purpose	Vendor	COTS/Hardware
Virus Protection and Management	McAfee	McAfee Endpoint AntiVirus (for desktop) real-time anti-malware protection—Block viruses, Trojans, worms, adware, spyware, and other potentially unwanted programs that steal confidential data
AntiVirus for Servers	Symantec	Symantec AntiVirus (for HP-UX and Windows Server) combines Symantec AntiVirus with advanced threat prevention to deliver unmatched defense against malware and secures physical and virtual environments

Run Penetration Test (Req. 16)

HPES uses the NIST-800 guidelines as control standards to meet compliance with security, confidentiality, and audit controls. We will comply with these strict control standards and work with BMS to minimize risk and maintain compliance with the HIPAA Privacy and Security Rules.

HPES will continuously monitor WV-iC activities. Tasks include testing configuration management and control of information system components, security impact analyses of changes to the system, ongoing assessment of security controls, vulnerability scans, penetration tests, and status reporting. We will work with BMS to provide logical and physical security assessments—for example, every six months.

Provide Additional Security and Confidentiality Capabilities (Req. 17)

WV-iC is built on the proven moderate- to high-security baseline our healthcare security experts have established for 22 Medicaid accounts nationwide. Because security risks constantly change, HPES will regularly work with BMS to evolve the system and data security and confidentiality plans to accommodate advances in technology and new capabilities.

Conduct Monthly Physical Security Audit (Req. 18)

HPES will protect information, property, and assets we hold or maintain for BMS. In accordance with Federal Information Processing Standards (FIPS) Publication 201; National Institute of Standards and Technology (NIST) Special Publications 800-73, 800-76, 800-78; Intelligence Community Directives (ICD) 704; and Director of Central Intelligence Directives (DCID) 6/9, HPES will verify that the security privacy and confidentiality plan and associated procedures will apply to the HPES facilities associated with this contract. HPES will conduct monthly physical security audits of BMS-specified requirements and forward the results to BMS.

Review Non-BMS Employee MMIS Access (Req. 19)

Security for the WV-iC is built on a fundamental philosophy—providing the right information to the right authorized user and only to the right authorized user. HPES will implement a comprehensive security management function across the applications to provide authorized, role-based access to system and applications.

The security administration module allows for efficient security creation and maintenance. The WV-iC security repository maintains MMIS security and user permissions. User security enables categorizing access into different security levels defined by BMS, including non-BMS employees. At a minimum, the categories will include users, groups, and roles. Through these security levels, the MMIS provides the permission settings necessary to perform actions. We maintain appropriate security and access controls by limiting access to MMIS tables to authorized users, using application-level security measures, and allowing only authorized users to access web pages, the network, and applications.

Provide Staff Read Access (Req. 20)

User security within the WV-iC system is based on user ID, user group, and business role, at a minimum. Additionally, database roles are used to control WV-iC program access to the Oracle database. Security protection is extended at the application level (screen access) and the system level (file access). HPES will verify that BMS authorized IT staff members have appropriate read access to each database in each region.

Secure Software (Req. 21)

HPES will secure the software at our site by the individual, group, or type of requestor.

Report Inaccurate Processing Results (Req. 22)

Security is critical to protecting our employees, our assets, and information entrusted to us by our customers. Security also is the foundation of our relationship with our customer base. Our business is built on the trust our customers put in our teams to protect and properly manage the information and assets they entrust with us to provide uninterrupted, high-quality service. A basic goal of security management is to facilitate adequate information security. In turn, the primary goal of information security is to protect information assets against risks and maintain their value to the organization. This is commonly expressed in terms of facilitating the information assets' confidentiality, integrity, availability, and related properties or goals such as authenticity, accountability, nonrepudiation, and reliability.

For the HPES team, our primary goal is to protect sensitive information. To accomplish this goal, we will use our corporate resources to incorporate current privacy and security best practices into the WV-iC security, privacy, and confidentiality plan throughout the contract. We make this a priority by implementing the following five-step continuous improvement privacy and security program management model as part of our ongoing risk management and compliance process:

- **Assess**—Privacy and security regulatory review; legal advice; privacy risk assessment; Level 1 risk assessment (abridged risk assessment process for small or minimal system or account operational changes); Level 2 risk assessment (NIST 800-30 type assessment); cost-benefit analysis; vulnerability scan; penetration test; and risk management decision
- **Design**—This step comprises the following:
  - Management—Documentation, roles and responsibilities, contingency planning, and configuration management
  - Technical—Identification and authentication, account management, session controls, auditing, malicious code protection, maintenance, networking and connectivity, and communications security

  - Operational—Media controls, labeling, physical environment, personnel security, education training and awareness, and security concept of operations (SECONOPS)

- **Implement**—Policy, requirements, control standards, and implementation procedures; account security, privacy, and confidentiality plan; disaster recovery plan; and business continuity plan
- **Train**—New employee, annual refresher, privacy and security enhancements, specialized, technical, and professional training
- **Monitor**—Security and confidentiality compliance plans comprising monitoring activities and associated deliverables to verify that security and confidentiality requirements are maintained throughout the contract

HPES also can identify these errors from provider calls and verify that the error is corrected and the resolutions specialist is advised and, if needed, receives additional training. Our solution can run automated adjustments at the customer's direction for providers to resolve such issues and build in edits and audits that are a means of preventing claims from processing incorrectly. Additionally, WV-iC has documented processes for edits, audits, pricing updates, and other information that affects claims payment at the customer's direction and audit trails and quality procedures to check the accuracy of those updates. For example, the medical and dental quality assurance manager will have a quality process in place to review a random sample of claims and check for claims errors such as these.

Post-Implementation Monitoring and Quality Control (Req. 2 a-f)

Quality is a critical element in successfully managing the WV-iC. To facilitate continued confidence in the performance of the MMIS, we stress the importance of quality at each level. HPES has designed a QA and quality management program that provides maximum visibility into contract performance, beginning with project implementation and continuing throughout program operations.

The Medical/Dental and POS quality managers will work with operational leaders to monitor and provide oversight of compliance with the standards and metrics identified in the quality plan and that the activities are functioning properly. Using HPES tools, leaders can aggregate and display data from various data sources. HPES will develop interfaces to automate several of these processes, displaying data in tailored or customized reports, building metrics from data sources and applications, and capturing measurements in our project document repository.

The quality managers will work with BMS to define, implement, and measure quality metrics. These metrics will contribute to a strong foundation for predictive analysis about whether our performance and system is meeting expectations and that our manual and automated processes are functioning properly. With our monthly status report, BMS will receive a precise and clear picture of HPES' performance in each area of operations. We will conduct monthly quality reviews at the account leadership level, examining these results and looking for areas where additional research and a corrective action plan may be required. Using this communication tool, BMS can verify continuous improvement at each level of operations.

Medicaid is a unique and complex balance of the responsibilities and regulations of law, obligations to providers' business requirements, and members' special needs. To succeed, the program and fiscal agent must work together to provide outstanding service through fiscally challenging times and with no interruption in service to the member and provider communities. Achieving this complex balance demands a dedicated, account-wide approach to quality. To deliver this level of program quality, HPES will blend industry-standard QA processes that promote a quality-focused culture where process improvement and proactive prevention are everyday occurrences.

Issue management is critical to the success of the West Virginia Medicaid program. An issue is an active, current problem that needs to be resolved before it affects the program's objectives—including schedule, scope, quality, or budget. HPES will provide BMS with a thorough, integrated plan for identifying issues and then managing them to minimize their effect. Our issue management approach is a method to resolve problems encountered by the project teams to minimize possible negative effects to the program. Left unresolved, an issue will impede or prohibit project-related progress or development by affecting scope, budget, schedule, resources, or quality. We must actively manage and resolve issues to keep the projects and phases on track. This issue process defines how a specific issue should be identified, documented, resolved, tracked, and reported.

HPES will monitor the system, identify problems or issues immediately, and communicate the information. Problems are entered into our trouble ticket system by both BMS or HPES personnel and an email or telephone notification is made to the analyst within the stated time frames. Trouble tickets are exceptions that BMS or HPES have identified and that are researched by HPES. These tickets are high-priority and resolved as quickly as possible. The trouble ticket is assigned to a member of the HPES team for resolution. The assignee resolves the problem from the trouble ticket or follows the change order process for any maintenance or modification items to implement the proposed change. The status of the trouble ticket is kept current by the

person assigned. When a resolution for a trouble ticket has been identified, the Solution section of the trouble ticket is updated with details of the resolution. This allows everyone, including BMS, online current access to the status.

BMS will be provided weekly reporting of trouble ticket, defect, and change order. The specific details of the reporting, including the effect and the scheduled repair implementation date, will be defined with BMS and HPES during DDI and will continue into the Operations Phase. Satisfaction surveys provide a valuable tool for receiving feedback from the Medicaid community—providers, members, BMS staff, and other stakeholders. HPES conducts similar surveys for various states at various stages of the implementation and operation life cycle or the project.

HPES will provide personnel to work with BMS staff members to design, distribute, collect, and analyze results from a post-implementation evaluation of the user community. The first-run reports—federally required and State-specified—will be stored in the HP TRIM data repository with the subsequent runs. When a validation item in a Certification Checklist asks for a production report, such as the federally required reports, we will obtain them from the repository. The entire report, or a few key pages if it is large, can then be saved in the Certification Links with the Development Center's Certification Tool. See Phase 2b: CMS Certification (3.2.7.2) for more detail on the certification tools and collection of data runs.

A Post-Implementation Report detailing the results of implementation activities will be provided to BMS on completion the Operations Implementation.

3.2.7.2 Phase 2b: CMS Certification

The road to federal MMIS certification requires a joint effort between BMS and HPES, and we are committed to this joint effort. Our interChange system has been successfully certified in nine states, with the most recent Wisconsin certification using the CMS MECT and checklists with outstanding results, no CMS findings, and full retroactive funding to day one of operations.

HPES meets mandatory requirement 3.1.11. Per addendum 3, BMS and HPES will be responsible for determining that the system has met the certification standards before BMS requests CMS certification. HPES understands we will not be responsible for system certification of components that are not included in the scope of this RFP. We also meet mandatory requirement 3.1.26, in which HPES will meet CMS Certification Requirements as described in Appendix D. Our standardized process and experience with CMS certification reviews supports a positive result. We will use a certification review process for these components that has a strong project-based structure, clear communication channels, and robust reporting. We will use the new MECT checklists throughout.

Certification Activity Model

HPES' model for certification using the new CMS checklists requires us to incorporate the formal certification process into the overall DDI and carry it through to system operations, as detailed in the table, Certification Activity Model—From Certification Project Start-Up Through Post-CMS Review, in our response to section 3.2.6.5 Phase 1e: CMS Certification Planning.

Completion of the Phase 2b Deliverables and Milestones

The HPES approach for certification will include staff training on HP Development Center's certification tool, support as we define each validation item and its supporting system or business processes, and the navigation steps to production examples also within the certification tool and its data repository. Using the certification activities listed in the following table with the formal milestones and approvals as each activity milestone is completed, we will be successful and well informed every step of the certification planning and preparation through to presentation and final certification from CMS.

Certification Activity Milestones

Certification Activity Milestones	Approximate Time Frame
Phase 1e - CMS Certification Planning	
CMS Certification Readiness Plan sent to BMS (Deliverable 133)	Initial submission at the completion of Requirements Validation and then updated based on joint agreement with HPES & BMS
CMS Certification Readiness Plan sent to BMS	Updated version 9 Months prior to Go Live

Certification Activity Milestones	Approximate Time Frame
Status Reporting	Status reporting on Certification Activities throughout activities
MILESTONE - Completion and BMS Approval of Phase 1e	At the completion of the above set of tasks
Phase 2b - CMS Certification	
Certification Readiness Planning Meetings	Joint HPES & BMS meetings to determine Certification Activities starting at Go Live and continuing until the CMS Site Visit
MILESTONE - Completion and BMS Approval of Certification Readiness Planning Meetings	At the conclusion of above activities
Update CMS Certification Readiness Plan	Approximately 2 months after into Operational timeframe
Certification Protocols & Checklists	Approximately 3 months after into Operational timeframe
CMS Certification Documentation & Operational Examples	Start gathering at the conclusion of the first Operational processing cycle
Certification Preparation	Approximately 6 months into Operational timeframe
MILESTONE - Pre-Certification Meeting and/or CMS Call Complete	At the conclusion of Certification Preparation
Creation of the Shared Electronic Documentation Storage for Certification Artifacts	At the beginning of the Operational timeframe
CMS Certification Review	Approximately 8 months into Operational timeframe. After MILESTONE - Pre-Certification Meeting and/or CMS Call Complete
System Remediation -- Certification Corrective Action Plan	At the conclusion of CMS Certification if formal remediation is requested by CMS in the Final Certification Report
MILESTONE - CMS Certification	Final Certification from CMS after System is requested by CMS in the Final Certification Report is complete

Obtaining BMS Approval of the Completion of Phase 2b

As the milestone is completed, HPES will obtain BMS written approval, including final approval of each certification phase (Planning and CMS Certification) in accordance with the RFP requirements.

Methodology and Approach

The combination of HPES' Medicaid experience and document management technologies sets the foundation for a comprehensive and technically sound approach for achieving successful CMS certification. The HPES approach for certification demands that the certification process be intertwined with the DDI Phase by including the following:

- Proposal requirements and certification requirements are included in staff educational and technical assistance sessions. HPES maintains a staff to support certification efforts concurrent with operations.
- RFP requirements are loaded into HP Development Center and linked to their associated system objects to support creation of certification crosswalks.
- Certification requirements are linked in HP Development Center during implementation and requirement validation sessions.

The systems manager is responsible for managing modification and enhancement work and maintaining separate staffing and accounting of the modification and enhancement pool. Modifications are defined as changes arising from regular operations, including but not limited to: system maintenance, changes in rate or fee schedules, changes required for compliance with regulations and standards, and correction of system deficiencies, or defects. Enhancements are changes requested by the BMS to achieve objectives, implement new programs and mature business capabilities. The Modification and Enhancement Pool will be used for modifications throughout the life of Phase 2a Routine Operations, and will be used additionally for enhancements only after the achievement of CMS certification. Modifications and enhancements require BMS approval for implementation.

HP PPM includes rich capabilities that will facilitate this important process and allow for monitoring and reporting of the 15,000 hours for modifications and enhancements. Matt will make certain that the systems group follows cost management standards and processes and that appropriate BMS approvals are obtained before starting work. Please see the "Cost Management Plan" in our response to RFP section "3.2.2 Project Management" for more details.

The systems group will use methodologies, tools, and practices developed during Phase 1. As we move into Phase 2, we will use the best practices brought to and refined during the DDI of our solution. The combination of an exceptional ESDLC, established development and project management methodology and PMO suite of tools, and use of standards and practices will facilitate a strong relationship between HPES and BMS for a highly successful Phase 2. Please see our response to RFP section "3.2.1 Proposed West Virginia MMIS" for more detail on systems development methods.

ESDLC

HPES proposes our proven ESDLC for use as a cornerstone to managing development and implementation of modifications and enhancements of the MMIS Re-procurement. Our ESDLC is a systems engineering methodology developed across time and through our experience with other customers. HPES has used this ESDLC with our other MMIS projects during development and subsequent enhancements, and the outcome has yielded outstanding results for our Medicaid customers, just as it will for BMS. The ESDLC encompasses the entire process of taking systematic steps to analyze, develop, test, implement, and maintain software, application, and integrated systems. Our ESDLC is well-defined, traceable, structured, and will provide BMS with confidence that modifications and enhancements follow a prescribed methodology from inception to completion.

The HPES ESDLC is based on a comprehensive systems engineering methodology, customized to support various work types such as new application development, infrastructure engineering, system maintenance, enhancements, and systems integration. We encompass the work streams across the phases of the software development life cycle and into operations for system enhancements. Additionally, we bring forward lessons learned from our many previous MMIS implementations. We will continue to use and consistently follow the ESDLC throughout the life of the contract to change WV-iC. This approach combines the work stream components and activities running in parallel of each software development phase with oversight by project management.

Another benefit and control feature of our ESDLC is that the workflow is automated in the HP Project and Portfolio Management (HP PPM) tool, delivering more standards and consistency across the various steps from enhancement to enhancement. Microsoft Project schedules align to the ESDLC workflow and are uploaded into HP PPM. They provide integrated dashboard views of the project status in each phase of the ESDLC. BMS has complete visibility to the status of modification and enhancement work.

We depict the ESDLC steps in the following figure.

the project is delivered on time, within scope and budget, and in accordance with BMS' quality expectations. We meet mandatory requirement 3.1.32. Our tools and processes give clear visibility to BMS so enhancements and modifications can be submitted, reviewed, approved, prioritized, and monitored.

HPES will work with BMS to meet the demands of an exciting and challenging healthcare future. We bring our culture of dedication and innovation to support the range of modifications and changes arising from usual business operations and enhancements designed to achieve BMS' strategic objectives, including the implementation of new programs and the maturation of business capabilities.

Implementing Modifications and Enhancements with Minimal User Disruption

When political pressures, budget mandates, or legal action require complex, time-critical, changes impacting multiple moving parts, HPES can accommodate BMS with experienced, knowledgeable staff members who understand the technical intricacies of the MMIS and the sensitive nature of those served by the West Virginia Medicaid Program. Our staff has a proven track record of successfully accomplishing significant systems changes while appropriately managing and minimizing the effect to users. We will follow methodologies established during Phase 1 for testing, training, and determining implementation readiness. HPES will employ a three-phased approach—plan, prepare, and execute.

Plan

HPES will work with BMS to clearly define the enhancement or modification's scope and establish a schedule. We will use the Change Control Board (CCB), the PMO, and its project management processes and procedure and our ESDLC to make sure planning is complete and documented. We also will establish work product reviews early in the process to level-set expectations and establish appropriate accountability. Open and frequent communication will complete plans for WV-iC changes.

Prepare

Planning moves into preparing, and we continue this activity using our repeatable project management practices, schedule monitoring and management, and communication of plans, progress, and detailed implementation plans. We review plans for consistency and clearly defined deliverables and milestones in the implementation plan. With our vast MMIS experience, HPES has learned the importance of involving SMEs early. We will maintain a central record of project coordination and manage status tracking, issues, risks, and report to BMS consistently and promptly. We will communicate to BMS and users frequently and thoroughly of pending changes and help prepare users for training. It is critical that users are fully knowledgeable about the system enhancements and deployments that are occurring. Communication is critical to minimizing user disruption. As the project progresses, readiness activities will focus more heavily on training and go-live preparations, which need training and performance support.

Execute

A well-defined testing methodology will lay the foundation for successful implementation. Our testing methodology promotes productivity, quality, and efficiency in our testing practices, providing a better deliverable and reduced risk. User acceptance test (UAT) plans are well-defined and subject to reviews and approval before testing can begin. UAT enables defects to be caught at the earliest possible moment, reduces risks, and prepares the user community for changes. User training may cover a broad spectrum of training approaches—self-paced, instructor-led, or computer-based training—and will be determined during planning. At this stage, training will be delivered as planned. For more information on training, please see our responses to RFP sections "3.2.6.3.2 Testing Task" and "3.2.6.4 Phase 1d: Implementation Readiness."

Monitoring and Reporting Implementation of Enhancements and Modifications

HPES understands the importance of progress reporting and performance monitoring of enhancements and modifications, and has significant Medicaid-specific experience providing both. The PMO will use the HP PPM tool to monitor progress, review artifacts, determine resource allocations, and understand risks or issues identified. Additionally, the HP PPM tool will be the connection point for affected teams that will play a part in the successful deployment of the change after it is through the development stages. For example, BMS will have access to the change request through HP PPM and will know the current status and the expected completion date. BMS can access artifacts that can be used for their outreach, communication, and training for the affected provider community. Another example is how the release coordinator will use HP PPM to monitor the progress and help determine the appropriate place on the release schedule for the change. Meeting minutes and other artifacts from release meetings will be readily available through HP PPM.

The analysis, estimates, requirements documents, approvals, testing scripts, and other related artifacts will be accessible to appropriate users from the project and BMS. HP PPM will serve as the primary source of information about changes that take place. We will use it in support of changes to scope, schedule, and cost or configured items that go before the CCB. The outcomes of the CCB's decisions also will be documented and available in HP PPM.

HPES will report to BMS, project leadership, and stakeholders as defined in the communication plan. We also will provide project status information to the MMIS Re-procurement project manager in the time frames and in the agreed-on format and meet mandatory requirement 3.1.31. At a minimum, HPES will prepare and submit weekly and monthly status reports. Status reports will include quantitative and qualitative information on project progress, deliverable status, and risks and issue information. Reports will use stoplight reporting, key metrics, and charts to show program status at a high level so that stakeholders can get a quick look at the progress. The format for the weekly and monthly status reports will be finalized and approved by BMS.

We will update the project schedule throughout the project to capture and report the correct metrics as the project life cycle moves through the Development and Implementation phases. We update the plan to include changes to the status reporting formats BMS may require. We also would update the plan to include additional reports we mutually determine are helpful for providing the right information to decision-makers.

Tracking, Review, and Reporting

Project delays and negative effects are reduced through continuous review and evaluation, tracking, and sharing of risks. HPES will use our HP PPM tool to proactively track, monitor, and report status on enhancement and modification change requests transparently. The PMO will regularly track and report on project team-level, phase-level, and program-level change requests using HP PPM. Communication and reporting can occur directly through the user's access to HP PPM. MMIS Re-procurement users do not have to wait for status—it is provided to them as needed using the HP PPM tool. This includes the estimated and actual hours allocated to each change request, specific personnel assigned to each change request, scheduled completion date for each change request, total cost (if maximum allowable hours exceeded), total approved operations charge increase (if any), and a separate total for equipment requirements (if applicable) related to the modification.

Using the HP PPM tool, many progress metrics will be available at any time based on the current data in the tool. Project personnel are required to enter actual schedule and effort information into HP PPM regularly, which results in current time-tracking metrics being available for analysis. Metrics are included in the weekly and monthly and status reports for team members and leadership to get an objective view of the project progress.

After the metrics and reporting process have been defined and the project work has started, the metrics are analyzed. We review and analyze metrics to identify problems early on. Each week, project managers and team leads will review metrics on schedule, cost, risk, and quality and create corrective action plans when problems are identified with the metrics. The weekly and monthly status reports will include dashboard reporting and several graphs or charts to give a quick, visual view into the project's health.

3.2.8 Phase 3: Turnover and Close-Out

RFP Reference: 3.2.8 Phase 3: Turnover and Close-Out

Methodology and Approach to Phase 3 Turnover and Closeout

HPES looks forward to providing a high level of service to BMS throughout this contract. Along with the commitment to support the WV-iC MMIS, we also are committed to serving BMS in conducting a smooth turnover to the successor vendor if BMS chooses to contract with another fiscal agent. We will strive diligently to provide a smooth turnover for system users, providers, and members so that it does not affect or diminish the current operations and production of the WV-iC MMIS for which HPES will remain responsible through the end of the contract period.

On written notice from BMS, approximately 18 months before the end of the contract period, HPES will support an orderly, controlled turnover of contract operations by defining and communicating our activities, roles, and responsibilities. We will continue our services and provide a WV-iC system that is fully operational as required through the last day of operations. We will facilitate continuous claims payment and related fiscal agent services for smooth operation of BMS' programs until HPES' turnover tasks are successfully completed in full. This is our commitment to BMS.

The completion of the Turnover and Closeout Phase is just as critical as the DDI and Operations phases.

During the Turnover and Closeout Phase, the Account Executive will name a Turnover Project Manager who will be responsible for the oversight of the Turnover and Closeout Phase of the project. HPES will take the necessary action to support our turnover activities and tasks that minimize disruption to our West Virginia Medicaid Program services provided to members, providers, and operational users of the system.

Specifically, our turnover methodology supports the RFP's objectives: turnover and close-out management; working cooperatively with the successor Fiscal Agent, other vendors, and BMS to create and carry out a plan designed to promote a smooth and orderly transition to the new vendor; providing the necessary resources to perform fiscal agent responsibility through the effective date of the transfer of responsibility to the new vendor—including developing a Staff Transition Plan and completing contract close-out financial reconciliation to include: final settlement of vendor invoices, final reconciliation of accounts receivables, and final assessment of payment retainage and damages. Our turnover methodology for West Virginia is based on our past successful turnover plans. HPES has assumed operational responsibility from incumbent contractors, and we have turned responsibility over to state departments of health and successor vendors.

This experience provides us with lessons learned and proven practices in working with parties involved in turnover. Each of these projects follows a Turnover Plan based on the approach described in this section; as with other deliverables and approaches described in this proposal, turnover is based firmly on plans and approaches proven to work.

Completion of the Phase 3 Deliverables and Milestones (Req. 1)

HPES will supply Turnover and Closeout deliverables listed in the RFP and meet milestones as described in Appendix C of this RFP. We understand the activities, time, effort, and risks associated with the turnover of an MMIS—including the deliverables and milestones necessary to accomplish the turnover task. We will start with a previous successfully executed Turnover Plan as a base template and enhance it with West Virginia-specific tasks and activities. The plan will include a turnover project schedule that identifies turnover tasks and activities, their scheduled start and completion dates, their status, the assigned resource, and the responsible party. This is a shared activity requiring BMS' approval and HPES' commitment for executing the agreed-on Phase 3 Turnover and Closeout requirements. Our turnover plan will include system and operations tasks for each WV-iC functional area. We will provide BMS with a project plan that contains an extensive set of turnover tasks such as the following:

- Determine turnover approach
- Produce a work plan and schedule for BMS approval
- Identify facilities turnover activities
- Supply electronic WV-iC system documentation
- Define process for cutover of claims and financial activities and communicate to key fiscal agent stakeholders
- Provide claim, adjustment, and financial archive data from the WV-iC system.
- Establish communication processes to be used between BMS, stakeholders, the new fiscal agent, interface vendors, and the user community

BMS will receive an interChange MMIS requirement statement from HPES. This document is a detailed statement of resources that may be required to assume operation of the MMIS and fiscal agent services. Based on resources devoted to the program, we will provide three groupings of resources:

- **Personnel resources—**The requirements statement will include an estimate of the number and type of personnel required to operate the equipment and perform the other functions of the WV-iC MMIS.
- **Technology resources—**This list of technology resources details the technology resources needed to operate the WV-iC. The technology resources include the following elements: MMIS software and reference files, operations and system user documentation, hardware, data storage, and cycle processing requirements, and system and operations support services.
- **Facilities resources—**This list of facilities resources details the facilities and other resources needed to operate the interChange MMIS. The facilities resources will include the following elements: Data processing equipment, system and special software, shared equipment needs, telecommunications circuits, web URLs, and office space.

HPES will base our MMIS resource requirements statement on the inventory maintained in our inventory system and on our experience in the operation of the WV-iC MMIS and will include any contractor resources devoted to the operation of the system. We will work collaboratively with BMS and the incoming vendor to verify the transition of West Virginia interChange MMIS is supported in a manner that minimizes risk to BMS, service providers, and members.

MMIS Inventory Report

An MMIS Inventory Report will be created to list the in-process inventories that will be turned over to BMS or the new vendor. This Inventory Report will include items such as: inventory lists for MMIS software, files, and operations and user documentation; MMIS inventory report from the WV-iC system including in-process claims, prior authorizations, adjustments, and financial transactions; in-process provider written inquiries and provider manuals; in-process member written inquiries; and requests and other inventory as applicable.

Turnover Results Report

The Turnover Results Report will be created and delivered to BMS as final documentation of the Turnover and Closeout process. This report will provide turnover results of the Phase III turnover activities. Having participated in turnover and close-out activities on contracts we have turned over, as well as having been on the receiving end of turnover and close-out for contracts we have taken over, we have developed a set of Best Practices that we follow to facilitate the transition to a new vendor being a positive experience for BMS, the providers, the members and the new fiscal agent. For each functional area, we will identify the system files, paper and electronic documents, processes, and procedures that must be delivered for turnover to BMS' new fiscal agent. As the global healthcare leader within the state and local arena, we are stating for the record, "The last day is as important as the first day." We are fully committed to working with BMS, West Virginia providers, members, program stakeholders, and the successor contractor(s) in planning and performing the RFP turnover activities.

Obtaining BMS Approval (Req. 2)

To facilitate a smooth transition to the new vendor, we anticipate that an individual or team from BMS will be designated to oversee turnover activities. HPES will coordinate planning and execution of the interChange MMIS turnover with this individual or team. We look to BMS to facilitate the turnover process and serve as liaison between the current and successor fiscal agents and other interfacing organizations; as appropriate, acknowledge, review, and approve the turnover tasks, and milestones; and work with HPES regarding the development and finalization of the detailed turnover project plan and acceptance criteria for deliverables, participate in turnover walkthroughs and delivery of turnover items, provide HPES with written notification of any turnover issues or risks that require action or correction by HPES, acknowledge, review, accept, and sign off on each turnover deliverable and on review and acceptance of each turnover item. BMS will provide HPES with sign-off of completion for that turnover task. Using these proven processes, BMS and HPES can proactively identify and manage potential turnover issues and provide for the completion of Phase 3 deliverables, including agreement of the proposed acceptance criteria in a controlled, fully monitored positive way.

Methodology and Approach (Req. 3)

Turnover and Close-out Management

Whether turning over system and operation to BMS or another vendor, HPES consistently follows a formal and documented approach. We have successfully planned, executed, monitored, and controlled system turnovers for a wide range of customers and technologies under a myriad of circumstances. The HPES team does not approach turnover as an afterthought. We regard it as a critical part and no less important than the other phases of the project life cycle. If a turnover occurs, our experienced team will provide proven plans, processes, and professional delivery of these turnover tasks. To meet BMS' objectives, our team will provide the coordination necessary for the following turnover activities, along with a proven knowledge transfer process: planning turnover and developing a turnover schedule with BMS, developing the turnover plan for HPES activities, planning turnover collaboratively with BMS and the successor vendor, executing and managing the HPES Turnover and Closeout Phase, communicating turnover activities to BMS regularly, turning over WV interChange system documentation, producing final HPES MMIS Inventory and Turnover Results reports and reconciling WV-iC financials and turning over any funds due back to BMS.

The Turnover Project Manager and the supporting HPES team will collaborate with BMS, the successor fiscal agent, stakeholders, users, and appropriate interfacing organizations during the turnover process, from development of the plan through final delivery. The HP Project and Portfolio Management (PPM) tool will continue to be used during the turnover as it was through DDI and operations for insight into the critical aspects of the turnover project. Identified issues, assumptions, and constraints and will be readily accessible by BMS for viewing current information on these turnover items. The turnover work plan will be used to track deliverables, tasks, milestones, and resources. This will provide BMS full access to the turnover project progress. HPES will schedule walkthroughs of the plan with BMS and make agreed-on updates as required.

4.1.11 Subcontracting

RFP Reference: 4.1.11 Subcontracting

More than a year ago, HPES began evaluating the right mix of subcontractors to support the complexities of the West Virginia MMIS Re-procurement Project. HPES and the following subcontractors—proven leaders in their respective fields—converged to create the HPES team for West Virginia:

- Fenwick Technologies, Inc.
- Arkansas Foundation for Medical Care (AFMC)

We selected these HPES team members based on their strengths, which complement our own unparalleled MMIS and fiscal agent experience. The HPES team is the best possible combination of deep national and Charleston-based experience to meet BMS' needs. After extensive reviews, we selected these companies because of their expertise and the shared commitment to getting the job done right the first time, as illustrated in the following table.

HPES Team Members

Subcontractor	Role/Responsibilities	Value to the West Virginia MMIS Project
Fenwick Technologies, Inc.	Information Technology (IT) Staff	• Leadership has more than 26 years experience providing IT services to the State of West Virginia • At-the-ready IT experts experienced in the following: - Project management - Business requirements analytics - Application development o Web—J2EE, .NET, and ColdFusion o Client/Server—Java, VB, and ASP o Mainframe—COBOL - Database analytics o SQL Server, Oracle, DB2, and MySQL - Business intelligence and data warehousing - Network administration o Cisco routers and firewalls o Windows server, active directory o Security - System administration o Mainframe, AS/400, and UNIX - Help desk and PC support - Enterprise resource planning (ERP)
AFMC	Member Satisfaction Surveys	• Nearly 40 years of continuously improving the clinical evaluation and quality of healthcare • Highly experienced statisticians, analysts, and health experts have surveyed more than 100,000 members in more than 70 survey projects to date

The State of West Virginia needs a vendor with proven success in MMIS and multiple system implementation experiences. There is no higher priority for HPES than effective, continuous service and prompt, accurate payments to West Virginia Medicaid providers. By selecting HPES, BMS has the opportunity to minimize its risk of provider issues such as delayed or interim payments, duplicate payments, and recoupment issues that have recently occurred in other states. The HPES team supports BMS in efforts to successfully promote the continued provision of indispensable healthcare services to West Virginia's most vulnerable residents. With HPES and our proven subcontracting team of leaders in healthcare and technology, implementation and operational challenges will be successfully addressed.

The subcontractors we have chosen to help us meet our priority service level to providers have been selected for unique capabilities in their respective spheres of interest. AFMC is a not-for-profit 501c organization headquartered in Little Rock, Arkansas. As a federally designated quality improvement organization, AFMC is one of only 13 NCQA-certified vendors for 2011 and has served Medicaid and Medicare programs for more than 38 years. Its mission is to promote excellence in healthcare through evaluation and education. AFMC has extensive experience in developing and implementing surveys, providing data analysis and reporting results.

President and Chief Executive Officer Ray Hanley, a former Medicaid director for the State of Arkansas and former president of the National Association of State Medicaid Directors (NASMD), will oversee an experienced staff that will fulfill the requirements for surveys in the specification. HPES anticipates that AFMC will be a noteworthy part of our approach to supporting a human contact aspect in the important area of community outreach. Our “Magic Bus Tours” referenced elsewhere in this proposal, conducted across West Virginia during the last two years, have shown that too much emphasis can be placed on automatic, system-generated contact, education, and outreach. Sometimes the agency, the providers, and the program members really do need a person with whom to interact—it is our goal to emphasize this feature wherever possible.

AFMC will perform surveys of approximately 1,350 adults in contract years 3, 5, 7, and 9, and of approximately 1,650 children, in contract years 4, 6, and 8. In this manner, AFMC will help in assessing levels of satisfaction with program services and help identify opportunities for improvement.

Fenwick is a Charleston-based provider of IT project services, staffing services, and network services. Since 1994, Fenwick has served federal, state, and commercial markets by providing large-scale application development project and staffing solutions. Fenwick has successfully performed on dozens of projects delivering sophisticated IT systems to public and private sector customers across the United States and Canada. Ideally situated in West Virginia’s capital city, Fenwick has been a significant provider of IT and services to the State for many years and is a familiar name with a proven track record of excellence and dependability. Fenwick will provide a team of qualified and credentialed IT professionals under the overall project direction of HPES; this team will cover the range of functions from IT operations support and engineering to business analysts and consultants. Fenwick is another factor in the commitment by HPES to seek out and include people with West Virginia roots and sensitivities to help guide our relationships with BMS and its customer community during the next decade and beyond.

4.1.12 Special Terms and Conditions

RFP Reference: 4.1.12 Special Terms and Conditions

3.3.1 Bid and Performance Bonds

RFP Reference: 3.3.1 Bid and Performance Bonds

Per the RFP, no response is required for this section.

3.3.2 Insurance Requirements

RFP Reference: 3.3.2 Insurance Requirements

HPES will provide proof of insurance following contract award. We will maintain and furnish proof of coverage as stated in the RFP.

3.3.3 License Requirements

RFP Reference: 3.3.3 License Requirements

The following evidence is provided in the “Business Organization” section after the Transmittal Letter:

- West Virginia Certificate of Registration with the Secretary of State’s Office to do business in the State
- Certificate of Good Standing with the State Agency of Employment Programs regarding Unemployment Compensation coverage and Worker’s Compensation coverage

3.3.4 Litigation Bond

RFP Reference: 3.3.4 Litigation Bond

Per the RFP, no response is required for this section.

3.3.5 Debarment and Suspension

RFP Reference: 3.3.5 Debarment and Suspension

HPES certifies that to our reasonable knowledge and belief no entity, agency, or person associated with the vendor is debarred or suspended.

4.1.13 Signed Forms

RFP Reference: 4.1.13 Signed Forms

The following signed forms or documents are included in this section:

- Appendix I: MED 96 Agreement Addendum
- Appendix J: MED Purchasing Affidavit
- Vendor Preference Certificate
- Addenda 1 – 6

HPES will comply with the HIPAA Business Associate Addendum.

MED-96

AGREEMENT ADDENDUM

In the event of conflict between this addendum and the agreement, this addendum shall control:

1. **DISPUTES** - Any references in the agreement to arbitration or to the jurisdiction of any court are hereby deleted. Disputes arising out of the agreement shall be presented to the West Virginia Court of Claims.

2. **HOLD HARMLESS** - Any clause requiring the Agency to indemnify or hold harmless any party is hereby deleted in its entirety.

3. **GOVERNING LAW** - The agreement shall be governed by the laws of the State of West Virginia. This provision replaces any references to any other State's governing law.

4. **TAXES** - Provisions in the agreement requiring the Agency to pay taxes are deleted. As a State entity, the Agency is exempt from Federal, State, and local taxes and will not pay taxes for any Vendor including individuals, nor will the Agency file any tax returns or reports on behalf of Vendor or any other party.

5. **PAYMENT** - Any references to prepayment are deleted. Payment will be in arrears.

6. **INTEREST** - Should the agreement include a provision for interest on late payments, the Agency agrees to pay the maximum legal rate under West Virginia law. All other references to interest or late charges are deleted.

7. **RECOUPMENT** - Any language in the agreement waiving the Agency's right to set-off, counterclaim, recoupment, or other defense is hereby deleted.

8. **FISCAL YEAR FUNDING** - Service performed under the agreement may be continued in succeeding fiscal years for the term of the agreement, contingent upon funds being appropriated by the Legislature or otherwise being available for this service. In the event funds are not appropriated or otherwise available for this service, the agreement shall terminate without penalty on June 30. After that date, the agreement becomes of no effect and is null and void. However, the Agency agrees to use its best efforts to have the amounts contemplated under the agreement included in its budget. Non-appropriation or non-funding shall not be considered an event of default.

9. **STATUTE OF LIMITATION** - Any clauses limiting the time in which the Agency may bring suit against the Vendor, lessor, individual, or any other party are deleted.

10. **SIMILAR SERVICES** - Any provisions limiting the Agency's right to obtain similar services or equipment in the event of default or non-funding during the term of the agreement are hereby deleted.

11. **ATTORNEY FEES** - The Agency recognizes an obligation to pay attorney's fees or costs only when assessed by a court of competent jurisdiction. Any other provision is invalid and considered null and void.

12. **ASSIGNMENT** - Notwithstanding any clause to the contrary, the Agency reserves the right to assign the agreement to another State of West Virginia agency, board or commission upon thirty (30) days written notice to the Vendor and Vendor shall obtain the written consent of Agency prior to assigning the agreement.

13. **LIMITATION OF LIABILITY** - The Agency, as a State entity, cannot agree to assume the potential liability of a Vendor. Accordingly, any provision limiting the Vendor's liability for direct damages to a certain dollar amount or to the amount of the agreement is hereby deleted. Limitations on special, incidental or consequential damages are acceptable. In addition, any limitation is null and void to the extent that it precludes any action for injury to persons or for damages to personal property.

14. **RIGHT TO TERMINATE** - Agency shall have the right to terminate the agreement upon thirty (30) days written notice to Vendor. Agency agrees to pay Vendor for services rendered or goods received prior to the effective date of termination.

15. **TERMINATION CHARGES** - Any provision requiring the Agency to pay a fixed amount or liquidated damages upon termination of the agreement is hereby deleted. The Agency may only agree to reimburse a Vendor for actual costs incurred or losses sustained during the current fiscal year due to wrongful termination by the Agency prior to the end of any current agreement term.

16. **RENEWAL** - Any reference to automatic renewal is hereby deleted. The agreement may be renewed only upon mutual written agreement of the parties.

17. **INSURANCE** - Any provision requiring the Agency to insure equipment or property of any kind and name the Vendor as beneficiary or as an additional insured is hereby deleted.

18. **RIGHT TO NOTICE** - Any provision for repossession of equipment without notice is hereby deleted. However, the Agency does recognize a right of repossession with notice.

19. **ACCELERATION** - Any reference to acceleration of payments in the event of default or non-funding is hereby deleted.

20. **CONFIDENTIALITY:** -Any provision regarding confidentiality of the terms and conditions of the agreement is hereby deleted. State contracts are public records under the West Virginia Freedom of Information Act.

21. **AMENDMENTS** - All amendments, modifications, alterations or changes to the agreement shall be in writing and signed by both parties. No amendment, modification, alteration or change may be made to this addendum without the express written approval of the Purchasing Division and the Attorney General.

ACCEPTED BY DHHR OFFICE OF PURCHASING:

Spending Unit: _____

Signed: _____

Title: _____

Date: _____

VENDOR

Company Name: HP Enterprise Services, LLC

Signed: Susan D. Arthur Susan D Arthur

Title: Vice President, Americas Healthcare Industry

Date: 4-22-11

RFQ No. MED 11014

BUREAU FOR MEDICAL SERVICES

MED PURCHASING AFFIDAVIT

West Virginia Code §5A-3-10a states: No contract or renewal of any contract may be awarded by the state or any of its political subdivisions to any vendor or prospective vendor when the vendor or prospective vendor or a related party to the vendor or prospective vendor is a debtor and the debt owned is an amount greater than one thousand dollars in the aggregate

DEFINITIONS:
"Debt" means any assessment, premium, penalty, fine, tax or other amount of money owed to the state or any of its political subdivisions because of a judgment, fine, permit violation, license assessment, defaulted workers' compensation premium, penalty or other assessment presently delinquent or due and required to be paid to the state or any of its political subdivisions, including any interest or additional penalties accrued thereon.

"Debtor" means any individual, corporation, partnership, association, Limited Liability Company or any other form or business association owing a debt to the state or any of its political subdivisions. "Political subdivision" means any county commission; municipality; county board of education; any instrumentality established by a county or municipality; any separate corporation or instrumentality established by one or more counties or municipalities, as permitted by law; or any public body charged by law with the performance of a government function or whose jurisdiction is coextensive with one or more counties or municipalities. "Related party" means a party, whether an individual, corporation, partnership, association, limited liability company or any other form or business association or other entity whatsoever, related to any vendor by blood, marriage, ownership or contract through which the party has a relationship of ownership or other interest with the vendor so that the party will actually or by effect receive or control a portion of the benefit, profit or other consideration from performance of a vendor contract with the party receiving an amount that meets or exceed five percent of the total contract amount.

EXCEPTION: The prohibition of this section does not apply where a vendor has contested any tax administered pursuant to chapter eleven of this code, workers' compensation premium, permit fee or environmental fee or assessment and the matter has not become final or where the vendor has entered into a payment plan or agreement and the vendor is not in default of any of the provisions of such plan or agreement.

Under penalty of law for false swearing ***(West Virginia Code*** §61-5-3), it is hereby certified that the vendor affirms and acknowledges the information in this affidavit and is in compliance with the requirements as stated.

WITNESS THE FOLLOWING SIGNATURE

Vendor's Name: HP Enterprise Services, LLC

Authorized Signature:. Susan D. Arthur Susan D. Arthur Date: 4-15-11

State of Delaware

County of New Castle , to-wit:

Taken, subscribed, and sworn to before me this 15th day of April , 2011.

My Commission expires September 26 , 2013.

AFFIX SEAL HERE

NOTORY PUBLIC Allison M Schlapfer

ALLISON M SCHLAPFER
NOTARY PUBLIC
STATE OF DELAWARE
My commission expires Sept. 26, 2013

Rev. 09/08

State of West Virginia
VENDOR PREFERENCE CERTIFICATE

Certification and application* is hereby made for Preference in accordance with ***West Virginia Code***, §5A-3-37. (Does not apply to construction contracts). ***West Virginia Code***, §5A-3-37, provides an opportunity for qualifying vendors to request (at the time of bid) preference for their residency status. Such preference is an evaluation method only and will be applied only to the cost bid in accordance with the ***West Virginia Code***. This certificate for application is to be used to request such preference. The Purchasing Division will make the determination of the Resident Vendor Preference, if applicable.

1. ____ **Application is made for 2.5% resident vendor preference for the reason checked:**
Bidder is an individual resident vendor and has resided continuously in West Virginia for four (4) years immediately preceding the date of this certification; **or,**

____ Bidder is a partnership, association or corporation resident vendor and has maintained its headquarters or principal place of business continuously in West Virginia for four (4) years immediately preceding the date of this certification; or 80% of the ownership interest of Bidder is held by another individual, partnership, association or corporation resident vendor who has maintained its headquarters or principal place of business continuously in West Virginia for four (4) years immediately preceding the date of this certification; **or,**

____ Bidder is a nonresident vendor which has an affiliate or subsidiary which employs a minimum of one hundred state residents and which has maintained its headquarters or principal place of business within West Virginia continuously for the four (4) years immediately preceding the date of this certification; **or,**

2. ____ **Application is made for 2.5% resident vendor preference for the reason checked:**
Bidder is a resident vendor who certifies that, during the life of the contract, on average at least 75% of the employees working on the project being bid are residents of West Virginia who have resided in the state continuously for the two years immediately preceding submission of this bid; **or,**

3. X ____ **Application is made for 2.5% resident vendor preference for the reason checked:**
Bidder is a nonresident vendor employing a minimum of one hundred state residents or is a nonresident vendor with an affiliate or subsidiary which maintains its headquarters or principal place of business within West Virginia employing a minimum of one hundred state residents who certifies that, during the life of the contract, on average at least 75% of the employees or Bidder's affiliate's or subsidiary's employees are residents of West Virginia who have resided in the state continuously for the two years immediately preceding submission of this bid; **or,**

4. ____ **Application is made for 5% resident vendor preference for the reason checked:**
Bidder meets either the requirement of both subdivisions (1) and (2) or subdivision (1) and (3) as stated above; **or,**

5. ____ **Application is made for 3.5% resident vendor preference who is a veteran for the reason checked:**
Bidder is an individual resident vendor who is a veteran of the United States armed forces, the reserves or the National Guard and has resided in West Virginia continuously for the four years immediately preceding the date on which the bid is submitted; **or,**

6. ____ **Application is made for 3.5% resident vendor preference who is a veteran for the reason checked:**
Bidder is a resident vendor who is a veteran of the United States armed forces, the reserves or the National Guard, if, for purposes of producing or distributing the commodities or completing the project which is the subject of the vendor's bid and continuously over the entire term of the project, on average at least seventy-five percent of the vendor's employees are residents of West Virginia who have resided in the state continuously for the two immediately preceding years.

Bidder understands if the Secretary of Revenue determines that a Bidder receiving preference has failed to continue to meet the requirements for such preference, the Secretary may order the Director of Purchasing to: (a) reject the bid; or (b) assess a penalty against such Bidder in an amount not to exceed 5% of the bid amount and that such penalty will be paid to the contracting agency or deducted from any unpaid balance on the contract or purchase order.

By submission of this certificate, Bidder agrees to disclose any reasonably requested information to the Purchasing Division and authorizes the Department of Revenue to disclose to the Director of Purchasing appropriate information verifying that Bidder has paid the required business taxes, provided that such information does not contain the amounts of taxes paid nor any other information deemed by the Tax Commissioner to be confidential.

Under penalty of law for false swearing (West Virginia Code, §61-5-3), Bidder hereby certifies that this certificate is true and accurate in all respects; and that if a contract is issued to Bidder and if anything contained within this certificate changes during the term of the contract, Bidder will notify the Purchasing Division in writing immediately.

Bidder: HP Enterprise Services, LLC **Signed:** Susan D. Arthur Susan D Arthur

Date: 4-15-11 **Title:** Vice President, Americas Healthcare Industry

**Check any combination of preference consideration(s) indicated above, which you are entitled to receive.*

Request for Quotation

State of West Virginia
Department of Health & Human Resources
Office of Purchasing
One Davis Square, Suite 100
Charleston, WV 25301

RFQ NUMBER	PAGE
MED11014	1

ADDRESS CORRESPONDENCE TO ATTENTION OF
DONNA D. SMITH
304-957-0218

VENDOR	SHIP TO
HP Enterprise Services, LLC 5400 Legacy Drive Plano, Texas 75024	BUREAU FOR MEDICAL SERVICES 350 CAPITOL STREET, ROOM 251 CHARLESTON, WV 25301-3706

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FUND

BID OPENING DATE: MAY 31, 2011 BID OPENING TIME: 1:30 PM

LINE	QUANTITY	UOP	CAT.NO.	ITEM NUMBER	UNIT PRICE	AMOUNT

ADDENDUM NO. 1

1. SECTION 2.4.7 PROCUREMENT LIBRARY HAS BEEN CHANGED TO READ:
THE PROCUREMENT LIBRARY CONTAINS INFORMATION WHICH SHOULD BE OF USE TO THE VENDOR IN DEVELOPING THEIR PROPOSED SOLUTION. THE PROCUREMENT LIBRARY IS BEING DISSEMINATED ON A CD, TO BE ONLY ACCESSIBLE BY A PREDETERMINED PASSWORD. CD AND PASSWORD ARE BEING DISTRIBUTED UNDER A SEPARATE COVER. ADDITIONALLY, THE BMS WEB-SITE IS NOW
2. THE BMS WEB-SITE IN SECTION 2.4.7 HAS BEEN CHANGED TO: www.dhhr.wv.gov/bms.
3. SECTION 1.17 SCHEDULE OF EVENTS IS BEING MODIFIED AS FOLLOWS:
VENDOR WRITTEN QUESTION SUBMISSION DEADLINE: FEBRUARY 25, 2011
QUESTIONS ADDENDUM ISSUED: MARCH 4, 2011.
4. CONTACT INFORMATION ON RFP COVER PAGE, SECTION 1.5 AND SECTION 1.10.3 FOR ALL DIRECT INQUIRIES IS MODIFIED AS FOLLOWS:
NAME CHANGE: FROM DONNA D. SMITH TO BRYAN D. ROSEN
PHONE NUMBER CHANGE FROM: (304) 957-0218 TO (304) 558-0953
EMAIL ADDRESS FROM: donna.d.smith@wv.gov TO: bryan.d.rosen@wv.gov
5 ADDENDUM ACKNOWLEDGEMENT IS ATTACHED. THIS DOCUMENT SHOULD BE SIGNED AND RETURNED WITH YOUR BID. FAILURE TO SIGN AND RETURN MAY RESULT IN DISQUALIFICATION OF YOUR PROPOSAL.

REQUISITION NO.: MED11014

ADDENDUM ACKNOWLEDGEMENT

I HEREBY ACKNOWLEDGE RECEIPT OF THE FOLLOWING CHECKED ADDENDUM(S) AND HAVE MADE THE NECESSARY REVISIONS TO MY PROPOSAL, PLANS AND/OR SPECIFICATION, ETC.

ADDENDUM NO.'S"

NO. 1 X
NO. 2 _____
NO. 3 _____
NO. 4 _____
NO. 5 _____

I UNDERSTAND THAT FAILURE TO CONFIRM THE RECEIPT OF THE ADDENDUM(S) MAY BE CAUSE FOR REJECTION OF PROPOSAL.

SEE REVERSE FOR TERMS AND CONDITIONS

SIGNATURE	TELEPHONE	DATE
Susan D. Arthur Susan D Arthur	+1 609 714 8931	4/15/11
TITLE Vice President, Americas Healthcare Industry	FEIN 75-2548221	ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO RFP, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED "VENDOR"

Request for Quotation

State of West Virginia
Department of Health & Human Resources
Office of Purchasing
One Davis Square, Suite 100
Charleston, WV 25301

RFQ NUMBER	PAGE
MED11014	2

ADDRESS CORRESPONDENCE TO ATTENTION OF
DONNA D. SMITH
304-957-0218

VENDOR
HP Enterprise Services, LLC 5400 Legacy Drive Plano, Texas 75024

SHIP TO
BUREAU FOR MEDICAL SERVICES 350 CAPITOL STREET, ROOM 251 CHARLESTON, WV 25301-3706

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FUND

BID OPENING DATE: MAY 31, 2011 BID OPENING TIME: 1:30 PM

LINE	QUANTITY	UOP	CAT.NO.	ITEM NUMBER	UNIT PRICE	AMOUNT
	VENDOR MUST CLEARLY UNDERSTAND THAT ANY VERBAL REPRESENTATION MADE OR ASSUMED TO BE MADE DURING ANY ORAL DISCUSSION HELD BETWEEN VENDOR'S REPRESENTATIVES AND ANY STATE PERSONNEL IS NOT BINDING. ONLY THE INFORMATION ISSUED IN WRITING AND ADDED TO THE SPECIFICATIONS BY AN OFFICIAL ADDENDUM IS BINDING.					

Susan D Arthur
SIGNATURE

HP Enterprise Services, LLC
COMPANY

4-15-11
DATE

END OF ADDENDUM NO. 1

SEE REVERSE FOR TERMS AND CONDITIONS

SIGNATURE Susan D. Arthur Susan D Arthur	TELEPHONE +1 609 714 8931	DATE 4-15-11
TITLE Vice President, Americas Healthcare Industry	FEIN 75-2548221	ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO RFP, INSERT NAME AND ADDRESS IN SAPCE ABOVE LABELED "VENDOR"

Request for Quotation

RFQ NUMBER	PAGE
MED11014	1

State of West Virginia
Department of Health & Human Resources
Office of Purchasing
One Davis Square, Suite 100
Charleston, WV 25301

ADDRESS CORRESPONDENCE TO ATTENTION OF
BRYAN D. ROSEN
304-558-0953

VENDOR	SHIP TO
HP Enterprise Services, LLC 5400 Legacy Drive Plano, Texas 75024	BUREAU FOR MEDICAL SERVICES 350 CAPITOL STREET, ROOM 251 CHARLESTON, WV 25301-3706

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FUND

BID OPENING DATE: 4/26/2011 BID OPENING TIME: 1:30 PM

LINE	QUANTITY	UOP	CAT.NO.	ITEM NUMBER	UNIT PRICE	AMOUNT

ADDENDUM NO. 2

1. SECTION 1.17 - SCHEDULE OF EVENTS IS BEING MODIFIED AS FOLLOWS:
TO CHANGE QUESTION ADDENDUM ISSUED FROM MARCH 4, 2011 TO MARCH 18, 2011

REQUISITION NO.: MED11014

ADDENDUM ACKNOWLEDGEMENT

I HEREBY ACKNOWLEDGE RECEIPT OF THE FOLLOWING CHECKED ADDENDUM(S) AND HAVE MADE THE NECESSARY REVISIONS TO MY PROPOSAL, PLANS AND/OR SPECIFICATION, ETC.

ADDENDUM NO.'S"

NO. 1 _____
NO. 2 X
NO. 3 _____
NO. 4 _____
NO. 5 _____

I UNDERSTAND THAT FAILURE TO CONFIRM THE RECEIPT OF THE ADDENDUM(S) MAY BE CAUSE FOR REJECTION OF PROPOSAL.

SEE REVERSE FOR TERMS AND CONDITIONS

SIGNATURE	TELEPHONE	DATE
Susan D. Arthur Susan D Arthur	+1 609 714 8931	4-15-11
TITLE Vice President, Americas Healthcare Industry	FEIN 75-2548221	

WHEN RESPONDING TO RFP, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED "VENDOR"

Request for Quotation

RFQ NUMBER	PAGE
MED11014	2

State of West Virginia
Department of Health & Human Resources
Office of Purchasing
One Davis Square, Suite 100
Charleston, WV 25301

ADDRESS CORRESPONDENCE TO ATTENTION OF
BRYAN D. ROSEN
304-558-0953

VENDOR	SHIP TO
HP Enterprise Services, LLC 5400 Legacy Drive Plano, Texas 75024	BUREAU FOR MEDICAL SERVICES 350 CAPITOL STREET, ROOM 251 CHARLESTON, WV 25301-3706

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FUND

BID OPENING DATE: 4/26/2011 BID OPENING TIME: 1:30 PM

LINE	QUANTITY	UOP	CAT.NO.	ITEM NUMBER	UNIT PRICE	AMOUNT
	VENDOR MUST CLEARLY UNDERSTAND THAT ANY VERBAL REPRESENTATION MADE OR ASSUMED TO BE MADE DURING ANY ORAL DISCUSSION HELD BETWEEN VENDOR'S REPRESENTATIVES AND ANY STATE PERSONNEL IS NOT BINDING. ONLY THE INFORMATION ISSUED IN WRITING AND ADDED TO THE SPECIFICATIONS BY AN OFFICIAL ADDENDUM IS BINDING.					

Susan D Arthur
SIGNATURE

HP Enterprise Services, LLC
COMPANY

4-15-11
DATE

END OF ADDENDUM NO. 2

SEE REVERSE FOR TERMS AND CONDITIONS

SIGNATURE	TELEPHONE	DATE
Susan D. Arthur Susan D Arthur	+1 609 714 8931	4-15-11
TITLE Vice President, Americas Healthcare Industry	FEIN 75-2548221	

WHEN RESPONDING TO RFP, INSERT NAME AND ADDRESS IN SAPCE ABOVE LABELED "VENDOR"

Request for Quotation

RFQ NUMBER	PAGE
MED11014	1

State of West Virginia
Department of Health & Human Resources
Office of Purchasing
One Davis Square, Suite 100
Charleston, WV 25301

ADDRESS CORRESPONDENCE TO ATTENTION OF
BRYAN D. ROSEN
304-558-0953

VENDOR	SHIP TO
HP Enterprise Services, LLC 5400 Legacy Drive Plano, Texas 75024	BUREAU FOR MEDICAL SERVICES 350 CAPITOL STREET, ROOM 251 CHARLESTON, WV 25301-3706

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FUND

BID OPENING DATE: 4/26/2011 BID OPENING TIME: 1:30 PM

LINE	QUANTITY	UOP	CAT.NO.	ITEM NUMBER	UNIT PRICE	AMOUNT
				ADDENDUM NO. 3		
	1. QUESTIONS AND ANSWERS ARE ATTACHED.					
				REQUISITION NO.: MED11014		
	ADDENDUM ACKNOWLEDGEMENT I HEREBY ACKNOWLEDGE RECEIPT OF THE FOLLOWING CHECKED ADDENDUM(S) AND HAVE MADE THE NECESSARY REVISIONS TO MY PROPOSAL, PLANS AND/OR SPECIFICATION, ETC. ADDENDUM NO.'S" NO. 1 _____ NO. 2 _____ NO. 3 X NO. 4 _____ NO. 5 _____ I UNDERSTAND THAT FAILURE TO CONFIRM THE RECEIPT OF THE ADDENDUM(S) MAY BE CAUSE FOR REJECTION OF PROPOSAL.					

SEE REVERSE FOR TERMS AND CONDITIONS

SIGNATURE	TELEPHONE	DATE
Susan D Arthur	+1 609 714 8931	4-15-11
TITLE Vice President, Americas Healthcare Industry	FEIN 75-2548221	

WHEN RESPONDING TO RFP, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED "VENDOR"

Request for Quotation

RFQ NUMBER	PAGE
MED11014	2

State of West Virginia
Department of Health & Human Resources
Office of Purchasing
One Davis Square, Suite 100
Charleston, WV 25301

ADDRESS CORRESPONDENCE TO ATTENTION OF
BRYAN D. ROSEN
304-558-0953

VENDOR	SHIP TO
HP Enterprise Services, LLC 5400 Legacy Drive Plano, Texas 75024	BUREAU FOR MEDICAL SERVICES 350 CAPITOL STREET, ROOM 251 CHARLESTON, WV 25301-3706

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FUND

BID OPENING DATE: 4/26/2011 BID OPENING TIME: 1:30 PM

LINE	QUANTITY	UOP	CAT.NO.	ITEM NUMBER	UNIT PRICE	AMOUNT
	VENDOR MUST CLEARLY UNDERSTAND THAT ANY VERBAL REPRESENTATION MADE OR ASSUMED TO BE MADE DURING ANY ORAL DISCUSSION HELD BETWEEN VENDOR'S REPRESENTATIVES AND ANY STATE PERSONNEL IS NOT BINDING. ONLY THE INFORMATION ISSUED IN WRITING AND ADDED TO THE SPECIFICATIONS BY AN OFFICIAL ADDENDUM IS BINDING.					

Susan D Arthur
SIGNATURE

HP Enterprise Services, LLC
COMPANY

4-15-11
DATE

END OF ADDENDUM NO. 3

SEE REVERSE FOR TERMS AND CONDITIONS

SIGNATURE	TELEPHONE	DATE
Susan D. Arthur Susan D Arthur	+1 609 714 8931	4-15-11

TITLE	FEIN	
Vice President, Americas Healthcare Industry	75-2548221	

WHEN RESPONDING TO RFP, INSERT NAME AND ADDRESS IN SAPCE ABOVE LABELED "VENDOR"

Request for Quotation

State of West Virginia
Department of Health & Human Resources
Office of Purchasing
One Davis Square, Suite 100
Charleston, WV 25301

RFQ NUMBER	PAGE
MED11014	1

ADDRESS CORRESPONDENCE TO ATTENTION OF
BRYAN D. ROSEN
304-558-0953

VENDOR
HP Enterprise Services, LLC 5400 Legacy Drive Plano, Texas 75034

SHIP TO
BUREAU FOR MEDICAL SERVICES 350 CAPITOL STREET, ROOM 251 CHARLESTON, WV 25301-3706

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FUND

BID OPENING DATE: 5/6/2011 BID OPENING TIME: 1:30 PM

LINE	QUANTITY	UOP	CAT.NO.	ITEM NUMBER	UNIT PRICE	AMOUNT

ADDENDUM NO. 4

1. THE BMS WILL ALLOW A SECOND ROUND OF VENDOR QUESTIONS

2. SECTION 1.17, SCHEDULE OF EVENTS IS BEING MODIFIED AS FOLLOWS:

SECOND ROUND WRITTEN QUESTION SUBMISSION DEADLINE QUESTION DUE BY 5:00 PM EST	MARCH 31, 2011
SECOND ROUND WRITTEN QUESTION ADDENDUM ISSUED	APRIL 7, 2011
VENDOR PROPOSAL OPENING DATE:	MAY 6, 2011

3. SECTION 1.10.3, PROPOSAL FORMAT AND SUBMISSION IS BEING MODIFIED AS FOLLOWS:
ALL PROPOSALS MUST BE RECEIVED PRIOR TO 01:30 PM ON MAY 6, 2011

REQUISITION NO.: MED11014

ADDENDUM ACKNOWLEDGEMENT

I HEREBY ACKNOWLEDGE RECEIPT OF THE FOLLOWING CHECKED ADDENDUM(S) AND HAVE MADE THE NECESSARY REVISIONS TO MY PROPOSAL, PLANS AND/OR SPECIFICATION, ETC.

ADDENDUM NO.'S"

NO. 1 _____
NO. 2 _____
NO. 3 _____
NO. 4 X
NO. 5 _____

I UNDERSTAND THAT FAILURE TO CONFIRM THE RECEIPT OF THE ADDENDUM(S) MAY BE CAUSE FOR REJECTION OF PROPOSAL.

SEE REVERSE FOR TERMS AND CONDITIONS

SIGNATURE	TELEPHONE	DATE
Susan D. Arthur Susan D Arthur	+1 609 714 8931	4-15-11
TITLE Vice President, Americas Healthcare Industry	FEIN 75-2548221	

WHEN RESPONDING TO RFP, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED "VENDOR"

Request for Quotation

RFQ NUMBER	PAGE
MED11014	2

State of West Virginia
Department of Health & Human Resources
Office of Purchasing
One Davis Square, Suite 100
Charleston, WV 25301

ADDRESS CORRESPONDENCE TO ATTENTION OF
BRYAN D. ROSEN
304-558-0953

VENDOR	SHIP TO
HP Enterprise Services, LLC 5400 Legacy Drive Plano, Texas 75024	BUREAU FOR MEDICAL SERVICES 350 CAPITOL STREET, ROOM 251 CHARLESTON, WV 25301-3706

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FUND

BID OPENING DATE: 5/6/2011 BID OPENING TIME: 1:30 PM

LINE	QUANTITY	UOP	CAT.NO.	ITEM NUMBER	UNIT PRICE	AMOUNT
	VENDOR MUST CLEARLY UNDERSTAND THAT ANY VERBAL REPRESENTATION MADE OR ASSUMED TO BE MADE DURING ANY ORAL DISCUSSION HELD BETWEEN VENDOR'S REPRESENTATIVES AND ANY STATE PERSONNEL IS NOT BINDING. ONLY THE INFORMATION ISSUED IN WRITING AND ADDED TO THE SPECIFICATIONS BY AN OFFICIAL ADDENDUM IS BINDING.					

Susan D Arthur
SIGNATURE

HP Enterprise Services, LLC
COMPANY

4-15-11
DATE

END OF ADDENDUM NO. 4

SEE REVERSE FOR TERMS AND CONDITIONS

SIGNATURE	TELEPHONE	DATE
Susan D. Arthur Susan D Arthur	+1 609 714 8931	4-15-11
TITLE Vice President, Americas Healthcare Industry	FEIN 75-2548221	

WHEN RESPONDING TO RFP, INSERT NAME AND ADDRESS IN SAPCE ABOVE LABELED "VENDOR"

Request for Quotation

RFQ NUMBER	PAGE
MED11014	1

State of West Virginia
Department of Health & Human Resources
Office of Purchasing
One Davis Square, Suite 100
Charleston, WV 25301

ADDRESS CORRESPONDENCE TO ATTENTION OF
BRYAN D. ROSEN
304-558-0953

VENDOR	SHIP TO
HP Enterprise Services, LLC 5400 Legacy Drive Plano, Texas 75034	BUREAU FOR MEDICAL SERVICES 350 CAPITOL STREET, ROOM 251 CHARLESTON, WV 25301-3706

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FUND

BID OPENING DATE: 5/6/2011 BID OPENING TIME: 1:30 PM

LINE	QUANTITY	UOP	CAT.NO.	ITEM NUMBER	UNIT PRICE	AMOUNT
				ADDENDUM NO. 5		
	1. QUESTIONS AND ANSWERS ARE ATTACHED.					
				REQUISITION NO.: MED11014		
	ADDENDUM ACKNOWLEDGEMENT I HEREBY ACKNOWLEDGE RECEIPT OF THE FOLLOWING CHECKED ADDENDUM(S) AND HAVE MADE THE NECESSARY REVISIONS TO MY PROPOSAL, PLANS AND/OR SPECIFICATION, ETC. ADDENDUM NO.'S" NO. 1 _____ NO. 2 _____ NO. 3 _____ NO. 4 _____ NO. 5 X I UNDERSTAND THAT FAILURE TO CONFIRM THE RECEIPT OF THE ADDENDUM(S) MAY BE CAUSE FOR REJECTION OF PROPOSAL.					

SEE REVERSE FOR TERMS AND CONDITIONS

SIGNATURE	TELEPHONE	DATE
Susan D. Arthur Susan D Arthur	+1 609 714 8931	4-15-11
TITLE Vice President, Americas Healthcare Industry	FEIN 75-2548221	

WHEN RESPONDING TO RFP, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED "VENDOR"

Request for Quotation

RFQ NUMBER	PAGE
MED11014	2

State of West Virginia
Department of Health & Human Resources
Office of Purchasing
One Davis Square, Suite 100
Charleston, WV 25301

ADDRESS CORRESPONDENCE TO ATTENTION OF
BRYAN D. ROSEN
304-558-0953

VENDOR	SHIP TO
HP Enterprise Services, LLC 5400 Legacy Drive Plano, Texas 75024	BUREAU FOR MEDICAL SERVICES 350 CAPITOL STREET, ROOM 251 CHARLESTON, WV 25301-3706

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FUND

BID OPENING DATE: 5/6/2011 BID OPENING TIME: 1:30 PM

LINE	QUANTITY	UOP	CAT.NO.	ITEM NUMBER	UNIT PRICE	AMOUNT
	VENDOR MUST CLEARLY UNDERSTAND THAT ANY VERBAL REPRESENTATION MADE OR ASSUMED TO BE MADE DURING ANY ORAL DISCUSSION HELD BETWEEN VENDOR'S REPRESENTATIVES AND ANY STATE PERSONNEL IS NOT BINDING. ONLY THE INFORMATION ISSUED IN WRITING AND ADDED TO THE SPECIFICATIONS BY AN OFFICIAL ADDENDUM IS BINDING.					

Susan D Arthur
SIGNATURE

HP Enterprise Services, LLC
COMPANY

4-15-11
DATE

END OF ADDENDUM NO. 5

SEE REVERSE FOR TERMS AND CONDITIONS

SIGNATURE	TELEPHONE	DATE
Susan D. Arthur Susan D Arthur	+1 609 714 8931	4-15-11
TITLE Vice President, Americas Healthcare Industry	FEIN 75-2548221	

WHEN RESPONDING TO RFP, INSERT NAME AND ADDRESS IN SAPCE ABOVE LABELED "VENDOR"

Request for Quotation

State of West Virginia
Department of Health & Human Resources
Office of Purchasing
One Davis Square, Suite 100
Charleston, WV 25301

RFQ NUMBER	PAGE
MED11014	1

ADDRESS CORRESPONDENCE TO ATTENTION OF
BRYAN D. ROSEN
304-558-0953

VENDOR	SHIP TO
	BUREAU FOR MEDICAL SERVICES 350 CAPITOL STREET, ROOM 251 CHARLESTON, WV 25301-3706

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FUND

BID OPENING DATE: 5/6/2011 BID OPENING TIME: 1:30 PM

LINE	QUANTITY	UOP	CAT.NO.	ITEM NUMBER	UNIT PRICE	AMOUNT

ADDENDUM NO. 6

1. TO ADD INFORMATION ON OWNERSHIP AND CONTROL REQUIREMENT AS REQUIRED BY 42 CFR 455.104. DISCLOSURE FORM ATTACHED.
2. TO PROVIDE CLARIFICATION ON CALL CENTER STAFFING RESPONSE FROM ADDENDUM 3.
3. TO CORRECT A FORMULA ERROR IN CALCULATING TOTAL OPERATING COSTS FROM ADDENDUM 5.
4. TO NOTIFY VENDORS THAT ORAL PRESENTATIONS WILL BE SCHEDULED SUBSEQUENT TO THE TECHNICAL BID OPENING.

REQUISITION NO.: MED11014

ADDENDUM ACKNOWLEDGEMENT

I HEREBY ACKNOWLEDGE RECEIPT OF THE FOLLOWING CHECKED ADDENDUM(S) AND HAVE MADE THE NECESSARY REVISIONS TO MY PROPOSAL, PLANS AND/OR SPECIFICATION, ETC.

ADDENDUM NO.'S"

NO. 1 _____
NO. 2 _____
NO. 3 _____
NO. 4 _____
NO. 5 _____
NO. 6 X

I UNDERSTAND THAT FAILURE TO CONFIRM THE RECEIPT OF THE ADDENDUM(S) MAY BE CAUSE FOR REJECTION OF PROPOSAL.

SEE REVERSE FOR TERMS AND CONDITIONS

SIGNATURE	TELEPHONE	DATE
Susan D. Arthur Susan D Arthur	+1 609 714 8931	4-27-11
TITLE Vice President, Americas Healthcare Industry	FEIN 75-2548221	

WHEN RESPONDING TO RFP, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED "VENDOR"

Request for Quotation

RFQ NUMBER	PAGE
MED11014	2

State of West Virginia
Department of Health & Human Resources
Office of Purchasing
One Davis Square, Suite 100
Charleston, WV 25301

ADDRESS CORRESPONDENCE TO ATTENTION OF
BRYAN D. ROSEN
304-558-0953

VENDOR	

SHIP TO	
	BUREAU FOR MEDICAL SERVICES 350 CAPITOL STREET, ROOM 251 CHARLESTON, WV 25301-3706

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FUND

BID OPENING DATE: 5/6/2011 BID OPENING TIME: 1:30 PM

LINE	QUANTITY	UOP	CAT.NO.	ITEM NUMBER	UNIT PRICE	AMOUNT
	VENDOR MUST CLEARLY UNDERSTAND THAT ANY VERBAL REPRESENTATION MADE OR ASSUMED TO BE MADE DURING ANY ORAL DISCUSSION HELD BETWEEN VENDOR'S REPRESENTATIVES AND ANY STATE PERSONNEL IS NOT BINDING. ONLY THE INFORMATION ISSUED IN WRITING AND ADDED TO THE SPECIFICATIONS BY AN OFFICIAL ADDENDUM IS BINDING.					

Susan D Arthur
SIGNATURE

HP Enterprise Services, LLC
COMPANY

4-27-11
DATE

END OF ADDENDUM NO. 6

SEE REVERSE FOR TERMS AND CONDITIONS

SIGNATURE	TELEPHONE	DATE
Susan D. Arthur Susan D Arthur	+1 609 714 8931	4-27-11
TITLE Vice President, Americas Healthcare Industry	FEIN 75-2548221	

WHEN RESPONDING TO RFP, INSERT NAME AND ADDRESS IN SAPCE ABOVE LABELED "VENDOR"

GENERAL TERMS & CONDITIONS
PURCHASE ORDER/CONTRACT

1. ACCEPTANCE: Seller shall be bound by this order and its terms and conditions upon receipt of this order.

2. APPLICABLE LAW: The laws of the State of West Virginia and the BMS Purchasing Manual shall govern all rights and duties under the Contract, including without limitation the validity of this Purchase Order/Contract.

3. NON-FUNDING: All services performed or goods delivered under BMS Purchase Orders/Contracts are to be continued for the terms of the Purchase Order/Contract, contingent upon funds being appropriated by the Legislature or otherwise being made available. In the event funds are not appropriated or otherwise available for these services or goods, the Purchase Order/Contract becomes void and of no effect after June 30.

4. COMPLIANCE: Seller shall comply with all federal, state and local laws, regulations and ordinance including, but not limited to, the prevailing wage rates of the WV Division of Labor.

5. MODIFICATIONS: This writing is the parties' final expression of intent. No modification of this order shall be binding unless agreed to in writing by the Buyer.

6. ASSIGNMENT: Neither this Order or any monies due, or to become due hereunder may be assigned by the Seller without the Buyer's consent.

7. WARRANTY: The Seller expressly warrants that the goods and/or services covered by this order will: {a} conform to the specifications, drawings, samples or other description furnished or specified by the BUYER; {b} be merchantable and fit for the purpose intended; and/or {c} be free from defect in material and workmanship.

8. CANCELLATION: The director of the DHHR Office of Purchasing may cancel any Purchase Order/Contract upon 30 days written notice to the seller.

9. SHIPPING, BILLING & PRICES: Prices are those stated in this order. No price increase will be accepted without written authority from the Buyer. All goods or services shall be shipped on or before the date specified in the Order.

10. LATE PAYMENTS: Payment may only be made after the delivery of goods or services. Interest may be paid on late payments in accordance with the ***West Virginia Code*** .

11. TAXES: The State of West Virginia is exempt from the federal and state taxes and will not pay or reimburse such taxes.

12. RENEWAL: Any reference to automatic renewal is hereby deleted. The Contract may be renewed only upon contract null and void, and terminate such contract without further order.

13. BANKRUPTCY: In the event the vendor/contractor files for bankruptcy protection, the State may deem this contract null and void, and terminate such contract without further order.

14. HIPAA BUSINESS ASSOCIATE ADDENDUM: The West Virginia State Government HIPAA Business Associate Addendum (BAA), approved by the Attorney General, is available online at www.state.wv.us/admin/purchase/vrc/hipaa.htm and is hereby made part of the agreement provided that the Agency meets the definition of a Cover Entity (45 CFR § 160.103) and will be disclosing Protected Health Information (45 CFR § 160.103) to the vendor.

15. CONFIDENTIALITY: The vendor agrees that he or she will not disclose to anyone, directly or indirectly, any such personally identifiable information or other confidential information gained from the agency, unless the individual who is the subject of the information consents to the disclosure in writing or the disclosure in writing or the disclosure is made pursuant to the agency's policies, procedure, and rules.

16. LICENSING: Vendors much be licensed and in good standing in accordance with any and all state and local laws and requirement by any state or local agency of West Virginia, including but not limited to, the West Virginia Secretary of State's Officer, the West Virginia Insurance Commission, or any other state agency or political subdivision. Furthermore, the vendor much provide all necessary releases to obtain information to enable the Director or spending unit to verify that the vendor is licensed and in good standing with the above entities.

4.1.14 RFP Requirements Checklist

RFP Reference: 4.1.14 RFP Requirements Checklist

A		B	C
MMIS RFP Requirements		Proposal Section	Proposal Page No.
3.1		Tab 4.1.4 Executive Summary	3
3.1.1		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	73, 148
3.1.2		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	148
3.1.3		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	73
3.1.4		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	148
3.1.5		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	149, 166
3.1.6		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	147
3.1.7		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	241
3.1.8		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	155
3.1.9		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	73, 147
3.1.10		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	1, 165
3.1.11		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	209, 304
3.1.12		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	247
3.1.13		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	248
3.1.14		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	229, 265
3.1.15		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	177
3.1.16		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	175
3.1.17		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	3
3.1.18		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	4
3.1.19		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	245, 268
3.1.20		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	247, 268
3.1.21		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	147, 156
3.1.22		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	156
3.1.23		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	308
3.1.24		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	45
3.1.25		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	39
3.1.26		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	304
3.1.27		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	214
3.1.28		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	215
3.1.29		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	215
3.1.30		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	13
3.1.31		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	37, 312
3.1.32		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	34, 311

A		B	C
MMIS RFP Requirements		Proposal Section	Proposal Page No.
3.1.33		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	175
3.1.34		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	15
3.1.35		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	250
3.1.36		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	1
3.1.37		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	157, 235, 254. 267, 290
3.1.38		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	265
3.1.39		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	165
3.1.40		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	73
3.1.41		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	73
3.1.42		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	73
3.1.43		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	73
3.1.44		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	73
3.1.45		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	155
3.1.46		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	155
3.1.47		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	9
3.1.48		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	9
3.1.49		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	269
4.1		Tab 4.1.4 Executive Summary	3
4.1.1		Tab 4.1.1 Title Page	Tab 4.1.1
4.1.2		Tab 4.1.2 Transmittal Letter	Tab 4.1.2
4.1.3		Tab 4.1.3 Table of Contents	Tab 4.1.3
4.1.4		Tab 4.1.4 Executive Summary	Tab 4.1.4
4.1.5		Tab 4.1.5 Vendor's Organization	Tab 4.1.5
4.1.6		Tab 4.1.6 Location	Tab 4.1.6
4.1.7		Tab 4.1.7 Vendor Capacity, Qualifications, References and Experience	Tab 4.1.7
4.1.8		Tab. 4.1.8 Staff Capacity, Qualifications and Experience	Tab 4.1.8
4.1.9		Tab 4.1.9 Project Approach and Solution	Tab 4.1.9
4.1.10		Tab 4.1.10 Solution Alignment with BMS' Business and Technical Needs	Tab 4.1.10
4.1.11		Tab 4.1.11 Subcontracting	Tab 4.1.11
4.1.12		Tab 4.1.12 Special Terms and Conditions	Tab 4.1.12
4.1.13		Tab 4.1.13 Signed Forms	Tab 4.1.13
4.1.14		Tab 4.1.14 RFP Requirements Checklist	Tab 4.1.14
4.1.15		Cost Proposal, Tab 4.1.15 Cost Summary	Tab 4.1.15
4.1.16		Per Addendum 3, No response was required	N/A
4.1.17		Per Addendum 3, 4.1.17 RFP Requirement Checklist is the same as 4.1.14	Tab 4.1.14

Ownership and Control Interest Disclosures

Any person with an ownership or control interest in the disclosing entity or fiscal agent or subcontractor in which the disclosing entity has a 5% or more interest must be listed. This includes owners and managing employee(s) of the disclosing entity. The address for corporate entities must include primary business address, every business location and P.O. Box Address. If you are required to provide this information for multiple persons (individuals and corporations) you may attach a separate page. For the attached page label it at the top of the page with **Supplement, Ownership Disclosures.**

Name Hewlett-Packard Company (HP)*

Address: 3000 Hanover Street

Address: Palo Alto, CA 94304

Address: _____

Date of Birth: N/A

Social Security Number: N/A

Federal Employer Id Number: 94-1081436

*HP is a global company with locations worldwide. If the State requires additional information, HPES will respond appropriately. Any specific information required in regards to individual account personnel managing this engagement will be supplied after finalization of the contract.

Relationship and Subcontractor Disclosures:

For each ownership or control interest listed, disclose any relationship to another person (parent, spouse, child or sibling) including control interest in subcontractors who has an ownership or control interest in the disclosing entity. If additional space is needed, you may attach a separate page. For the attached page, label it at the top of the page with **Supplement, Owner Relationships**

Owner Name	Relationship	Owner Name
N/A		

Statement of Confidentiality

The descriptive materials and related information in this proposal contain information that is confidential and proprietary to HP Enterprise Services, LLC (HPES). This information is submitted with the express understanding that in accordance with West Virginia's Freedom of Information Act (FOIA), it will be held in strict confidence and will not be disclosed, duplicated, or used, in whole or in part, for any purpose other than evaluation of this proposal and without express written permission from HPES. To the fullest extent allowed under applicable federal or State law, HPES requests that certain of the descriptive materials and related information in this proposal that contain information that is considered proprietary, trade secret, or confidential by HPES and for which the release, use, or distribution to organizations other than the State and its designees would subject HPES to harm and the loss of competitive advantage.

The pages that contain proprietary information are marked as follows: "HP Confidential – Use Subject to Restriction."

Appendix E: Business and Technical Requirements

In this section, HPES provides responses to the Appendix E: Business and Technical Requirements as referenced in section “4.1.10 Solution Alignment with BMS’ Business and Technical Needs.”

Requirements with “Other systems as specified by the BMS during DDI” or similar statements have been marked “YES without customization.” Per Addendum 3, we understand that such requirements will go through a formalized change control process.

Requirements that introduce a subset of requirements are marked “YES without customization” as HPES supports the functional area. The specific subset requirements checklist column is marked to identify the level of fit against the stated BMS technical need.

Requirements that have been amended by Addendum 3 have a strike-through through the old requirement and the new requirements are in bold.