HMS:: A Proposal to The State of West Virginia

Bureau for Medical Services

Recovery Audit Contract Medical/Dental/DME

Request for Proposal MED 13001 Response Due: July 27, 2012 / 1:30 pm

Technical Proposal Redacted



5615 High Point Drive Irving, Texas 75038 Telephone: 214.453.3000 Fax: 469.359.4413



July 27, 2012

Donna D. Smith, Senior Buyer WV Department of Health and Human Resources Office of Purchasing One Davis Square, Suite 100 Charleston, WV 25301

Re: RFP MED 13001, Recovery Audit Contract, Medical/Dental/DME

Dear Ms. Smith:

The West Virginia Department of Health and Human Resources, Bureau for Medical Services

(BMS), in its commitment to healthcare excellence, has issued a formal Request for Proposal (RFP) for Recovery Audit Contractor Services. HMS is pleased to submit our response to the RFP for the provision of a comprehensive solution, which encompasses review of the West Virginia Medicaid fee-for-service program.

On June 28, 2012, the Supreme Court upheld the Affordable Care Act, and most of its provisions, as being constitutional. All of the program integrity requirements and Medicaid RAC provisions were upheld, making this procurement and subsequent contract a necessary component of the State's compliance with federal law, in addition to being a means to ensure that improper payments in the Medicaid program are identified and recovered. Our solution ensures that BMS is in compliance with section 6411 of the Patient Protection and Affordable Care Act (P.L. 111-148) (ACA) and CMS' recently published Medicaid RAC final rule.

Meeting the BMS's Needs

BMS demonstrates a strong commitment to the citizens of West Virginia through the provision of quality healthcare to thousands of residents that comprise billions in annual expenditures. With rising healthcare costs, HMS understands that BMS must attempt to contain the costs of healthcare without sacrificing the quality of care, and we are prepared and experienced to assist BMS in that endeavor. With billions in Medicaid expenditures and recent budget cuts, HMS understands BMS's need to safeguard its Medicaid program by identifying and collecting improperly paid claims. Medicaid cost containment is HMS's core business, and we bring BMS the RAC solution that will satisfy its needs through tested recovery audit techniques.

BMS is seeking an experienced vendor to conduct RAC reviews related to medical, dental, and DME services. HMS brings 27 years of proven program integrity and healthcare claims audit and recovery experience with state Medicaid agencies, including 24 years with BMS.

HMS's Demonstrated Experience in Providing Detection and Recovery of Overpayments

HMS serves as the Medicaid RAC prime contractor or subcontractor in 16 states. We provide program integrity/auditing services in 37

states. In addition, HMS was a pioneer as a Medicare RAC during the CMS pilot from 2005 - 2008. HealthDataInsights, Inc. (HDI), a subsidiary of HMS Holdings, Corp., which is HMS's parent company, is the leading Medicare RAC provider today. Our approach includes use of nationally accepted and valid protocols and methods for identifying and validating improper payments and adheres to federal and state program rules, regulations, and laws. All of our program functions for BMS will be performed by experienced registered nurses, certified coders, physician reviewers, medical directors, pharmacy technicians, statisticians, and other experienced claims auditors with expertise in every area of Medicaid expenditure.

HMS brings unsurpassed RAC expertise gained through our Medicaid Program Integrity contracts and the lessons learned from our sister company HDI, the nation's leading Medicare RAC. HMS will combine HDI's superior technology and proven best practices with our strong knowledge of Medicaid and West Virginia programs, to produce superior results for BMS.

While we believe that our national experience provides BMS with a distinct benefit, we also recognize that most savings identified through our RAC contracts are related to state-specific Medicaid policies. HMS's deep commitment to understanding our clients, and their comprehensive Medicaid programs, including our understanding of BMS's programs, is what sets us apart from our competitors. Unlike other vendors, we are not owned by an insurance company, and we do not offer medical coding, claims review, and RAC compliance and appeals services to providers, which would be a conflict of interest. At the same time, we do not contract with

healthcare providers to perform their credit balance audits or process their claims; any company that does, presents the risk of not maintaining objectivity when dealing with West Virginia providers. This risk is heightened further when vendors are embedded with the same hospitals and healthcare providers they are auditing.

Our solution for BMS is based on robust systems, analytics, audit procedures, and expert consultation and is backed by our talented team's understanding of the Medicaid claim environment and ability to validate improper payment scenarios—including those not covered under Medicare RAC programs, such as home health, long term care, hospice, dental, and home and community-based waiver services. Exhibit 1 summarizes our approach to designing and deploying BMS's RAC program. In the paragraphs Focus on Integrity:

HMS is committed to protecting the integrity of government-sponsored healthcare payers. HMS does not provide payment integrity and claimsrelated services (i.e., RAC Compliance and Medical Coding) to providers.

following our approach, we include demonstrated proof of HMS's success and solution for BMS.

July 27, 2012

Exhibit 1 > BMS Will Maximize Its RAC Program by Relying on HMS's Customized Solution

The HMS Solution	
	HMS performs a complete review of BMS's scope of work and program components, including systems, state requirements; program data; regulations; policies; manuals; state codes; administrative rules; provider manuals and bulletins; Medicaid publications; Code of Federal Regulations (CFR 42); OIG Exclusion Database; and plans. In addition, we will meet with the various internal and external stakeholders to ensure that we meet BMS's program goals, provide BMS-specific education on program requirements/processes, and coordinate with other audit efforts.
Detection of Improper Payments	Currently, HMS accurately and securely performs intake of BMS's claims data, program eligibility, provider, reference, and other MMIS data. This provides a significant advantage and allows HMS to expedite the implementation process for BMS. HMS has a well-established, secured method of transmission of all BMS data. In addition, HMS already has data receipt protocols and reformatting in place for BMS's data files, including BMS paid claims. If needed, we will customize these mechanisms for this engagement.
	Working with BMS, we have already interpreted BMS's policy, billing rules, and State Plan into our rules engine and this information is readily available for this engagement.
	While we bring to BMS a standard set of data mining algorithms, we do not stop at the standard list. Using our library of improper payment algorithms, HMS will develop and configure data routines specifically for this engagement. HMS's Regulatory and Reimbursement Research and Development department reviews state and plan regulations and policies to ensure the applicability of each algorithm to the program, and to set the appropriate parameters for each algorithm. HMS will seek BMS's approval for the data routines that we will implement for this engagement.

The HMS Solution			
	HMS is structured with the tools and personnel necessary to determine if an overpayment or underpayment occurred. Our experienced staff have years of in- the-field training. Relying on this experience, team members not only review documentation and assess if the improper payment occurred, but also can identify additional target referrals for other improper payments. HMS has available for this scope of work an experienced and prominent West Virginia-licensed physician to support the clinical reviews as well as any appeals.		
Automated, Semi- automated, or Complex Review - Validation of Improper Payments	We identify improper payments by conducting automated reviews (no review of documentation) or complex reviews (review of medical record or other documentation). An automated review is used for improper payment claims identified through data analysis routines approved for producing clearly improper payments. For complex reviews, we conduct a thorough review of medical records and other documentation using nationally recognized and West Virginia-specific criteria. A semi-automated review is used when either some additional documentation or information is required from the provider, but the full medical record is not needed or the provider is not required to provide the full record. HMS auditors review the documentation to ensure that the claim was appropriately billed. Our reviews are performed through a combination of desk and onsite audits.		
	Our staff, who are trained to identify suspected fraud and abuse, will report any suspected fraud directly to BMS.		
Tracking and Reporting of Improper Payments	HMS's state of the art case tracking system, Program Integrity Enterprise (PIE), documents the activities of each identified improper payment and generates detailed reports to our clients. This case tracking system specifically supports the efficient administration of RAC program activities - this eliminates the need to be retrofitted to accommodate the evolving ACA and CMS requirements. BMS will have direct access to PIE.		
Recoupment and Recovery of Improper Payments	HMS will work with providers to maximize BMS's collection of improper payments. HMS's effective approach minimizes the administrative burden for providers, and our experienced Provider Relations team is available to communicate with providers throughout the recovery process, address their concerns, and ensure prompt payment. Our collaborative approach to working with the provider community has been a key component of our ability to consistently achieve a high level of recovery for our clients.		

The Right Experience Is Necessary to Meet BMS's Medicaid RAC Qualifications

As a qualified Medicaid RAC vendor, HMS possesses the experience that BMS requires to confirm, track, report, and recoup improper payments. Our Medicaid and Medicare RAC experience has taught us that there are important differences between the two types of projects in terms of data coordination, recovery, and coordination with other audit stakeholders. A vendor should not undertake a Medicaid RAC project by simply mirroring the processes used for a Medicare RAC project. The differences between the two are so vast that success in one does not necessarily translate into success in the other. HMS can complement our deep Medicare experience with significant state-specific Medicaid experience; this ensures the implementation and ongoing operations of a successful Medicaid RAC program for BMS. Vendors with limited Medicaid RAC

experience can be expected to face significant challenges in customizing their federal solution to meet BMS's specific needs.

The following details outline the lessons that we have learned from working with **both** Medicaid and Medicare RACs.

Important Differences Between Medicaid and Medicare RACs

Medicare RAC experience is not enough to understand the complexities and myriad issues surrounding the successful implementation of a Medicaid RAC. Simply put, experience with Medicare data and Medicare RACs falls far short of the expertise needed to meet the qualifications that BMS has set forth in its RFP:

- Medicare RACs work with a single reimbursement rule set—Medicare. A Medicaid RAC, on the other hand, requires a thorough understanding of the state's Medicaid program, state legislative and provider interests, and the interplay among various programs. Further, Medicaid RACs must be able to build queries based on dynamic Medicaid State Plan and Provider Manual updates.
- Medicare RACs receive data from the Centers for Medicare & Medicaid Services (CMS) in a standard format. Medicaid RACs will receive data from states, requiring that vendors possess a comprehensive understanding of both Medicaid data, FADS, and MMIS, including the ability to efficiently load and format data.
- Medicare RACs do not actually collect overpayments; they submit overpayments to be processed through offsets performed by Medicare Administrative Contractors. Medicaid RACs, on the other hand, will perform the actual recoupment efforts, including recovery, processing, and posting requirements.
- For the most part, Medicare RACs do not overlap with other Medicare audit programs. Medicaid RACs, however, may overlap with state efforts executed by other agencies. Consequently, coordination with the state Medicaid program audit activity will be necessary. HMS is well versed in coordinating audit activities to ensure nonduplication of effort.
- Medicare RACs are used to working at the direction of CMS in almost every project step, requiring extensive contract management, decision making, and daily direction by multiple CMS employees. If the Medicaid RAC required this much oversight, the burden on the state's employees would be overwhelming. The Medicaid RAC must be able to quickly understand the state's needs and institute responsible review and recovery activities without making constant demands on state employees.

Unlike other vendors for whom Medicaid cost containment is new or where healthcare is one market among many others competing for resources, **our singular focus is cost containment solutions for government-sponsored healthcare entities, with a strong focus on Medicaid**. To achieve the ever-growing levels of recoveries and savings that have characterized our record of client service, HMS's innovative approaches augment our clients' existing cost savings services, increase their recovery yields, and ensure the ongoing integrity and viability of the valuable programs that they administer.

BMS's Success with HMS

HMS currently delivers Program Integrity and Third Party Liability (TPL) identification and recovery services to BMS. We are proud of our success in implementing these services to reduce healthcare spend and improve processes. We have significant experience working with BMS on a variety of issues including State Plan Amendments, provider education and outreach. By selecting HMS, BMS will be choosing continued success with a partner that brings:

Maximized recoveries:

 HMS has been providing services to BMS since 1988, and we recovered more than \$10.8 million in recoveries and provided \$92 million in cost savings to BMS in 2011. With BMS's public resources being squeezed by decreasing revenue and other state budget priorities, HMS can offer a highquality, efficient, and risk-free solution. HMS has worked successfully with West Virginia providers (e.g., WV
 HMS Program Integrity Activities in West Virginia:
 Credit Balance Audits
 Medicare Repricing

Health Care Association, WV Medical Institute, and WV Senior Services), particularly hospitals, over the years for various recovery projects and education on Medicare Repricing.

In-place processes and expert staff:

In-place processes, data exchange protocols, and information systems.

HMS staff have a solid understanding of

- Duplicate Claims Analysis
- Medicaid/Medicare Primary Payment Analysis
- LTC/Hospice Duplicate Billing Analysis
- Inpatient/Outpatient Claims Analysis

the BMS Medicaid programs coverage and billing requirements, and payment methodologies. Our in-place processes significantly reduce the time and effort needed for implementation activities for a new engagement, resulting in minimal administrative burden to state staff, faster results, and no learning curve, as would be required by an untested vendor.

Expert staff who know BMS. HMS knows West Virginia state and federal laws, regulations, and administrative rules and procedures that will affect the RAC engagement. Moreover, our staff have a strong understanding of BMS program goals and expectations, stakeholders, and the provider community. Leveraging these resources, BMS will avoid the financial impact of switching to an inexperienced vendor, which could significantly delay and ultimately reduce recoveries. HMS has a strong presence in West Virginia. Our office, located at 405 Capitol Street, Suite 503 Charleston, WV 25301, is within minutes from BMS, and our staff can be onsite quickly. HMS staff in this office are integral in interpreting CMS policy guidelines, including the recent Medicaid RAC Final Rule.

In addition to meeting and even exceeding BMS's expectations for a qualified partner, HMS's solution fully complies with the Affordable Care Act and Medicaid RAC Final Rule, which means that BMS will be able to meet the federal requirement to implement its program by the implementation date. HMS is eager to expand our service offering to BMS.

Ms. Smith WV Department of Health and Human Resources July 27, 2012 Page 7

Should you have questions or need additional information, please contact David Dawson, Vice President, Government Services, South, at 214.453.3112 or ddawson@hms.com. Thank you for the opportunity to respond to this RFP. We look forward to providing the RAC solution for BMS.

Sincerely,

David M. Dawson Vice President, Government Services, South



V E N D R

Request for Quotation

	RFQ NUMBER PAGE
State of West Virginia	MED13001 1
Department of Health & Human Resources	
Office of Purchasing	ADDRESS CORRESPONDENCE TO ATTENTION OF
One Davis Square, Suite 100	BRYAN D. ROSEN
Charleston, WV 25301	304-558-0953
Health Management Systems, Inc. (HMS) 5615 High Point Drive Irving, TX 75038	S BUREAU FOR MEDICAL SERVICES H 350 CAPITOL STREET, ROOM 251 I CHARLESTON, WV 25301-3706 P T O

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Bureau of Medical Services

Recovery Audit Contract Medical/Dental/DME

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Authorized Signature

Date



David Dawson, Vice President, Government Services South Health Management Systems, Inc. 5615 High Point Drive, Irving, Texas 75038 Telephone: 214.453.3112 / Fax: 469.359.4413 ddawson@hms.com



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Appendix 1: Certificate of Good Standing Appendix 2: Key Staff Licensure and Certification Appendix 3: Resumes

Note: HMS has designated portions of Attachment A as "Confidential" as defined by the West Virginia Code and this information is proprietary to HMS. Specifically, the information reflects unique identification, review, audit, audit coordination, recovery, and provider education processes. In addition, the information includes proprietary systems, outcomes from proprietary systems, reports, and overpayment algorithms. Such compilations, systems, data, and the process of such are not generally known nor are they readily ascertainable by proper means by other persons. Said documents are the results of substantial efforts, time, and monies expended over years of research and implementation.



Attachment A: Vendor Response Sheet

Provide a response regarding the following: firm and staff qualifications and experience in completing similar projects; references; copies of any staff certifications or degrees applicable to this project; proposed staffing plan; descriptions of past projects completed entailing the location of the project, project manager name and contact information, type of project, and what the project goals and objectives were and how they were met.

Qualifications and Experience

2.3.1 The Vendor should have at least eighteen (18) months experience in each of the following; and the Vendor's proposal should include a description of their experience with each of the following:

HMS Is Qualified to Meet the Bureau for Medical Services' Needs

Today, more than ever, it is critical to identify every possible dollar that can be recovered as Medicaid

agencies are under continual fiscal pressure regarding healthcare reform, spending efficiencies, and the need to provide services to a greater number of beneficiaries. As a trusted partner of state Medicaid agencies for more than 27 years, HMS has the breadth of experience and the resources in place to help the Bureau for Medical Services (BMS) realize its full recovery potential while ensuring maximum efficiency and full compliance with state and federal regulations, including the recently published provisions of the Centers for Medicare & Medicaid Services (CMS) Medicaid Recovery Audit Contractor (RAC) Final Rule.

HMS leads the nation in designing and deploying improper Medicaid overpayment identification and recovery, cost



containment, and coordination of benefits (COB) services for government and public Healthcare programs. Since 1985, HMS has worked with Medicaid agencies to deploy our state-of-the-art technology, effective operational processes, and best practices to identify providers, claims, and patterns that may indicate fraud, waste, or abuse. Since 1994, we have provided third Party Liability (TPL) recoveries and cost avoidance services to BMS, and we are proud of our success, recovering more than **\$72.3 million for the State and achieving cost avoidance savings of \$517 million. Exhibit A-1** illustrates the years of related experience that HMS brings to BMS.



Exhibit A-1 > HMS Brings Experience in Each of the Services Requested by BMS

HMS Area of Expertise	Years of Experience
Serving West Virginia Medicaid Program	24
Serving State Medicaid and Other Government Agencies	27
Medicaid Program Integrity Issues	27
Identifying and Auditing Improper Payments	27
Provider Administrative Hearings and Appeals	27
Data Analysis	27
Overpayment Recovery	27
Fraud/Abuse	27

Experienced HMS Team

HMS has assembled a team that meets CMS' Medicaid RAC Final Rule requirements and includes a bestof-breed subcontractor with extensive program integrity experience to supplement the RAC services that HMS proposes to perform for BMS. We have selected Public Consulting Group (PCG) to review long term care (LTC) support services, including Personal Care Service (PCS), Community Behavioral Health (CBH), home health, and hospice services. These services alone represent more than \$400 million in annual Medicaid spend in West Virginia and are associated with significant exposure to risk of overbilling. HMS is confident that a review of these services will yield a positive Return on Investment (ROI) for BMS.

Public Consulting Group

A national firm headquartered in Boston, MA, PCG maintains local offices in Morgantown, WV, and

Charleston, WV, and provides management consulting and technology services to help public sector education, health, human services, and other government clients achieve their performance goals and better serve populations in need. Currently, PCG and HMS successfully work together to perform recovery audit projects and expect to begin Medicaid RAC engagements together in several states over the next few months.

PCG has assisted clients in all 50 states in expanding program financing options available from public and private sources, reducing or containing costs, and improving business processes and outcomes. PCG will apply its first-hand knowledge of postpayment provider reviews from other states and knowledge



For one client, PCG's work resulted in overpayment findings in excess of \$200 million related to the payment of noncompliant Medicaid claims.

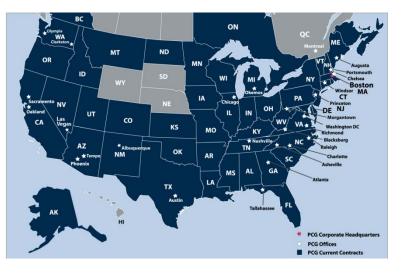
gained from 24 years of serving agencies within the health and human service delivery model to yield optimal results for BMS. The firm has built an end-to-end solution for conducting audits of PCS and behavioral health and other related services. Such services are often the most prone to error because few



edits and audits exist to manage payments to their providers. PCG has audited these services in both

North Carolina and Virginia (as a subcontractor to HMS), with significant success.

PCG has significant experience in fulfilling complex scopes of work for health and human service agencies both in West Virginia and throughout the nation and has established successful working relationships within its provider communities. The firm will leverage that experience to implement best practices and develop innovative solutions for this engagement.



Importantly, PCG has a long, successful history across many agencies within DHHR, including current project work with BMS. PCG has a proven track record with DHHR dating back to 2002, completing a variety of revenue maximization, cost avoidance, and program design projects. PCG's original contract with DHHR included a comprehensive assessment and implementation plan to maximize federal recoveries for the State; the firm worked closely with DHHR to conduct comprehensive reviews of agencies and programs at the state and local level and identified more than 50 opportunities for potential revenue. PCG selected, assessed, and implemented eight project initiatives that generated more than \$100 million in Title IV-E, Title XVIII, Title XIX, Title IV-D, Graduate Medical Expense (GME), and other Federal Financial Participation recoveries.

HMS is confident that no other vendor can match the experience and capabilities that our team offers BMS.

Enhancing Our Partnership with BMS

Based on our understanding of BMS's Medicaid RAC requirements, HMS brings state-specific knowledge of the following to this engagement:

- ► West Virginia and federal laws—the laws, regulations, and rules that govern the Medicaid program and processes for the identification and recovery of improper payments
- ► Methods to operationalize Medicaid RAC functions—identification, confirmation, recovery, appeals, fraud referral, reporting, and provider outreach and education
- CMS and BMS Medicaid RAC guidelines—performance standards and measures to ensure that we produce case deliverables in accordance with both CMS and BMS guidelines
- Seasoned Medicaid RAC staff—a qualified Medical Director, certified coders, registered nurses, Certified Fraud Examiners, and auditors who consistently deliver results across improper



payment identification, audit, and recovery activities and West Virginia–experienced Project and Leadership staff who will successfully manage this engagement

- Detailed work plan—comprehensive plans that outline time frames, assigned resources, and operations activities
- **BMS information systems**—extensive system knowledge, interfaces, infrastructure, capacity, and security to support the information management requirements of the project

Expertise in State and Federal Rules and Regulations

HMS's success in every jurisdiction in which we provide services is the clearest indicator of our

knowledge of the laws, regulations, rules, and policies governing Medicaid. Through our existing contract work, HMS has gained knowledge of many of BMS's regulations, rules, and policies, including provider billing and reimbursement rules and methodologies. HMS will ensure that our audit protocols and Internal Review Guidelines (IRGs) are developed and executed in accordance with all state and federal rules and regulations governing BMS's RAC program.

HMS Audit staff are regularly trained on state coverage policies, rules and regulations, and coding requirements and have access to reference tools and systems that support highquality decisions. HMS has a comprehensive quality assurance (QA) process that reviews both decisions and deliverables to ensure that decisions are clear on letters and reports. On June 28, 2012, the Supreme Court upheld the ACA, and most of its provisions, as being constitutional. A comprehensive RAC program is a necessary component of the State's compliance with federal law and a means to ensure that improper payments in the Medicaid program are identified and recovered.

In **Exhibit A-2**, we demonstrate our understanding of some of the key regulatory provisions related to the Medicaid RAC program, including requirements established in the West Virginia State Codes, which detail RAC expansion, fraud/waste/abuse guidelines, record maintenance, and information safeguarding guidelines, which include eligibility, coverage, billing, payment, and recordkeeping requirements.

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Law/Regulation	Description	HMS Understanding
Patient Protection and Affordable Care Act (ACA) Public Law 111 –	Expansion of RAC program	Section 6411 requires state Medicaid agencies to establish a RAC program modeled after the Medicare RAC program and hire a RAC contractor to identify over/underpayments and recover overpayments.
148 Section 6411		As a long-standing provider of healthcare program integrity services to state and federal agencies, HMS has been on the forefront of the ACA. One of our principal priorities since its

Exhibit A-2 > HMS's Understanding of Key Regulatory Provisions



Law/Regulation	Description	HMS Understanding
		passing is to confirm our understanding of the law and how it will impact our clients. HMS is prepared to respond to changes resulting from ACA and aid BMS in both understanding and fulfilling the new requirements of the law. As a Medicaid RAC in 16 states and a former Medicare RAC, we are acutely aware of the requirements and implications associated with establishing and maintaining a RAC program.
Code of Federal Regulations (CFR) Title 42 Public Health	Medicaid program integrity—Fraud Detection and Investigation program	Part 455 defines requirements for a state to establish a program that identifies, investigates, and refers suspected fraud and abuse cases. The section also covers reporting requirements, payment withholding, and provider disclosure.
Part 455		HMS has significant experience in assisting state and federal agencies to carry out their programs to detect and counter fraud. In our program integrity projects, we are required to report suspected instances of provider and recipient fraud and refer such cases to the designated state agencies, including the Medicaid Fraud Control Unit and other authorities as directed.
		455.500-518: Provides final regulation and clarification of Medicaid RAC program, including RAC eligibility requirements, activities to be conducted, appeals, payments to RACs, and exceptions.
CFR Title 42 Public Health Part 456	Control of the utilization of Medicaid services	Part 456 defines the utilization controls that states must establish for Medicaid institutional services and outpatient drug claims to safeguard against unnecessary or inappropriate use of services and evaluate quality of care. Requirements related to certification of need, admission criteria, plan of care, continued stay, records, reporting, and confidentiality are delineated.
		Permedion, HMS's wholly owned subsidiary, is URAC accredited and performs Utilization Management/Review services for eight Medicaid programs. We have a complete understanding of the federal requirements related to Utilization Review and the importance of medical necessity, appropriateness of setting, quality of care, and excess payments.
CFR Title 42 Public Health Part 433 Subpart D	TPL services	Part 433D describes the efforts that states must take to identify third parties liable for payment of Medicaid services and obtain payments from those third parties. Requirements related to obtaining health insurance information, data exchange, cost avoidance, and recovery are also defined.
		As the nation's leader in TPL services, HMS currently performs TPL identification and recovery services for 40 of the 51 state Medicaid agencies and is very well versed in all aspects of TPL overpayment services. We understand that a high percentage of overpayments made by Medicaid programs involves Medicare and private insurance TPL issues.
CFR Title 42 Public Health Part 431 Subpart F	Safeguarding information on applicants and recipients	Part 431F describes the required safeguards related to the use or disclosure of information concerning applicants and recipients. The types of information to be safeguarded (i.e., medical services provided) are detailed as well as conditions for release of and access to the information.
		HMS has physical and administrative safeguards in place that restrict information access and disclosure to only authorized individuals.



Law/Regulation	Description	HMS Understanding
CFR Title 45 Public Welfare Part 164	Security and privacy	Part 164 outlines the requirements that Covered Entities, such as HMS, must meet regarding administrative, physical, and technical safeguards of electronic Protected Health Information (PHI). The section also details the approved uses and disclosures of PHI. HMS brings BMS a sound infrastructure for protecting the confidentiality, integrity, and security of medical records, claims, and all other PHI.
WVC §9-5-11. Assignment of rights; right of subrogation by Department of Health and Human Resources to the rights of recipients of medical assistance; rules as to effect of subrogation	Subrogation rights	This section outlines DHHR's requirements concerning the rules of subrogation when medical assistance is provided and states that DHHR has the right to recover full reimbursement from any award or settlement for such medical assistance. The right of subrogation includes all portions of the cause of action by either settlement, compromise, judgment, or award, notwithstanding any settlement allocation or apportionment that purports to dispose of portions of the cause not subject to subrogation.
WVC Chapter 9, Article 7. Fraud and Abuse in the Medicaid Program State Medicaid Rule Section 4.5 – Medicaid Agency Fraud Detection and Investigation Program	Medicaid program integrity: Fraud Detection and Investigation program	Article 7 Section 9-7-1 through 9-7-9 outlines the definitions, legislative purpose, and findings and related powers/ \duties of the fraud control unit. It also states that remedies and penalties are not exclusive and outlines severability provisions. Further, the article sets forth investigation and related procedures, such as the criminal penalties that apply to a person found in violation of the section. Any person found violating Subsection a, b, or c of this section is guilty of a felony and shall be imprisoned not less than one nor more than 10 years, or shall be fined not to exceed \$10,000 or both fined and imprisoned. Civil remedies and the liability of DHHR employees regarding fraud/waste/abuse are also outlined in this section.
WVC §9-5-11b. Release of information	Fair information (personal data) practices as related to members and health insurers	Section 9-5-11b. addresses the release of information and states that all recipients of medical assistance under the Medicaid program have authorized third parties to release to DHHR information needed to secure or enforce its rights as assignee under this chapter. Health insurers, including self-insured plans, group health plans as defined in Section 60749(a) of the Employee Retirement Income Security Act, service benefit plans, Third Party Administrators, managed care organizations (MCOs), Pharmacy Benefit Managers (PBMs), or other parties that are by statute, contract, or agreement legally responsible for payment of healthcare claims, items, or services, are required to provide information to determine benefits coverage. Health insurers must respond within 60 days of receipt of a written request for enrollment data from the department or its contractor. Also, they must accept the right of BMS of recovery and assignment to the state to payment from the party for which payment has been made by BMS. Further, this section states that insurers must respond to any inquiry by BMS regarding a claim for payment for an healthcare service or item that is submitted not later than three years after the date of the provision. The insurer must also accept a claim submitted by BMS regardless of the date of claim submission, type or format of the claim form, or lack of



Law/Regulation

Description

HMS Understanding

preauthorization or the failure to present proper documentation at the point of sale that is the basis of the claim, provided that the claim is submitted within the three-year period beginning on the date of service. Any action by BMS to enforce its right is started within six years of the BMS claim submission date.

HMS's Experience and Success with BMS

Through our proven approaches and practices, HMS has continually provided comprehensive TPL

program services to BMS since 1988. Our TPL program generates recoveries from commercial insurance, PBMs, and other entities operating in West Virginia by performing data matches to identify other medical and pharmacy coverage available to Medicaid recipients when Medicaid paid as primary. In 1994, HMS launched our Medicare Part A disallowance project, in which we identify claims paid by BMS for which Medicare coverage was in effect. After identifying the BMS overpayment amount, we prepare a listing of claims identified for recoupment for review and approval by BMS.



HMS's successful partnership with BMS is proven - we recovered more than \$10.8 million for BMS in 2011 alone.

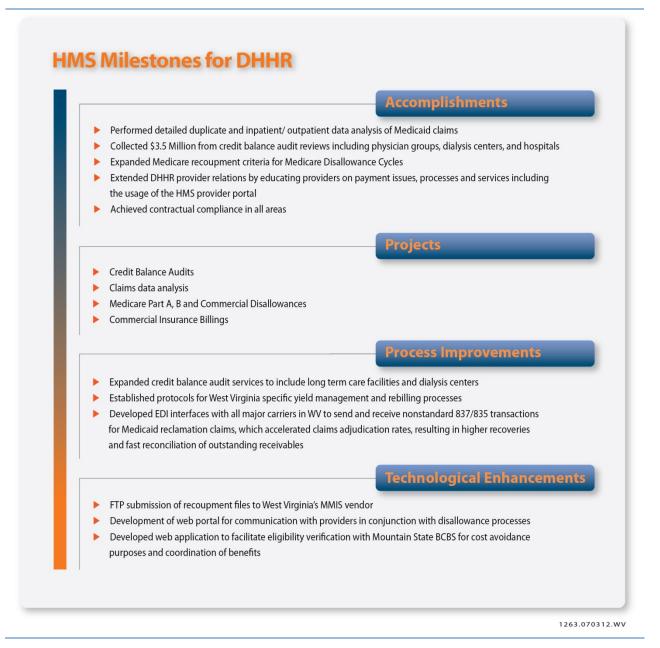
HMS works with providers to recover the overpayment and correctly bill Medicare. Due to success of the Medicare Part A disallowance project, BMS expanded the criteria to include commercial insurance disallowances in 1996 and added Part B disallowances in 2009.

HMS also provides identification of potential third party coverage (cost avoidance) for BMS enrollees through our data match database and processing of insurance leads from caseworkers, members, providers, etc. These services have generated \$517 million in savings to BMS. In addition, we implemented our Provider Portal two years ago to manage our recovery process in West Virginia, and we will use this portal for the RAC engagement.

The best evidence of our success for BMS is a description of how we have implemented and managed key projects and maximized results. **Exhibit A-3** highlights key events and milestones that we have accomplished for West Virginia during our partnership with DHHR.



Exhibit A-3 HMS-DHHR Accomplishments Add Value to the State of West Virginia



Experience with Molina's WV MMIS

Through our current work for the West Virginia Medicaid program, HMS has developed an in-depth understanding of the Molina Medicaid Management Information System (MMIS). We are very knowledgeable of the provider billing and payment rules and methodologies used in Molina. The services that we provide to BMS have a direct impact on member eligibility, and we are therefore proficient in navigating the Molina system to provide members and providers in West Virginia with outstanding customer service when they need assistance with claims details.



HMS regularly receives information from Molina regarding eligibility and paid claims data, with secure weekly and monthly data feeds exchanged as appropriate. HMS and BMS have implemented File Transfer Protocol Secure (FTPS) interfaces for all Electronic Data Interchange (EDI) transactions, which further streamlines the development of data formatting and transmission protocols between parties.

HMS has expertise in interpreting the various files produced by BMS-related agency systems from which we currently receive information for our other West Virginia contract work, including, but not limited to, claims, eligibility, and provider data. We use this knowledge to provide and enhance the services that we perform for BMS. We have built effective relationships with BMS, Molina, and RAPIDS staff, thereby strengthening our knowledge and allowing us to serve as an important partner

HMS Is Ready to Deliver on Day One

- HMS has established protocols with Molina, and we have processed BMS MMIS data for many years.
- HMS knows BMS file structures and data field values.
- HMS has performed data mining and analytics on BMS data.

for BMS programs in terms of data transmission to and from systems and the understanding of data fields and values.

2.3.1.1 State Medicaid programs operations;

Our Extensive Knowledge of State Medicaid Programs

HMS works with more than 40 Medicaid agencies, and we have successfully operationalized program integrity and cost containment activities for these agencies since 1985. **In 2011, we recovered more than \$2 billion for our COB, RAC, and program integrity clients**. HMS understands the Medicaid environment and the issues confronting our Medicaid clients.

HMS brings hands-on experience and an in-depth understanding of Medicaid programs—both national and state specific. We know the dramatic variances in state Medicaid programs, including those in audit/review regulations, provider sensitivity, state agency organizational structures, and program integrity practices, and we are experts in interpreting Medicaid policies. In contrast, our competitors perform Medicare RAC work with a single set of reimbursement rules and protocols across states. BMS needs a vendor with experience in both Medicaid and Medicare.

For years, we have successfully provided customized data mining and analysis, overpayment identification and validation, auditing, and recovery services to Medicaid agencies. HMS does more than just identify potential improper payments—we actually recover the identified overpayments and put those monies back into the Medicaid programs that we serve. The success that we have achieved on behalf of our clients substantiates our ability to understand the critical components of each Medicaid program and to operate successfully within each state's unique environment.



HMS has built databases of state program regulations, providers, claiming and policy practices and requirements, and reimbursement methodologies. Our library of "ad hoc" and "production" queries will

serve as a foundation for this engagement. We recognize that each Medicaid program is unique in its reimbursement and business practices. We will thoroughly study the West Virginia Medicaid State Plan, provider manuals, and business practices to create a customized program while simultaneously leveraging our other Medicaid RAC best practices to ensure a rapid implementation for BMS.

As a full-service cost containment and program integrity organization, HMS has the operational expertise, regulatory background, human resource talent, overpayment identification logic, and technological resources to perform the entire scope of requested services identified in BMS's Request for Proposal (RFP). We have a solid foundation of Medicaid experience in efficiently processing claims and eligibility information, establishing provider and other stakeholder relationships, and



BMS deserves a vendor that understands the differences between Medicaid and Medicare and knows how to correctly interpret policies from state to state. Success in managing a Medicare RAC project does not necessarily translate into guaranteed success in managing a Medicaid RAC project.

deploying local and national Subject Matter Experts (SMEs) to quickly generate measurable results.

Unlike other vendors or processes that focus on one targeted aspect of the billing and reimbursement process, HMS takes a prismatic approach. We look at each episode of care and each claim from every angle, understanding how eligibility, coverage, utilization, clinical, and financial analyses can be used together to profile errors and identify more potential over/underpayments than one-dimensional, bucket-type analyses. We share data, insights, and results across all of our cost containment and recovery audit functions, and we leverage our understanding of Medicaid operations to maximize the identification and recovery of improper payments. Our many years of experience have also given us a keen understanding of Medicaid reimbursement rules, provider protocols, state legislative and regulatory efforts, and MMIS processes.

2.3.1.2 Program Integrity Experience and Understanding

2.3.1.2 Medicaid program integrity issues and risk areas for waste, fraud and abuse;

HMS's 27 years of program integrity experience and expertise across more than 40 Medicaid agencies of various size and complexity have established us as a leader in the evolving improper Medicaid payment arena. Ensuring the integrity of government-sponsored Healthcare programs is a primary focus of our business. To achieve the ever-growing levels of recoveries and savings that have characterized our record of client service, HMS has developed innovative approaches to augment our clients' existing cost savings services, increase their recovery yields, and ensure the ongoing integrity and



viability of the valuable programs that they administer. We have translated these innovations into positive results for our clients.

Special Techniques, Skills, and Abilities

As indicated by our track record of success, HMS provides a special set of techniques, skills, and abilities and applies best practices in similar program integrity engagements with clients across the nation, including:

- An ability to rapidly implement improper payment projects due to our knowledge of BMS's Medicaid programs, data structures, billing and payment requirements, and reimbursement logic and our familiarity with West Virginia providers.
- Proven ability to implement successful Provider Outreach and Education programs to facilitate smooth implementation of the project.

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HMS has developed innovative approaches to augment our clients' existing cost savings services, increase their recovery yields, and ensure the ongoing integrity and viability of the valuable programs that they administer.

- Successful nationwide experience in applying a wide range of customized improper payment algorithms across all Medicaid provider types.
- Rapid configuration and testing of improper payment algorithms and audit/review protocols to ensure compliance with state policies and requirements.
- Incorporation of state reimbursement methodologies into our processes to accurately reprice improperly paid claims.
- Highly skilled Clinical Review team comprising nurses, certified coders, and physicians experienced in the review of medical records, using state-specific criteria and national guidelines to determine if claims are inappropriately billed or coded or for services not provided in the appropriate setting or medically necessary, resulting in higher-than-necessary Medicaid payments. This level of experience and attention to detail enhances our ability to complete reviews within client-specific time frames.
- Experienced data analysts, auditors, and clinicians with expertise across all Medicaid service types, including Hospital, LTC, Pharmacy/Durable Medical Equipment (DME), Behavioral Health, and Waiver programs.
- Comprehensive case management system that tracks all audit activity and results and an already implemented Provider Portal that facilitates efficient communication with providers related to record requests, audit findings, and improper payments.
- Ability to create detailed yet easy-to-understand Improper Payment Notification (IPN) letters and notice of violation letters regarding the reason for the improper payment, thus providing documentation that minimizes provider questions and appeals and helps educate providers.



- Many years of experience in supporting our determinations through the provider reconsideration and appeal process, with an outstanding track record of defending our findings.
- Established Provider Relations department to resolve questions related to the identified improper payment and recovery process, maintain effective provider relationships, and educate providers on improper payment issues.

Our proven methodology reviews patterns across provider types, service areas, and providers or groups, and we review the entire potential universe of claims. **This survey of the entire claims file means that we deliver an impartial review of all providers and provider types.** HMS's process provides a comprehensive range of payment review of claims services because we combine the joint review of claims payment data and supporting provider documentation. As a team, we have significant strength in the number of professionals on our roster, including coders, nurse case reviewers, and physicians with varying specialties and experience in conducting systematic complex data matching.

HMS Routinely Analyzes Laws, Rules, and Policies

HMS analyzes state and federal laws and policies related to provider billing/reimbursement, Utilization Review, fraud and abuse, provider compliance, improper payment recovery, and appeals and hearings for more than 40 Medicaid agency clients. We understand that our processes must align with both state and federal requirements; therefore, we deem it critical to review all elements that are relevant to the program's success and compliance with state and federal regulations. Over the years, we have reviewed thousands of Medicaid laws and documents, including the following:

- State Plans
- State Codes
- ► State Administrative Rules
- State Medicaid Provider Manuals
- ► State Medicaid Provider Bulletins
- ► State Medicaid Official Publications
- State Board of Pharmacy Rules and Regulations

- CFR 42
- Medicaid State Operations Manual
- Office of the Inspector General (OIG) Exclusion Database
- State Exclusion Databases (various)
- National Coding Determinations
- ► Federal Policy Guidance
- ► CMS Informational Bulletins

Our recovery operations are based on and supported by valid regulatory source authority/requirements as well as local standards of practice. We apply the rule in effect at the time the claim was made unless regulatory authority explicitly states that a retroactive rule applies. We cite the applicable regulatory authority in our communications with providers during the recovery process.

We research all applicable resources during our overpayment analysis and consult with our clients to share guidance when it is determined to be in the best interest of the state to modify existing regulations, polices, or the State Plan to correct a deficiency that allows overpayments to occur. We also recommend updates that reflect current guidance or industry standards. We take pride in not only identifying and recovering overpayments but also helping to implement long-term changes that benefit the Medicaid program.



Additionally, we have staff and processes in place to monitor new and changing laws and regulations as they relate to the ACA. Interpretations, guidance, and the legal mandates regarding this law change daily, and HMS continuously gathers information to help our clients prepare for the future.

Experience in Analyzing Laws, Rules, and Policies

Some examples of our ability to analyze state and federal Medicaid laws, rules, and policies within the past five years are included below:

- Working to identify overpayments in a long-term contract for California's Department of Health Care Services (DHCS), HMS identified a state regulation, the California Welfare and Institutions Code, Section 10022, that did not allow providers to retrospectively bill carriers to the full limits of the federal law under Title 42 U.S.C. 1396a(25)(A)(i)(ii)(B), 1396b(d)(2) and 1396b(o). Commercial insurance carriers were contractually limiting providers to shortened timely filing periods of six months to one year, not the three years allowed by federal law. This caused Medicaid to risk losing an estimated \$11.7 million in recoveries per year. When brought to the attention of DHCS in 2010, the State of California passed amending legislation clarifying state law to meet the allowance in federal law, thereby allowing overpayment recoveries to continue.
- ► The Alaska Division of Health Care Services (DHCS) partners with HMS to ensure that institutional crossover claims are priced correctly according to the Medicaid State Plan (paying up to the lesser of the coinsurance/deductible or the Medicaid rate). Through a review of the current process and comparison with the State Plan conducted last year, HMS discovered that certain institutional providers were not included in the process to ensure the correct pricing of these claims. HMS identified the claims for these providers that were overpaid per State Plan guidelines and worked under the direction of DHCS to recover overpaid funds paid to these providers over the previous three years (totaling \$1,000,000) and to ensure that the providers were included in the ongoing crossover claim repricing process for estimated annual savings/recoveries of \$750,000-\$1,000,000.
- For our RAC program in South Carolina, we researched and worked with the State to clarify state policy on balance billing to Medicaid following primary payment. Through the assistance of our research and legal counsel, we were able to help the State clarify these regulations internally and for providers and identified a total of \$3.8 million in overpayments from April 2010 through February 2011. We anticipate continuing to identifying additional overpayments as the audit continues.

As part of our RAC program for BMS, HMS will perform a thorough analysis of West Virginia Medicaid laws, rules, and policies to enhance our understanding and generate positive outcomes for the State. HMS bases all recovery efforts on existing laws and regulations in order to support clear and defensible evidence of overpayment and to help avoid appeals and provider abrasion. We know that it is not enough to identify payment errors and that research of the supporting laws, regulations, and policies must support actual funds recovery.



Audit and Recovery Clients: Program Integrity Experience

Exhibit A-4 summarizes the audit and recovery services that we have provided as the prime contractor to state Medicaid agencies and other entities of various size, type, and scope. This list demonstrates the experience that we will bring to performing both automated and complex claims reviews for improper payment on behalf of BMS.







HMS Medicaid Program Client (Current)	Overpayment Recovery	Clinical/Medical Review	TPL/COB Recovery	Fraud, Waste, and Abuse	Audit and Recovery Services
Massachusetts – EOHHS/University of Massachusetts Medical School	✓	✓	✓		
Michigan Dept. of Community Health	✓	✓	✓		✓
Missouri Division of Medical Services	✓		✓		
Nevada Division of Health Care Financing and Policy	✓				√
New Jersey Department of Human Services	✓	✓	✓	✓	√
New Mexico Human Services Department	✓	✓	✓		✓
New York Office of the Medicaid Inspector General	✓	✓	✓	✓	✓
North Carolina Dept. of Health and Human Services	✓	✓	✓		
Ohio Department of Job and Family Services	✓	✓	✓	✓	
Oregon Department of Human Services	✓		✓		✓
South Carolina Department of Health and Human Services	✓	✓		✓	✓
Tennessee TennCare	✓		✓		√
Utah Division of Medicaid and Health Financing	✓	✓	✓		✓
Virginia Department of Medical Assistance Services	✓	✓	✓	~	✓
West Virginia Dept. of Health and Human Resources	~		✓		



2.3.1.3 Medicaid data analysis used to identify Medicaid overpayments , underpayments and improper billings;

HMS uses a multilayered set of algorithms and analytics customized for each state's program to identify and target potential improper payments. In the following paragraphs, we provide details on the types of analytics that we will employ for BMS for the RAC project. These include:

- Coding edits and algorithms
- ▶ Rules-based billing error algorithms
- Clinical targeting algorithms
- Provider profiling
- Recipient profiling
- Predictive data modeling
- Cross-state benchmarking
- Custom processes

In 2010, HMS recovered \$160,000 in a duplicate analysis project for the State of West Virginia. Using claims analysis, HMS was able to identify claims paid for the same date of service and to the same provider under different provider numbers.

We describe these processes in **Response 2.4.1** later in this section.

HMS has been a long-standing partner with BMS in identifying large cost containment initiatives. Members of our proposed team worked alongside BMS in developing a Medicare payment method. Instead of paying the Medicare coinsurance and deductible amount from the crossover file, we assisted in an additional comparison accounting for the Medicaid allowable amount for each procedure. This "lessor of" logic enabled BMS to save \$36 million. HMS has proposed a team with a history of implementing successful initiatives on behalf of BMS.

Enhanced Understanding of Program Integrity

HMS provides a variety of other program integrity services to our clients. BMS will discover, through these descriptions of our contracts, that HMS has broad experience in the overall program integrity arena.

Medical Bill Audits

HMS has specialized divisions that provide medical bill audit services to seven clients, including Medicaid agencies, MCOs, and employer groups. Bill error review services are critical to an effective improper payment Audit and Recovery program. When a program pays providers based upon provider charges, the risk of overcharging is high; a bill error review provides an opportunity for BMS to recover those overcharges and identify underpayments by comparing medical records to medical bills. In addition, our detailed bill review determinations often serve as a teaching moment, helping providers understand how to bill services appropriately.



Coding and Clinical Analysis Reviews

HMS performs coding and clinical review projects for 16 clients. In these programs, in which coding

practices have been in place for many years, we have recovered **more than \$300 million in improper payments to hospitals** made by state Medicaid agencies. In many of these states, HMS has recovered millons of dollars in improper payments for services that were erroneously coded/assigned or performed in an inappropriate setting. Throughout these projects, we have developed data analysis and claim review processes that effectively target and review a variety of improper payment issues, and we are confident that our approach will yield cost savings for BMS. The same process can identify underpayments for this engagement.

Using sophisticated inpatient targeting algorithms, HMS identifies approximately \$50 million in improper payments annually for one of our Medicaid clients.

In programs in which our full range of coding targets have been implemented, the process typically identifies 6%–10% of coding

claims as reviewable. Our medical record versus claim review history has shown that 20%–30% of the claims identified by these rules are recommended for payment adjustment or denial. We expect a much lower percentage to show as underpayments.

Billing Reviews

HMS's billing review services are distinguished by our ability to integrate with other provider audit and

disallowance projects to minimize the administrative burden on providers. Our program offers a two-pronged approach to tailor the validation approach for the issue complexity and provider size/claim volume, i.e., onsite audits and desk audits. A prime example of a best-practice billing review project is our long-term work with the New York State Office of the Medicaid Inspector General (NYS OMIG). **Our recoveries have grown by 400% in the past 24 months attributable to the rollout of a robust Medicaid RAC–like approach**. In fact, HMS co-presented this success story with the NYS OMIG at the 2010 National Association of Medicaid Program Integrity Directors conference.



In 2010, HMS recovered more than \$48.1 million in LTC improper payments.

Our approach to billing review services goes far beyond typical credit balance review services. To supplement a provider's patient accounting system, we apply our proprietary set of comprehensive algorithms designed to leverage the information contained in our clients' Paid Claims Files (PCFs) and identify improper payments of which the provider is unaware. By supplementing provider data with information contained in the PCF, the breadth and type of improper payments identified during the audit are significant. To our knowledge, **HMS is the only national Medicaid vendor that uses paid claims information in conjunction with provider account information to identify improper payments.** In



2011, we assisted our clients in **recovering \$150 million in provider improper payments**. In addition, we **identified \$1.5 million in underpayments**.

HMS Combines Data Mining and Clinical Review of Medicaid Claims

HMS has successfully developed and implemented a provider scorecard methodology to analyze suspect utilization and billing patterns in our Virginia behavioral health audit project and NYS OMIG payment integrity audit projects.

Our analytical processes are based on experience in Medicaid and Medicare claims review for coding/billing and medical necessity issues. The analysis processes and algorithms that we propose to use to supplement BMS's efforts will be configured to conform to West Virginia's specific coverage, billing, and reimbursement policies.

Medicare RAC Experience

HMS was a pioneer as a Medicare RAC during the CMS pilot from 2005–2008 and was the only contractor performing RAC pilot services in two of the three pilot states—Florida and New York.

Focusing on the Medicare Secondary Payor (MSP) component of the RAC, HMS identified improper payments resulting from errors in COB for Medicare beneficiaries. Specifically, HMS determined when a Medicare beneficiary had primary coverage, identified claims paid by a Medicare Fiscal Intermediary during the period of primary coverage, and sought recovery on those claims.

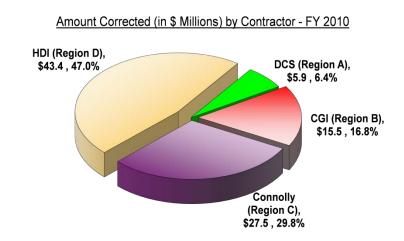
HMS's specialized Audit divisions provided services during the Medicare RAC pilot for the non-MSP (claim audit) component. We performed sampling and review of inpatient HMS understands that policy interpretation is key to the success of a RAC program. Our staff are trained to correctly interpret Medicaid policies across more than 40 states.

hospital claims for medical necessity and appropriate coding. Reviews included an initial nurse review with a referral to a physician for approval or denial as necessary as well as identification of improper payments on cases reviewed. The success of this project is apparent when the rebuttal statistics are reviewed: only 10% of our improper payment decisions were rebutted, and the majority of the rebuttal decisions were upheld in Medicare's favor following further review. These results were superior to those attained by all other RAC vendors.



HMS brings positive results, robust technology, and unsurpassed expertise gained through the relationship and lessons learned from our sister company, HealthDataInsights (HDI), who

understands first-hand the complexities and differences that are associated with implementing Medicare and Medicaid RAC programs. With more than 25 years of claims integrity experience, HDI was the top performing Medicare RAC for CMS in its demonstration project; implementation of the Medicare RAC demonstration project entailed multiple claim payment systems, interfacing



with all Medicare provider and supplier types, working with various claims processing contractors, and coordinating its efforts with CMS. Currently ranked as the top-performing Medicare RAC in the country according to CMS, HDI implemented the permanent Medicare RAC program for 17 western states as well as three territories. As the Medicare Demonstration RAC contractor for the states of Florida and South Carolina and the Medicare RAC Region D contractor for the permanent RAC contract, HDI's experience in implementing and managing large government RAC programs is unsurpassed. For this engagement, **HMS will combine HDI's superior technology and proven best practices with our strong knowledge of Medicaid and West Virginia programs to obtain enhanced results**.

HMS has superior knowledge of the program improvements that were implemented as part of the national Medicare RAC program rollout, including those implemented in response to feedback from the American Hospital Association concerning provider education, excessive medical record requests, and coordination of audits to avoid duplication. This knowledge of the past issues and improvements made to the Medicare program, combined with HMS's knowledge of interpreting Medicaid policy in West Virginia and our established rapport with West Virginia's provider community, uniquely positions us to be successful on Day One of this engagement.

2.3.1.4 Auditing Medicaid claims and reviewing medical records to determine overpayments, underpayments and/or improper payments;

HMS Brings BMS Documented Clinical Experience

HMS knows West Virginia. We understand the reimbursement methodologies used. Our team has reviewed inpatient claims from a coordination of benefits as well as a financial audit perspective. HMS is prepared to review the DRG code used by providers in billing Medicaid. Our experience enables us to review claims when clients use either current or older versions of the DRG grouper. By combining our knowledge of West Virginia with an industry leading clinical audit capability, HMS is poised to rapidly implement all aspects of this engagement.



A key element of our improper payment audit and recovery success our use of proven project

management strategies and established audit and recovery measures supported by a best-in-class hardware infrastructure to process large numbers of claim lines with accuracy, consistency, and defensibility. We offer the following:

- Objective clinical reviews on issues of coding, quality of care, medical necessity, and experimental/investigational treatment to both state government and private clients across the country
- Staff that includes data analysts, statisticians, certified coders, registered nurses, behavioral



HMS's team has documented Medicaid experience in targeting, validating, and recovering improper payments for hospital, pharmacy, dental, LTC, home health, behavioral/mental health, DME, hospice, PCS, transportation, and other provider types.

health clinicians, and a panel of more than 900 physician reviewers, covering all specialties recognized by the American Board of Medical Specialties as well as many subspecialties

Well-developed operational processes and systems, including record scanning, case management, and online references, that enable HMS to efficiently provide accurate and well-documented determinations that reduce provider abrasion and stand up to appeal

HMS's Audit and Recovery Success

Due to our numerous past and current audit and recovery contracts, HMS has the knowledge and systems capabilities to identify specific trending behaviors, spiking, multiple claim issuance, repeat billings, miscoded claims, and a variety of other patterns of billing that can result in excessive or improperly paid claims. HMS also continuously builds upon our extensive library of hundreds of proven, tested algorithms and complex queries that have been used successfully to determine improper claims payment.

HMS performs various types of audits for our clients as depicted in **Exhibit A-5**. We conduct short- and long-term prospective, concurrent, and retrospective reviews of a variety of service types and provide clinical support services to state and managed care Surveillance and Utilization and Review units/Special Investigation Units.



Category	Type of Analysis/Review	Average Recoveries for 2010 and 2011
Data Mining–Based Improper Payment Recovery Scenarios (All Claim Types)	 Data analysis targets clearly improper payments resulting from duplicate billing, readmissions and transfers, coding errors, Diagnosis-Related Group (DRG) upcoding, COB reporting errors, excess days paid, date of death vs. service date issues, clear unit billing errors, and other billing/ reimbursement errors. Providers are notified of the error and improper payment and have an opportunity to refute the finding online or by mail. 	\$21 million
	Improper payments are recovered, refutations are reconsidered, and a final determination is made.	
	 Providers have an opportunity to appeal. 	
Clinical Review Scenarios (All Claim Types)	Data analysis targets likely coding, inappropriate setting, and medical necessity/utilization errors, including improper documentation.	
	 Clinical staff review medical records against clinical criteria (i.e., InterQual). 	\$55 million
	 Providers are notified of the determination and have an opportunity to discuss the determination. 	
	 A full reconsideration/appeal process is supported. 	
	 Improper payments are recovered. 	
Focused Behavioral Health, Home and Community-Based Service Audit Scenarios	 Data analysis targets/prioritizes providers. 	
	 Audit team performs onsite documentation and staff qualification reviews. 	
	 Audit team issues audit report. 	\$12 million
	 Approved audit report is sent to provider, who has an opportunity to discuss the findings, 	
	 A full reconsideration/appeal process is supported. 	
	 Improper payments are recovered. 	

For the contracts listed above, we obtain medical records from providers and our qualified Clinical, Coding, or Financial Audit staff members review the documentation according to an approved audit/review plan and IRGs, protocols developed specifically for each state to ensure that our review incorporates the appropriate state rules, regulations, guidelines, and clinical criteria that were in place for the specific date of service being reviewed. Our clinical review also determines whether the acute hospital level of care was necessary based on the intensity of services provided and/or the severity of the patient's illness.

We use nationally recognized medical criteria to validate the necessity and appropriateness of setting issues. Our Review/Audit staff document their findings and rationales in our case management system within client-specific time frames. Detailed determination notices and reports are generated to notify the provider of the findings and the improper payment amount. Our review/audit processes vary depending on the claim type and issues. We consistently achieve low overturn rates to our final decisions. This audit structure has provided our clients with extreme accuracy, consistency, and defensibility on the



reviews that we conduct. It is our vision that HMS will deploy similar processes for West Virginia's claims audit and recovery contract.

HMS has experience with all provider types, as illustrated in Exhibit A-6.



2.3.1.5 Medicaid overpayment recovery;

Savings to Our Clients: HMS's Success

Our efforts produce real results. **In 2011, HMS recovered more than \$2 billion for our healthcare clients**. These are **real dollars** returned— in addition, cost avoidance figures account for more than \$7 billion in savings each year for our clients due to overpayment recovery.

Exhibit A-7 highlights some of the overpayment recovery and cost savings generated through our projects of similar scope over recent years.



Project Name	Savings
Colorado Retrospective Review	Within the first year of this limited review contract, we identified more than \$2 million in Medicaid overpayments, primarily from claim coding errors. To date, more than \$4.3 million in Medicaid overpayments have been recovered.
Kentucky Medicaid Home Health and Inpatient Review Services	Within a 13-month period, we identified savings of more than \$19 million through prior authorization of home health services.
University of Massachusetts Medical School Acute Hospital Utilization Management Contract	Within the first year of this contract, we identified MassHealth savings of more than \$40 million through our preadmission, pre-payment, and post-payment review services.
New Jersey Retrospective Review	HMS began retrospective review services in 2008. To date, we have identified more than \$2.4 million in Medicaid overpayments. In 2010, HMS was awarded a statewide contract to perform retrospective and concurrent review of Medicaid inpatient claims, including medical necessity, appropriateness of setting, appropriateness of coding, and quality of care.
Ohio Medicaid Prior Authorization and Retrospective Review Services	We have averaged \$44 million in savings for each of the past five years, an ROI of 44:1 .
NYS OMIG Audits	HMS currently performs overpayment audits of hospitals, physician groups, LTC facilities, and pharmacies and has helped the NYS OMIG recover more than \$128 million since 2006.
North Carolina Medicaid Retrospective Reviews	In 2010 alone, HMS recovered \$10.5 million in Medicaid improper payments from hospitals, physician groups, LTC, and dialysis providers.
South Carolina Department of Health and Human Services (SCDHHS)	HMS serves as an extension to the Department's Program Integrity division. We are the primary Utilization Review vendor, the State's RAC, and also perform post-adjudication, pre-pay editing on Medicaid claims. We began retrospective review services in 2009, targeting inpatient hospital claims for medical necessity, billing errors and readmissions, but have expanded scope to include DRG upcoding, Credit Balance Audits (COB errors), MCO Premium and Medicare Buy-in projects, and Community LTC audits. HMS has identified and recovered more than \$6.1 million for SCDHHS.
Utah Division of Medicaid and Health Financing	Using two years of the State's data and running limited scenarios, our data analysis has identified more than \$30 million in potential provider overpayments for excessive units, duplicate crossover claims, credit balances, readmissions, operating room procedures unrelated to principal diagnosis, and COB.
Virginia Medicaid Retrospective Review	We have identified approximately \$7.4 million in overpayments from provider coding and billing errors.
Virginia Medicaid Behavioral Health Review	To date, we have identified more than \$10.9 million in overpayments due to undocumented services and unlicensed/unauthorized providers.
Kentucky Medicaid Dialysis Clinic Overpayment Project	HMS undertook an analysis of Epogen [®] claims by one Kentucky provider group from June 2007 to April 2010. We are in the process of recovering more than \$5 million in overpayments due for refund to the Commonwealth.



2.3.1.6 Medicaid fraud and abuse identification, notification, and support; and.

Experience in Medicaid Fraud and Abuse

HMS understands the coverage, utilization, billing, reimbursement, and abuse issues that are common to government-sponsored Healthcare programs. In our RAC engagement, we conduct thorough, in-depth analyses of overpayments and target likely or outlier providers, claims, and patterns for review, audit, and investigation. Our approach is driven by data and analytics, and we know how to leverage the interrelatedness of the COB and program integrity services that we offer to identify overpayments across the entire paid claims population. The majority of our findings are categorized as "overpayments" and recovered as such. "Fraud and abuse" implies a legal category that requires prosecution and proof of intent beyond a reasonable doubt. Where we identify a "pattern and practice" of abuse, we alert our state clients and allow them to decide whether to prosecute the activity. In these cases, we make specific recommendations based on well-founded proof of the aberrant behavior and provide assistance as requested by the state.

We provide a comprehensive suite of retrospective fraud services, summarized as follows:

Analyze paid claims data to determine overpaid or inappropriately paid services in accordance with applicable state and federal laws and regulations. HMS incorporates all applicable state and federal regulations and state agency policies into our systems and processes.

Support preliminary and extensive investigations on a retrospective basis to support overall Fraud and Abuse programs and objectives and meet state reporting requirements. While

conducting investigations retrospectively, we have uncovered substantial fraudulent activity, one example of which is the case of a Medicaid physician who illegally prescribed medication in order to resell it in South America.

Detect new, emerging, or otherwise unknown fraud schemes within the Medicaid program. One of the newer schemes our investigators have identified is lab panel unbundling. This scheme, one of the most common forms of lab panel fraud, entails a provider unbundling a lab panel and charging for each test individually so the lab or hospital receives a



HMS has the proven ability to deliver fraud and abuse identification services through our program integrity offering.

higher payment. However, because this form of potential fraud can be easily detected, schemers are learning other ways to circumvent standard editing solutions. Instead of unbundling a lab panel and charging for each test individually, schemers are individually charging for all but one test or all but two or three tests. By doing this, the payment amount is still higher than it would be for the lab bundle, but it is much harder for standard editing systems to detect.



HMS has more than two decades of experience in developing analyses for states that look specifically for potential abusive practices. Our analysis and review experience in this area includes:

- ► Upcoding
- ► TPL override abuse
- Excess utilization patterns
- Referring provider abuse
- Orphan lab/transport

Investigations of Medical and Pharmacy Fraud/Waste/Abuse

HMS provides thorough preliminary and extensive investigations on behalf of our state Medicaid clients for use in the prosecution of medical-related fraud/waste/abuse cases. In addition, we provide supporting documentation and research to support in-house Clinical Audit staff. HMS's programs have recouped millions of dollars in critical healthcare funds on behalf of state Medicaid programs, Medicaid MCOs (MMCOs), and CMS. Our efforts lead to the effective discontinuation of fraudulent billing practices and hinder the development of additional unethical billing practices. HMS is nationally recognized for Fraud and Abuse Identification programs that deliver statistical evidence backed by clinical expertise.

Representative Examples of Recent Fraud Identification and Referral

While we are not at liberty to provide all of the details of fraud referrals, we can provide some general examples from several contracts:

- HMS played a key role in the recent conviction of a Maryland cardiologist for defrauding government and private insurers of more than \$700,000. As part of our work with the State of Maryland's Board of Physicians, the physician review of the cardiologist uncovered that he had implanted unnecessary cardiac stents in over 100 patients, ordered needless tests, and falsified medical records. According to a report in *HealthLeaders Media*, the physician was convicted on six counts of fraud.
- HMS Holdings Corp. received an anonymous tip through our fraud hot line from a person who identified herself as an employee of a pharmacy that HMS had recently audited. The fraud that she reported was a potential scheme between the pharmacy and several physicians to bill "add-on" prescriptions. Our source alleged that these prescriptions were billed to the health plan but not dispensed to the patient. Upon receiving the tip and studying historical claims data, HMS reported the investigation to our client. Our systems infrastructure allowed for a rapid compilation of data for substantiated reporting to the federal Drug Enforcement Agency, and the case is currently pending under that agency's jurisdiction.
- HMS's New Jersey Program Integrity team referred a New Jersey Medicaid provider to the New Jersey State OMIG office. This provider had unusually high payments compared with similar practicing physicians:
 - Billed for more than 140 recipients per day
 - Billed for 91% of all Rocephin[®] injections in the New Jersey



Billed for nearly 50% of all hepatitis A & B vaccine adult dosage (90632-90636) in New Jersey

The provider was subsequently arrested and charged with fraudulently obtaining a minimum of \$1.8 million in overpayments from the New Jersey Medicaid program.

- On behalf of an MCO, HMS was asked to review physician records to identify physicians billing a disproportionately greater volume of claims with higher reimbursement codes. Evaluation and Management (E&M) Current Procedural Terminology (CPT) codes were reviewed for services provided from 2006 through 2009 against a randomized physician selection process that ultimately identified a physician upcoding E&M CPT codes in over 88% of submitted claims. This case is currently pending litigation.
- ▶ HMS reviewed a Virginia Behavioral Health provider for Intensive In-Home (IIH) services per our client's request. The provider had unusually high payment compared with peers, for example:
 - Medicaid growth of 369% from 2007 to 2008. Received over \$3 million in payments for IIH services in 2008 compared with \$800,000 in 2007.
 - Billed for 35.69 units per recipient, per month in 2008, which is unusually high compared with peers.
 - 277 units identified as overlapping with case management, which is against policy in Virginia and high compared with peers.

The provider was audited and following a review of the provider files, employee records, and medical records was referred to the Department of Medical Assistance Services for possible fraud. The case was then accepted by the Attorney General's office and is currently under review.

2.3.1.7 Medicaid provider appeals.

Experience with Provider Administrative Hearings and Appeals

HMS brings more than 27 years of experience in appeals for many Medicaid agencies, MCOs, health plans, and other clients, including attending or providing support through the various fair hearing, administrative hearing, presettlement, and preappeals processes. HMS will comply with all provider appeal processes defined by the State as described in the West Virginia Provider Policy Manual, and we will work closely with the State to ensure that we execute our responsibilities per the Bureau's requirements.

HMS Provides Support throughout the Appeals Process

HMS recognizes that West Virginia has a legal requirement to provide due process to providers when they are notified of improper payments. We will work with the State to adhere to required time frames for giving those providers an opportunity to appeal and provide additional documentation. If a provider appeals our decision, HMS will not be paid until the appeal is resolved and the overpayments have been recovered.





HMS will provide support to the Bureau or its authorized representatives throughout all levels of an appeal. We will also provide comprehensive support to the State in response to any other litigation or dispute resolution associated with our Medicaid RAC services. Appeal support will include, as appropriate:

- Preparation and submission of all supporting documentation
- Organization and presentation of references to applicable Medicaid statutes, regulations, manuals, and instructions
- Hearing appearances
- Court appearances

To comprehensively support appeals submitted from providers, HMS will apply our extensive audit appeal experience and resources. We understand that the goal of the appeals process is to efficiently allow an opportunity for reconsideration when a provider disagrees with the results of our improper payment analyses, and we fully support providers' rights in this area. Additionally, our experience in other RAC contracts has shown that providers are beginning to appeal findings in cases in which they disagree with the payment policy or provider handbook instructions.

Additionally, HMS has experience in providing witness testimony services for our clients. Our staff resources will be available to answer questions, explain the review process and rationale for the determination, and otherwise defend the determination that we made. We recognize that providers may appeal decisions that have an adverse financial impact on their business, especially when they believe that they are in compliance with regulations. HMS agrees that a case is not closed until either the time to appeal has expired or the appeal has been finalized. We will provide ongoing support to BMS throughout the reconsideration/appeal and fair hearing processes. The following are examples of our appeal experience.





- In Fiscal Year (FY) 2010, for Ohio Medicaid, we reviewed more than 12,000 records, with only a 16.6% reconsideration rate. About 29% of those reconsiderations were reversed because the provider submitted additional information. In State FY 2010, only 138 (1.2%) of our reviews were appealed to the State, and 80% of those decisions were upheld.
- For our Virginia Department of Medical Assistance Services Medicaid program, we received only 7 appeal requests to our more than 7,000 review decisions over a 2-year period. We also have seen a low rate of State overturn decisions, which demonstrates that we are in line with our clients' goals and review processes.
- As a subcontractor to HDI in support of CMS' RAC pilot project to perform Medicare post-payment reviews, only 10% of our overpayment decisions were rebutted, and the majority of the rebuttal decisions were upheld following further review. These statistics were superior to those attained by the other RAC vendors. Over the two-year span of our contract, we reviewed approximately 1,250 Florida Medicare inpatient medical records monthly for DRG errors, the medical necessity of services, and the need for an inpatient stay.

2.3.2 The Vendor's proposal should provide a summary of their previous work similar to the services requested in this RFP, in size, scope, and complexity. Each project summary should include:

HMS has provided similar services as requested in the RFP in New Mexico, New York, Tennessee, New Jersey, South Carolina, North Carolina, Connecticut, Massachusetts, Virginia, Utah, and Maine. HMS provides program integrity services in 37 states. Please refer to **Response 2.3.2.1, 2.3.2.2, and 2.3.2.3** for a representative sample of the clients to which HMS provides these services.

2.3.2.1 A brief description of the project, including type of project, project goals and objectives, project beginning and end dates, services provided, and project outcomes regarding scope, budget, and schedule.

2.3.2.2 A narrative description to highlight the similarities between the Vendor's experience and the work requested in this RFP. Vendor and sub-vendor experience should be listed separately.

Below, we have provided project summaries for 11 clients, which include a project description and type, project goals and objectives, project beginning and end dates, services provided, and project outcomes regarding scope, budget, and schedule.

HMS has been providing program integrity services for more than 27 years. We provide these services to 37 Medicaid agencies. In **Response 2.3.1.2** above, we list state agencies where we provide audit and recovery services. As described in **Response 2.3.1.3** above, we provide details on similar audit services, including medical bill audits, coding and clinical reviews, credit balance audits and LTC audits, and our Medicare RAC experience. HMS provides RAC services in 16 states. Our RAC services, which are the same services requested in this RFP, include identification, validation, and recovery of improper payments.



The HMS RAC Solution	
Detection of Improper Payments	HMS performs a complete review of BMS's scope of work and program components, including systems, state requirements; program data; regulations; policies; manuals; state codes; administrative rules; provider manuals and bulletins; Medicaid publications; Code of Federal Regulations (CFR 42); OIG Exclusion Database; and plans. In addition, we will meet with the various internal and external stakeholders to ensure that we meet BMS's program goals, provide BMS-specific education on program requirements/processes, and coordinate with other audit efforts.
	Currently, HMS accurately and securely performs intake of BMS's claims data, program eligibility, provider, reference, and other MMIS data. This provides a significant advantage and allows HMS to expedite the implementation process for BMS. HMS has a well-established, secured method of transmission of all BMS data. In addition, HMS already has data receipt protocols and reformatting in place for BMS's data files, including BMS paid claims. If needed, we will customize these mechanisms for this engagement.
	Working with BMS, we have already interpreted BMS's policy, billing rules, and State Plan into our rules engine and this information is readily available for this engagement.
	While we bring to BMS a standard set of data mining algorithms, we do not stop at the standard list. Using our library of improper payment algorithms, HMS will develop and configure data routines specifically for this engagement. HMS's Regulatory and Reimbursement Research and Development department reviews state and plan regulations and policies to ensure the applicability of each algorithm to the program, and to set the appropriate parameters for each algorithm. HMS will seek BMS's approval for the data routines that we will implement for this engagement.
	HMS is structured with the tools and personnel necessary to determine if an overpayment or underpayment occurred. Our experienced staff have years of in- the-field training. Relying on this experience, team members not only review documentation and assess if the improper payment occurred, but also can identify additional target referrals for other improper payments. HMS has available for this scope of work an experienced and prominent West Virginia-licensed physician to support the clinical reviews as well as any appeals.
Automated, Semi- automated, or Complex Review - Validation of Improper Payments	We identify improper payments by conducting automated reviews (no review of documentation) or complex reviews (review of medical record or other documentation). An automated review is used for improper payment claims identified through data analysis routines approved for producing clearly improper payments. For complex reviews, we conduct a thorough review of medical records and other documentation using nationally recognized and West Virginia-specific criteria. A semi-automated review is used when either some additional documentation or information is required from the provider, but the full medical record is not needed or the provider is not required to provide the full record. HMS auditors review the documentation to ensure that the claim was appropriately billed. Our reviews are performed through a combination of desk and onsite audits.
	Our staff, who are trained to identify suspected fraud and abuse, will report any suspected fraud directly to BMS.



The HMS RAC Solution	
Tracking and Reporting of Improper Payments	HMS's state of the art case tracking system, Program Integrity Enterprise (PIE), documents the activities of each identified improper payment and generates detailed reports to our clients. This case tracking system specifically supports the efficient administration of RAC program activities - this eliminates the need to be retrofitted to accommodate the evolving ACA and CMS requirements. BMS will have direct access to PIE.
Recoupment and Recovery of Improper Payments	HMS will work with providers to maximize BMS's collection of improper payments. HMS's effective approach minimizes the administrative burden for providers, and our experienced Provider Relations team is available to communicate with providers throughout the recovery process, address their concerns, and ensure prompt payment. Our collaborative approach to working with the provider community has been a key component of our ability to consistently achieve a high level of recovery for our clients.



ыме	Client	Organization:	Now	Movico	Human	Sorvicos	Dopartmont
ПИЗ	Client	Organization:	New	Mexico	пипап	Services	Department

Project Title/Scope: Third Party Liability, Program Integrity and Revenue Enhancement/ Expense Reduction	Contract Start and End Dates/Schedule: May 2011–April 2015
Project Address/Phone	Contact Reference, Title, Email, and Phone Number
P.O. Box 2348 Santa Fe, NM 87504-2348 505.827.3161	Sandra Chavez, Bureau Chief Quality Assurance Program SandraB.Chavez@state.nm.us 505.827.3161
Contract Value/Budget: \$650,000/year	Project Goals/Objectives: To identify, audit, and maximize recoveries for Medicaid improper payments

Brief Description of Work/ Services Provided/Project Outcomes: HMS supports New Mexico's Quality Assurance Bureau and Program Integrity and TPL units in the expansion of services to identify mispayments, over/underpayments, and other recoverable funds for the State of New Mexico. The scope of this engagement covers the entire New Mexico Medicaid population of more than 1 million members, including the approximately 800,000 (80% of the total population) who are enrolled in an MCO. The scope of payment integrity work includes:

- Provider audits for credit balances
- Automated and complex patient account reviews
- Data mining
- Provider self-disclosure research and reporting
- MCO premium payment analysis and recovery
- Provider outreach and education
- Identification and recovery of third party commercial coverage
- Casualty subrogation case identification and recovery
- Estates recovery
- Come-behind recovery of MCO recovery efforts

Transaction Processing Volumes:

- Received 60 million claims from State
- Billed insurance carriers more than 300,000 claims
- Recovered more than \$3 million from commercial carriers
- Provided State with 3,700 dates of death updates resulting in premium overpayments of \$1.15 million



HMS Client Organization: New	Vork State Office of t	the Medicaid Increator	Gonoral
rivis chefit Organization. New	TUR State Unice Uni	ine medicalu inspecioi	General

Project Title/Scope: New York State Medicaid Matching Recovery Project	Contract Start and End Dates/Schedule: January 7, 2009– January 6, 2015		
Project Address/Phone	Contact Reference, Title, Email, and Phone Number		
800 North Pearl Albany, NY 12204 518.402.0045	Jeff Flora, Director, Bureau of Third Party Liability joseph.flora@omig.ny.gov 518.402.0045		
Contract Value/Budget: \$120,000,000	Project Goals/Objectives: To identify, audit, and maximize recoveries for Medicaid improper payments		

Brief Description of Work/Services Provided/Project Outcomes: HMS has collaborated with the NYS OMIG since 2006. The objective of this ongoing and comprehensive payment integrity (now RAC) engagement is to assist the NYS OMIG in identifying, recovering, and preventing Medicaid overpayments. HMS identifies and recovers Medicaid overpayments through various methods, including onsite and remote reviews of providers' patient accounts, Medicaid policy analysis, data mining, and reverse data analytics. Reviews cover a wide range of provider types, including hospitals, freestanding clinics, LTC facilities, pharmacies, physicians, DME suppliers, and MCOs. Because this is a long-standing program integrity contract, HMS has developed and implemented numerous reviews, and the current service scope includes the following overpayment reviews:

- Hospital overpayment reviews. HMS performs more than 150 onsite reviews and 330 desk reviews of NYS hospitals each year, during which the following analysis is performed:
 - Credit balance overpayment review and recovery
 - Balance bill
 - Office of Alcohol and Substance Abuse Services DRG/per diem review
 - GME/Fee for Service (FFS) overlap
 - Inpatient encounter/inpatient FFS overlap
 - Third party disallowance soft-denial follow-up
 - Medicare Part A benefit period analysis
 - Vaccines for Children overpayments.
- Pharmacy overpayment reviews. We conduct various data analytics to detect potential Medicaid overpayments and review targeted claims with pharmacies to verify findings and recover overpayments, including:
 - COB potential duplicate payment review
 - Incorrect third party patient liability review.
- LTC overpayment reviews. HMS initiated LTC reviews in October 2009 and conducted more than 430 reviews during that time frame. We identified more than \$40 million in overpayments through December 2011, which we are actively recovering. HMS reviews claims on a number of criteria, including, but not limited to, the following:
 - Net Available Monthly Income review
 - COB
 - Dual eligible rate review
 - Bed-hold days
 - Estate referrals
- Physician COB reviews. Review payments made to physicians to ensure that they are consistent with New York Medicaid's Medicare cost-sharing rules. Payments exceeding Medicaid's liability are recovered.
- Emergency Department upcoding. Complex review of claims made to Emergency Department physicians to determine coding accuracy. Recovery occurs following review of medical records that do not substantiate the E&M level billed by the provider.
- Managed care encounter data COB review. Provider-based review of encounter data for recipients eligible for third party coverage that was not pursued prospectively by the provider or retrospectively by the responsible MMCO as contractually obligated.



Managed care capitation overpayment identification review. Review of MMCO's compliance with the NYS managed care contract requiring retroactive disenvolument of managed care recipients when the recipient has both commercial coverage and managed care coverage from the same Health Maintenance Organization.

In 2010, HMS began assisting the NYS OMIG in transforming and expanding its program integrity projects to meet ACA mandates, including enforcing mandatory provider self-disclosure and establishing a Medicaid RAC program. As part of these efforts, HMS is implementing a coordinated approach across all provider and overpayment types to create a comprehensive program integrity process that not only streamlines recoveries but also expands the State's ability to track and monitor overpayments. Key developments related to this approach include:

- eReview. We match NYS commercial carriers paid claims against NYS Medicaid paid claims to identify overpayments and potentially fraudulent providers. HMS actively recruits and acquires data sets that were not previously available to Medicaid programs to expand our data analytics capabilities. Particular focus is given to obtaining data that allows for independent data analytics, which reduces or eliminates reliance on provider data. This gives New York Medicaid pinpoint accuracy in detecting overpayments, which enables it to validate the overpayment amount at the point of identification.
- Self-disclosure portal. Our web-based application allows providers to securely disclose overpayments identified through self-review. We actively engage and assist providers in self-reporting Medicaid overpayments and conduct reverse data analytics to identify root causes and potential intra- and interprovider trends to detect previously unknown Medicaid overpayments.
- Expansion into additional claims types. HMS works with the NYS OMIG to continually expand the scope of review across all provider and claim types, such as freestanding clinics, DME suppliers, and transportation providers.
- Underpayment identification. HMS is incorporating underpayment identification and reporting into its payment integrity reviews under the guidance of the ACA.

Recoveries by Year: Since 2006, HMS has more than doubled our program integrity recoveries every year, recovering more than \$135 million for the State. This figure represents the added value from conducting data mining to identify overpayments that might have gone unidentified without our service.

Client Organization: State of Tennessee Department of Finance and Administration			
Project Title/Scope: Recovery Audit Contractor and Third Party Liability services	Contract Start and End Dates/Schedule: February 1, 2011–January 31, 2014		
Project Address/Phone	Contact Reference, Title, Email, and Phone Number		
310 Great Circle Road Nashville, TN 37243 615.507.6696	Dennis J. Garvey, Director, Program Integrity Dennis.J.Garvey@tn.gov 615.507.6696		
Contract Value/Budget: \$6.7 million/year	Project Goals/Objectives: To identify, audit, and maximize recoveries for Medicaid improper payments		

Brief Description of Work/Services Provided/Project Outcomes: HMS is the sole RAC vendor for the Bureau of TennCare. Under the RAC scope of work, HMS identifies and recovers over/underpayments for both FFS and encounter claims. There are currently no limitations on the scope of work, besides first allowing MCOs to pursue overpayment recoveries.

To date, HMS has presented 15 scenarios ranging from such claim types as dialysis, LTC, inpatient, transportation, pharmacy, maternity and emergency.

Working closely with the State, HMS has helped develop a RAC model that carefully coordinates the recovery activities of MCOs and HMS to minimize provider abrasion yet still optimize the recovery opportunities for TennCare. Also as a result of HMS's RAC work in Tennessee, multiple opportunities to improve data quality have been identified. HMS is currently leading the effort to improve the quality and completeness of the date captured and delivered by TennCare's MCOs, PBM, and Dental Benefit Manager.

Recoveries: \$15 million potential overpayments identified to date.



HMS Client Organization: State of New Jersey Department of Human Services Division of Medical
Assistance and Health Services (DMAHS)

Project Title/Scope: Comprehensive Recovery and Cost Containment Contract	Contract Start and End Dates/Schedule: January 1, 2008– December 31, 2012
Project Address/Phone	Contact Reference, Title, Email, and Phone Number
5 Quakerbridge Plaza, P.O. Box 720 Trenton, NJ 08625-072 609.588.2550	Dick Hurd, Chief of Staff Richard.H.Hurd@dhs.state.nj.us 609.588.2550
Contract Value/Budget: \$12,000,000/year	Project Goals/Objectives: To identify, audit, and maximize recoveries for Medicaid improper payments

Brief Description of Work/Services Provided/Project Outcomes: HMS has provided recovery services on behalf of the New Jersey DMAHS continuously since 1986. Throughout the past 24 years, we have acquired a level of understanding regarding the operations and financial requirements that sustain New Jersey's government healthcare programs.

The State of New Jersey has designated HMS as its Medicaid RAC; the contract includes:

- Contingency fee credit balance recovery
- Comprehensive provider, beneficiary, and claim (FFS, encounter, and charity care) reviews to identify and remediate fraud/waste/abuse
- Complex, automated, and onsite reviews
- Random sampling and targeted claim selections
- Focused cost center reviews, including hospital, pharmacy, and LTC
- Advanced data storage, mining, and analytics technology, including predictive analytics and provider and consumer behavioral modeling
- Medicaid industry subject matter expertise
- Provider disallowances for Blue Cross, commercial insurance, CHAMPUS/TRICARE, and Medicare
- State-wide Medicaid hospital utilization, medical necessity, and DRG coding reviews
- State-wide Medicaid pharmacy reviews.
- Enhancement to New Jersey eligibility validation processes to identify deceased and nonresident beneficiaries
- Enhancement to New Jersey enrollment outreach efforts to uninsured children and families

The longevity of our service relationship to the State is a direct result of our success, demonstrated in part by **our** total recoveries and cost savings of more than \$306 million during Calendar Year 2011 alone. Our achievement derives from services that integrate a comprehensive understanding of DMAHS's revenue recovery goals with innovative solutions and industry best practices.



Client Organization: South Carolina Department of Health and Human Services				
Project Title/Scope: Consulting and Audit Services for Medicaid Overpayment	Contract Start and End Dates/Schedule: April 1, 2009– March 31, 2012			
Project Address/Phone	Contact Reference, Title, Email, and Phone Number			
P.O. Box 8206, 1801 Main Street, Columbia, SC 29202-8206 803.898.1050	Kathleen C. Snider, Bureau Chief sniderk@scdhhs.gov 803.898.1050			
Contract Value/Budget: \$728,000/year	Project Goals/Objectives: To identify, audit, and maximize recoveries for Medicaid improper payments			

Brief Description of Work/Services Provided/Project Outcomes: HMS supports the State Program Integrity unit in the expansion of South Carolina Medicaid claims review and recovery and was named the State's Medicaid RAC in 2011. As part of this scope, we use data mining, proprietary algorithms, and targeted coding analysis to identify potential areas of recovery:

- Inpatient hospital admission claims. We target payment errors resulting from inaccurate coding assignments, billing errors, readmissions, and/or lack of medical necessity. Our analysts selected claims with the greatest statistical probability of having an overpayment based upon our years of experience in this area. To date, \$2.8 million in overpayments have been recovered from provider coding, billing, and medical necessity errors, with an additional \$800,000 in the recovery process.
- ▶ Medicare crossover claims. Through paid claims analysis, we targeted and recovered \$300,000.
- Coinsurance balance bill targets. Through paid claims analysis, we targeted and recovered \$3 million. This, in conjunction with Medicare crossover claims, has become an ongoing project, where new claims data is analyzed and rolling audits are performed.
- Policy reviews. Our analysts selected paid outpatient claims that conflicted with South Carolina Medicaid payment policies: \$300,000 was identified and is in the recovery process.

We continue to work with South Carolina to analyze other claim types for payment errors under our Medicaid recovery audit. In addition, we work closely with the South Carolina Hospital Association to educate providers on processes before audits begin. We also present annual provider updates at Association meetings that include such topics as results of reviews, announcement of new reviews, CMS updates, and other relevant topics of interest to the Association.

Technical Environment: Proprietary software includes Program Integrity Enterprise (PIE) and our Provider Portal, proprietary/customized algorithms and edits, and secure Internet connections via 3DES or 256 AES Virtual Private Network (VPN) tunneling technology for transfers of data. For physical media transfers (magnetic tapes), HMS uses IBM's data encryption hardware and software technologies. HMS's internal data communications, network, and hardware also supports:

- Secure Web Mailbox for Hypertext Transfer Protocol Secure file exchanges via web browser
- FTPS via Secure Socket Layer
- FTP via Secure Shell and Network Data Mover

Transaction Processing Volumes:

- Desktop audits: 16,290 life of contract
- Complex overpayments: \$3,867,522 identified/\$3,260,000 recovered
- Complex underpayments: \$49,528
- Semi-automated: \$5,171,371 identified/\$5,153,766 recovered



HMS Client Organization: North Carolina Department of Health and Human Services Division of Medical Assistance (DMA)

Project Title: Comprehensive Overpayment Review and Recovery	Contract Start and End Dates: January 1, 2010–December 31, 2012		
Project Address/Phone	Contact Reference, Title, Email, and Phone Number		
2508 Mail Service Center, Raleigh, NC 27699-2508 919.647.8136	Ms. Pat Allen, Administrative and Financial Services pat.allen@dhhs.nc.gov 919.647.8136 Dionne Toney, Third Party Recovery – Chief		
	dionne.toney@dhhs.nc.gov 919.647.8105		
Contract Value/Budget: \$9 million/year	Project Goals/Objectives: To identify, audit, and maximize recoveries for Medicaid improper payments		

Brief Description of Work/Services Provided/Project Outcomes: HMS has been working with the North Carolina DMA for more than 14 years. In 2010 alone, HMS recovered \$10.5 million in North Carolina Medicaid improper payments from hospitals, physician groups, LTC, and dialysis providers.

Dialysis centers: Based on our significant findings in other states, HMS initiated an audit of dialysis providers in North Carolina. We identified \$800,000 in improper payments and worked with the appropriate provider Billing staff to recover the funds.

Hospital audits: HMS has discovered that a large portion of overpayments are the result of commercial insurance balance billing, which means that providers are often reimbursed in excess of patient liability. Since 2010, HMS has identified and recovered approximately \$11.7 million in overpayments.

LTC audits: HMS has recovered approximately \$8 million in a 24-month review cycle and identified another \$6 million pending policy review. Overpayment discrepancy findings are typically related to patient's monthly liability being incorrectly applied, coinsurance calculation errors, and COB issues.



HMS Client Ord	nanization.	Connecticut [)enartment	of Social	Services		
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Project Title/Scope: Acute Care Hospital and Skilled Nursing Facility Credit Balance/ Overpayment Audits, Applied Income Project, and Maintenance of Online Credit Balance Reporting System for LTC Facilities	Contract Start and End Dates/Schedule: October 2008– September 2012
Project Address/Phone	Contact Reference, Title, Email, and Phone Number
25 Sigourney Street Hartford, CT 06106 860.424.5977	John McCormick, Director John.mccormick@ct.gov 860.424.5920
Contract Value/Budget: \$16.5 million/year in recoveries	Project Goals/Objectives: To identify, audit, and maximize recoveries for Medicaid improper payments

Brief Description of Work/ Services Provided/Project Outcomes: HMS has performed nursing home and hospital improper payment reviews for the Connecticut DSS since 1999. During this time, more than \$177 million in nursing home improper payments and more than \$3 million in hospital improper payments have been identified and recovered. HMS identifies and recovers any overpayments due DSS by hospitals in Connecticut. All overpayments identified are researched and presented to the appropriate provider representative for review and approval before recoupment. HMS reviews many types of documentation from the hospital providers, including, but not limited to, credit balance reports, financial system reporting, MMIS remittances, and original claim submissions. Finalized hospital improper payments are recouped from the providers through an offset to a future Medicaid remittance advice.

Nursing home improper payments are identified through a comparative analysis of the facility's Aged Trial Balance, census, and Accounts Receivable ledgers to the State's MMIS claims and eligibility data. Types of improper payments identified include payments made after the date of death and discharge, payments made during Medicare- and/or other insurance-covered periods, disallowed bed reserve payments, disallowed coinsurance payments, Applied Income (AI) increases not reported and/or updated by the State, AI deduction/diversion improper payments, AI not applied properly to claims, and private improper payments prior to the Medicaid eligibility start date. For all AI improper payments identified as a result of the reviews, HMS performs updates directly to the State's Eligibility Management System to minimize project burden on the regional office caseworkers. Providers also use a web-based application for self-reporting of overpayments. This user-friendly system allows providers to securely log in and report the information needed for HMS/DSS to recoup overpayments as reported by the provider. Providers have begun to use this system in preference to onsite reviews because they find it less time consuming and easier to report overpayments as they discover them.

In addition, HMS has performed several overpayment identification and recovery projects for DSS that include the matching of Medicaid and Medicare paid claims to identify duplicate and overlapping payments, improper deductibles and coinsurance payments, and rules/benefit-based payment errors made by DSS. These audit projects have generated more than \$11.7 million in recoveries to DSS.

HMS is the current Medicaid RAC contractor for the DSS, with the RAC scope of work commencing in December 2011. HMS is in the process of implementing four different automated and complex audit projects in conjunction with the State and expects to see recoveries on these projects in the next few months.



HMS Client Organization: Massachusetts Executive Office of Health and Human Services (University of Massachusetts Medical School)

Project Title/Scope: Acute Hospital Utilization Management Program	Contract Start and End Dates/Schedule: October 2009– January 2013
Project Address/Phone	Contact Reference, Title, Email, and Phone Number
100 Hancock Street, 6th Floor North Quincy, MA 02171 617.847.3717	Margaret S. Ryder RN CPC, Manager Acute & Chronic Hospital Utilization Management Program margi.ryder@state.ma.us 617.847.3717
Contract Value/Budget: \$5.7 million/year	Project Goals/Objectives: To identify, audit, and maximize recoveries for Medicaid improper payments

Brief Description of Work/Services Provided/Project Outcomes: Following award of the MassHealth acute hospital Utilization Management contract, HMS's wholly owned subsidiary, Permedion, launched and implemented the contract within 60 days. The previous vendor held this contract for 20 years, necessitating a full-scale transitional plan. Rapid implementation involved setting up a fully operational preadmission screening center integral to the Utilization Management program, including direct integration into the Massachusetts MMIS. In addition to preadmission screening, the project involves medical informatics, including data analysis and sample selection to drive pre- and post-payment retrospective review of 55,000 claims annually for services provided to MassHealth clients.

Implementation of the contract required an aggressive hiring plan, which added 32 staff members. Our team assessed and provided orientation, training, facility changes, and technical requirements to all new employees. Education focused on MassHealth acute care regulations, concurrent review of acute rehabilitation services, medical necessity guidelines, and quality studies—including an approach that anticipates future National Committee for Quality Assurance certification needs.

Permedion-HMS's preadmission screening services began operations in November 2009. SMEs trained the team on the utilization of clinical criteria, review systems, customer service, and other procedures and compliance standards. We work with the State's MMIS to screen all elective inpatient admissions, including medical, surgical, and acute hospital rehabilitation admissions (approximately 7,000 cases per year). Our nurses use clinical criteria for review, including InterQual adult and pediatric criteria, MassHealth Regulations on Medical Necessity, acute rehab hospital screening criteria (Medicare), and the current International Statistical Classifications of Diseases (ICD) coding rules. Requests are received via fax, telephone, web, and mail.

In addition, Permedion-HMS performs pre-payment inpatient review (20,000 cases/year), post-payment inpatient review (15,000 cases/year), and outpatient review (20,000 cases/year). For pre-payment reviews, a retrospective chart review is performed after the care has been provided but before the hospital is paid. For post-payment reviews, a retrospective chart review is performed after the hospital has been paid. Permedion-HMS performs data analysis to target and select the cases to be reviewed. Our physicians and nurses also review Serious Reportable Events, providing a full report on clinical findings. Our Utilization Management projects combined save the MassHealth program more than \$55 million each year.

Our contract includes conducting one Quality study per year. In the first two years, the topic selected by the study group was admissions/readmissions to Massachusetts acute care hospitals (adults and pediatric). We analyzed admissions and readmissions within 7-, 15-, 20-, and 30-day time periods in the MassHealth population. The 2012 Quality study will focus on Emergency Department admissions.



HMS Client Organize	ation: Virginia Departm	ont of Modical Assista	nco Sorvicos (DMAS)
		CIIL UI MEUICAI ASSISIA	

Project Title/Scope: Coding Review and Audit Services and Behavioral Health Review	Contract Start and End Dates/Schedule
Cervices and Denavioral Ficalar Review	November 2007–October 2012 July 2009–June 2012
Dreiset Address/Phone	
Project Address/Phone	Contact Reference, Title, Email, and Phone Number
600 E. Broad Street, #1300	Kathy Colley, Manager, TPL Unit
Richmond, VA 23219	Kathy.Colley@dmas.virginia.gov
804.786.3839	804.786.3839
Contract Value/Budget: \$2.05 million/year	Project Goals/Objectives: To identify, audit, and maximize recoveries for Medicaid improper payments

Brief Description of Work/Services Provided/Project Outcomes: HMS, in conjunction with a subcontractor, performs inpatient audit services. Through our annual audits, we identify and recover overpayments made by the Virginia DMAS to acute care hospitals as the result of inaccurate or inappropriate coding assignments.

Our staff of highly qualified Certified Coding Specialists (CCSs) have access to all current and past Coding Clinics and resources necessary to make accurate coding decisions. The team focuses on educational outreach efforts with the providers to rectify any incorrect billing practices that we have observed.

Contract Start/End Dates: 11/2007–10/2012, with the possibility of one 1-year extension

In a separate contract with DMAS, also in conjunction with a subcontractor, we perform audits of in-state and out-ofstate provider services, including outpatient psychotherapy and substance abuse, therapeutic day treatment, mental health support services, and IIH therapy. We provide DMAS with information necessary to validate or substantiate erroneous claims or issues, notify providers of audit findings, and support recovery of any overpayments. As part of the process, we work with DMAS to educate providers on billing and compliance issues identified so providers and the program can reduce billing errors and avoid future overpayments.

Contract Start/End Dates: 7/2009-6/2012, with the possibility of three 1-year extensions

Results: To date, we have recovered approximately \$10.8 million in overpayments from provider coding and billing errors and \$7.5 million for our behavioral health contract.

HMS Client Organization: Utah Department of Health		
Project Title/Scope: Medicaid Overpayment Recovery Audit ServicesContract Start and End Dates/Schedule: December 20 June 2013		
Project Address/Phone	Contact Reference, Title, Email, and Phone Number	
288 North 1460 West P.O. Box 143103 Salt Lake City, UT 84116 801.538.6856	Lee Wyckoff, Inspector General leewyckoff@utah.gov 801.538.6856	
Contract Value/Budget: \$1.5 million/year	Project Goals/Objectives: To identify, audit, and maximize recoveries for Medicaid improper payments	

Brief Description of Work/Services Provided/Project Outcomes: HMS has provided recovery audit services to Utah since 2011. Our program generates recoveries from identifying overpayments, mispayment errors stemming from provider billing, MMIS adjudication, and policy misinterpretation errors. These recovery audit services have identified more than \$20 million in potential overpayments and generated more than \$2 million in actual recoveries.



HMS Client Organization: Maine Department of Health and Human Services (MaineCare)		
Project Title/Scope: MaineCare Hospital and LTC Credit Balance Audits (RAC-like services) and MaineCare RAC	Contract Start and End Dates/Schedule: July 1, 2011–June 30, 2012, with the option of three 1-year extensions	
Project Address/Phone	Contact Reference, Title, Email, and Phone Number	
242 State Street, 11 State House Station Augusta, ME 04333 207.287.6126	Deen Dunn, Benefits Recovery Manager, Third Party Liability (Hospital and Long Term Care Audits) deen.dunn@maine.gov 207.287.6126	
	Herb Downs, Director, Division of Audit (RAC Contract) herb.f.fdowns@maine.gov 207.287.2403	
Contract Value/Budget: \$1.9 million/year	Project Goals/Objectives: To identify, audit, and maximize recoveries for Medicaid improper payments	

Brief Description of Work/Services Provided/Project Outcomes: In May 2009, the Maine Department of Health and Human Services (DHHS) asked HMS to perform a nursing home improper payment review project. The primary focus is cost of care (patient pay) improper payments. Through this project, HMS identified more than \$35 million in cost of care improper payments (over/underpayments) in the past two years, and we have performed more than 400 audits of Maine nursing homes and private nursing medical institutions.

HMS has performed hospital improper payment audits for DHHS since 2001. During that time, HMS has identified and recovered more than \$30 million in improper Medicaid payments. HMS annually performs audits of more than 130 hospitals in Maine, New Hampshire, and Massachusetts on behalf of the MaineCare program.

All improper payments identified are researched and presented to the appropriate provider representative for review and approval before recoupment. HMS reviews many types of documentation from the providers, including but not limited to, credit balance reports, financial system reporting, MMIS remittances, and original claim submissions. Finalized improper payments are recouped from the providers through an offset to a future Medicaid remittance advice.

In addition, to providing a robust Provider Audit program to hospital and LTC providers over the past 10 years, HMS was recently selected through a competitive procurement to serve as the State's RAC; we are currently implementing this program for Maine under a separate contract with the State.

2.3.3 The Vendor's proposal should include at least three (3) business references that demonstrate the Vendor's prior experience providing RAC services. Each reference should include:

HMS's Corporate Experience References

HMS is proud of our client retention rate and our client-centered approach. Our references include clients

that have purchased and implemented similar improper payment identification and recovery services for which we serve as the prime contractor: we currently process 150 million transactions across 170 payers. We encourage BMS to contact the entities below and inquire about our commitment and dedication to our clients as well as our record of accomplishment of timely implementation of improper payment recovery projects. HMS serves as the prime contractor for each of the references provided.



HMS has never been terminated from a contract for nonperformance—a testament to the fact that all of our clients receive a high level of focus and attention.



Each of these organizations can attest to our ability to implement our services effectively and our:

- Overall performance
- Experience in overpayment recovery audits
- ► Timeliness of conducting reviews/audits
- System capabilities (e.g., system availability and access to real-time information)
- Punctuality in submitting reports

- Quality
- Staff competence
- ► Flexibility
- Cooperation and communication with agencies
- Provider relations and outreach
- Reputation and sensitivity

2.3.3.1 The name, address, and telephone number of the organization;

2.3.3.2 The name, telephone number, and email address of the responsible project administrator or project manager familiar with the Vendor's performance; and

2.3.3.3 A brief description of the project, including type of project, project goals and objectives, project beginning and end dates, services provided, and project outcomes regarding scope, budget, and schedule.

We have provided summaries for three business references (New Mexico, New York, and Tennessee), which include a project description and type, project goals and objectives, project beginning and end dates, services provided, and project outcomes regarding scope, budget, and schedule.



HMS Client Organization: New Mexico Human Services Department		
Project Title/Scope: Third Party Liability, Program Integrity and Revenue Enhancement/ Expense ReductionContract Start and End Dates/Schedule: May 201		
oject Address/Phone Contact Reference, Title, Email, and Phone Number		
P.O. Box 2348 Santa Fe, NM 87504-2348 505.827.3161	Sandra Chavez, Bureau Chief Quality Assurance Program SandraB.Chavez@state.nm.us 505.827.3161	
Contract Value/Budget: \$650,000/year	Project Goals/Objectives: To identify, audit, and maximize recoveries for Medicaid improper payments	

Brief Description of Work/ Services Provided/Project Outcomes: HMS supports New Mexico's Quality Assurance Bureau and Program Integrity and TPL units in the expansion of services to identify mispayments, over/underpayments, and other recoverable funds for the State of New Mexico. The scope of this engagement covers the entire New Mexico Medicaid population of more than 1 million members, including the approximately 800,000 (80% of the total population) who are enrolled in an MCO. The scope of payment integrity work includes:

- Provider audits for credit balances
- Automated and complex patient account reviews
- Data mining
- Provider self-disclosure research and reporting
- MCO premium payment analysis and recovery
- Provider outreach and education
- Identification and recovery of third party commercial coverage
- Casualty subrogation case identification and recovery
- Estates recovery
- Come-behind recovery of MCO recovery efforts

Transaction Processing Volumes:

- Received 60 million claims from State
- ▶ Billed insurance carriers more than 300,000 claims
- Recovered more than \$3 million from commercial carriers
- Provided State with 3,700 dates of death updates resulting in premium overpayments of \$1.15 million



HMS Client Organizatio	on: Now Yor	k State Office	of the Medicaid	Inspector General
HIMS Client Organization	on: new for	k State Office	of the medicald	Inspector General

Project Title/Scope: New York State Medicaid Matching Recovery Project	Contract Start and End Dates/Schedule: January 7, 2009– January 6, 2015
Project Address/Phone	Contact Reference, Title, Email, and Phone Number
800 North Pearl Albany, NY 12204 518.402.0045	Jeff Flora, Director, Bureau of Third Party Liability joseph.flora@omig.ny.gov 518.402.0045
Contract Value/Budget: \$120,000,000	Project Goals/Objectives: To identify, audit, and maximize recoveries for Medicaid improper payments

Brief Description of Work/Services Provided/Project Outcomes: HMS has collaborated with the NYS OMIG since 2006. The objective of this ongoing and comprehensive payment integrity (now RAC) engagement is to assist the NYS OMIG in identifying, recovering, and preventing Medicaid overpayments. HMS identifies and recovers Medicaid overpayments through various methods, including onsite and remote reviews of providers' patient accounts, Medicaid policy analysis, data mining, and reverse data analytics. Reviews cover a wide range of provider types, including hospitals, freestanding clinics, LTC facilities, pharmacies, physicians, DME suppliers, and MCOs. Because this is a long-standing program integrity contract, HMS has developed and implemented numerous reviews, and the current service scope includes the following overpayment reviews:

- Hospital overpayment reviews. HMS performs more than 150 onsite reviews and 330 desk reviews of NYS hospitals each year, during which the following analysis is performed:
 - Credit balance overpayment review and recovery
 - Balance bill
 - Office of Alcohol and Substance Abuse Services DRG/per diem review
 - GME/FFS overlap
 - Inpatient encounter/inpatient FFS overlap
 - Third party disallowance soft-denial follow-up
 - Medicare Part A benefit period analysis
 - Vaccines for Children overpayments.
- Pharmacy overpayment reviews. We conduct various data analytics to detect potential Medicaid overpayments and review targeted claims with pharmacies to verify findings and recover overpayments, including:
 - COB potential duplicate payment review
 - Incorrect third party patient liability review.
- LTC overpayment reviews. HMS initiated LTC reviews in October 2009 and conducted more than 430 reviews during that time frame. We identified more than \$40 million in overpayments through December 2011, which we are actively recovering. HMS reviews claims on a number of criteria, including, but not limited to, the following:
 - Net Available Monthly Income review
 - COB
 - Dual eligible rate review
 - Bed-hold days
 - Estate referrals



- Physician COB reviews. Review payments made to physicians to ensure that they are consistent with New York Medicaid's Medicare cost-sharing rules. Payments exceeding Medicaid's liability are recovered.
- Emergency Department upcoding. Complex review of claims made to Emergency Department physicians to determine coding accuracy. Recovery occurs following review of medical records that do not substantiate the E&M level billed by the provider.
- Managed care encounter data COB review. Provider-based review of encounter data for recipients eligible for third party coverage that was not pursued prospectively by the provider or retrospectively by the responsible MMCO as contractually obligated.
- Managed care capitation overpayment identification review. Review of MMCO's compliance with the NYS managed care contract requiring retroactive disenrollment of managed care recipients when the recipient has both commercial coverage and managed care coverage from the same HMO.

In 2010, HMS began assisting the NYS OMIG in transforming and expanding its program integrity projects to meet ACA mandates, including enforcing mandatory provider self-disclosure and establishing a Medicaid RAC program. As part of these efforts, HMS is implementing a coordinated approach across all provider and overpayment types to create a comprehensive program integrity process that not only streamlines recoveries but also expands the State's ability to track and monitor overpayments. Key developments related to this approach include:

- eReview. We match NYS commercial carriers paid claims against NYS Medicaid paid claims to identify overpayments and potentially fraudulent providers. HMS actively recruits and acquires data sets that were not previously available to Medicaid programs to expand our data analytics capabilities. Particular focus is given to obtaining data that allows for independent data analytics, which reduces or eliminates reliance on provider data. This gives New York Medicaid pinpoint accuracy in detecting overpayments, which enables it to validate the overpayment amount at the point of identification.
- Self-disclosure portal. Our web-based application allows providers to securely disclose overpayments identified through self-review. We actively engage and assist providers in self-reporting Medicaid overpayments and conduct reverse data analytics to identify root causes and potential intra- and interprovider trends to detect previously unknown Medicaid overpayments.
- Expansion into additional claims types. HMS works with the NYS OMIG to continually expand the scope of review across all provider and claim types, such as freestanding clinics, DME suppliers, and transportation providers.
- Underpayment identification. HMS is incorporating underpayment identification and reporting into its payment integrity reviews under the guidance of the ACA.

Recoveries by Year: Since 2006, HMS has more than doubled our program integrity recoveries every year, recovering more than \$135 million for the State. This figure represents the added value from conducting data mining to identify overpayments that might have gone unidentified without our service.



Client Organization: S	tate of Tennessee	Department of Finance	and Administration
Olicilit Organization. O			

Project Title/Scope: Recovery Audit Contractor and Third Party Liability services	Contract Start and End Dates/Schedule: February 1, 2011–January 31, 2014
Project Address/Phone	Contact Reference, Title, Email, and Phone Number
310 Great Circle Road Nashville, TN 37243 615.507.6696	Dennis J. Garvey, Director, Program Integrity Dennis.J.Garvey@tn.gov 615.507.6696
Contract Value/Budget: \$6.7 million/year	Project Goals/Objectives: To identify, audit, and maximize recoveries for Medicaid improper payments

Brief Description of Work/Services Provided/Project Outcomes: HMS is the sole RAC vendor for the Bureau of TennCare. Under the RAC scope of work, HMS identifies and recovers over/underpayments for both FFS and encounter claims. There are currently no limitations on the scope of work, besides first allowing MCOs to pursue overpayment recoveries.

To date, HMS has presented 15 scenarios ranging from such claim types as dialysis, LTC, inpatient, transportation, pharmacy, maternity and emergency.

Working closely with the State, HMS has helped develop a RAC model that carefully coordinates the recovery activities of MCOs and HMS to minimize provider abrasion yet still optimize the recovery opportunities for TennCare. Also as a result of HMS's RAC work in Tennessee, multiple opportunities to improve data quality have been identified. HMS is currently leading the effort to improve the quality and completeness of the date captured and delivered by TennCare's MCOs, PBM, and DBM.

Recoveries: \$15 million potential overpayments identified to date.



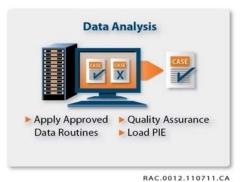
Projects and Goals

2.4.1 The Vendor should describe their approach to identify and audit high risk claims with the potential for Medicaid under/overpayment collections. The description of the approach should address the following:

HMS has developed data analysis processes that target improper payment scenarios across the full scope of Medicaid service types. HMS will configure these to West Virginia program policies. In addition,

HMS is continually researching and developing new algorithms to address each client's specific program issues. This combination offers BMS the best opportunity to maximize the identification and resolution of improper Medicaid payment issues that exist in West Virginia.

Exhibit A-8 summarizes by service area the types of improper payment scenarios that HMS has developed for other states and will review for BMS, where applicable.



Category	Description		
Inpatient	 Appropriate admission Inpatient coding (i.e., DRG) Bill audit Out-of-state reimbursement error Readmissions and transfers Never events/Hospital-Acquired Conditions (HACs) 	 Duplicate/overlapping payments (multiple types) Mother/Baby duplicates Inpatient/outpatient unbundling Balance billing overpayments Financial review/credit balance Medicare deductible/ coinsurance errors 	
Outpatient	 Duplicate/overlapping payments Unbundling Downcoding Radiology billing errors Anesthesia billing errors National Correct Coding Initiative (NCCI) coding errors 	 Bill audit ESRD issues High Cost Drug (HCD) errors Financial review/credit balance Medicare coinsurance errors 	
LTC	 Excess/duplicate days Patient-pay underreporting Bed hold days Date of death Crossover billing errors 	 LTC/hospice duplicate days Overlapping services included in per diem rate Financial review/credit balance Cost report auditing 	
Pharmacy	 Unit billing errors Duplicate payment/early refill Return to stock overpayments Other Third Party (OTB) COB issues 	 Duplicate pharmacy/physician therapy 340b overpayments Fraud patterns 	



Category	Description	
Home Health	Duplicate/excess billingExcess supply utilization	 Medicare-Medicaid (Medi-Medi) duplicate payment and COB
Professional	 Duplicate procedure billing Medi-Medi duplicate Billing for services not delivered Upcoding of E&M services Crossover duplicates Unbundling Global codes Professional/technical component errors 	 Modifier errors resulting in overpayment NCCI Unit billing errors Multiple/bilateral procedures/ co-surgeon cost reduction assistant surgeon Medical necessity Place-of-service errors
Radiology/Laboratory	 Unbundling Duplicate Professional/technical component errors NCCI Upcoding 	 Medically unlikely and excess billing Upcoding Medical necessity Orphan lab Medi-Medi duplicates
Dental	 Upcoding Duplicate billing NCCI Split billing 	 Medically unlikely Drug service ratio Age inappropriate
DME	 Duplicate billing Medi-Medi duplicate billing Utilization in excess of program limits "Miscellaneous code" review 	 Unbundling Upcoding Rental cap issues Services billed and not delivered
Ambulance	Duplicate billingMedi-Medi duplicates	Orphan transportationUnbundling
Behavioral Health	 Excess utilization Unit billing errors Nonqualified staff Billing for services not delivered Medical necessity issues 	 Prior authorization discrepancies Services do not match treatment plan Documentation issues
Home and Community-Based Waiver Services	 Excess utilization Unit billing errors Nonqualified staff Billing for services not delivered Medical necessity issues 	 Prior authorization discrepancies Services do not match treatment plan Documentation issues

HMS will review each issue with BMS prior to any implementation or development by HMS—we will pursue only approved issues. All HMS RAC processes will be completely configured and executed in accordance with BMS's guidance and instructions. If BMS prefers that HMS not pursue certain types of incorrect payments due to provider sensitivities or for any other reason, we can easily remove those targets from our process.



More than five million "coding combinations" are built into HMS's claim coding analysis system.





























































2.4.1.7 Developing an Improper Payment Prevention Plan, for any RAC identified vulnerability, to help prevent similar overpayments from occurring in the future.

The Vendor should submit examples of audit templates, protocols, and time frames for their process for identifying and auditing high risk claims.

Continuous Process Improvement and Recommendations

HMS is communicating regularly with BMS on quality and performance—working in

partnership to gather feedback as well as to provide creative and cost-effective ideas to improve quality and service. We work collaboratively with our clients and other stakeholders toward common goals by sharing knowledge and learned skills and by building consensus to improve performance, address challenges, and offer excellent service. We believe in open communication as a way to develop best practices to support programs and help protect the integrity of government healthcare systems.

In the course of our monthly meetings, via reports, conference calls, and any other requested method, HMS will work with BMS to identify vulnerabilities in the program and implement preventive and educational measures for controlling HMS is committed to sharing knowledge, learned skills, and building consensus to improve performance, address challenges, and offer BMS excellent service.

vulnerabilities in the West Virginia Medicaid program. We understand that an important component of our value is that in addition to recovering improper payments, we help BMS avoid future overpayments through the identification of potential MMIS issues, process enhancements, and provider education initiatives. HMS has assisted Medicaid agencies in avoiding millions of dollars in future costs through suggested/assisted process improvements.

Some examples of cases in which we have recommended system changes to our clients to prevent future improper payments are provided below:

- For one state client, we uncovered through data analysis that providers were billing and receiving reimbursement for Epogen claims that did not meet state regulations for coverage. We found more than 1,000 claims for \$300,000 over a two-year period that had been potentially overpaid. The State's Administrative Code stated that erythropoietins are covered for the treatment of anemia for patients with End-Stage Renal Disease (ESRD) when the hematocrit is less than 30 percent. We made recommendations to the State to recover the overpayments, update MMIS to capture and edit from a particular value code field, and provide provider education.
- ► In one eastern state, we flagged cases in which providers were receiving incorrect reimbursement amounts that resulted in significant potential overpayments. We noted on many claims that although providers were billing for "normal newborn," they were being reimbursed for the highest-weighted premature newborn code. HMS identified 28 claims in which the providers billed a total of \$286,980 but were reimbursed \$2,637,814. Upon further review, we discovered that the providers were incorrectly reporting the birth weight. If a provider enters the newborn weight incorrectly, the system reads the weight as a premature infant and regroups to the higher



Diagnosis-Related Group (DRG) code even if the provider has billed all other codes correctly. We advised our client to recover the overpayment and provide provider education on how to record the birth weight in the correct format while continuing to monitor these claim types for provider compliance.

HMS worked with one state to apply state regulations pertaining to qualified staffing, appropriate utilization of services per day, and medical necessity. We incorporated these concepts into our Audit program for the State, which identified more than \$12 million in overpayments related to these issues.

Based on the results of these overpayments, the State examined errors and the regulations related to those errors and worked to get stronger regulations in place. One example of this new policy is that staff qualification regulations were enhanced through the State legislature to more clearly describe the education and experience required to qualify as a mental health professional permitted to provide services for the programs that we audit.

- ► HMS identified overpayments for one northern state related to an error with the units/charge edits in the MMIS. HMS recovered more than \$3 million in overpayments related to the issue, and we provided the state/MMIS vendor with information and logic necessary to correct the error.
- HMS assisted one southern state in recovering more than \$70 million in overpayments related to Medicare crossover claims. We then provided our logic to the MMIS vendor and helped it develop and test system upgrade specifications to avoid future overpayments related to the issue.

The Vendor should submit examples of audit templates, protocols, and time frames for their process for identifying and auditing high risk claims.

In the exhibits below, we provide samples of our audit templates, protocols, and time frames for identifying and auditing high risk claims. **Exhibit A-28** provides a sample Algorithm Cluster/Mispayment Scenario Development Request. **Exhibit A-29** provides a sample Audit Findings letter, **Exhibit A-30** provides a sample Audit Notification letter, and **Exhibit 31** provides a sample Reminder Letter.





































2.4.2.1 Educating providers on the Vendor's business, purpose and process including notification of audit policy protocols;

Provider Education and Customer Service Requirements

HMS Provider Outreach

HMS's Medicaid RAC services work plan for BMS includes outreach efforts that will educate West Virginia providers, with whom we have been working on BMS's behalf since 1988, about our services and how they benefit the Medicaid program.

Our ability to provide education about the program helps providers gain a better understanding of state rules and regulations, identifies common ground for improvement, strengthens our credibility, and enables us to cultivate an environment of mutual trust and respect. This outreach also enables

provider stakeholder understanding and prevents abrasion that can result when providers have little or no notice of the reviews.

HMS understands that direct interaction with providers can enhance their overall understanding of and cooperation in achieving West Virginia's program goals. With communication and education, providers will support Medicaid policies, communicate regularly with our team, and promote evidencebased interventions.

We recognize that communication with hospitals, physicians, nursing facilities, community service providers, other provider associations, and Medicaid contractors is critical to building good provider relationships and minimizing abrasion. When



HMS is committed to positive provider relations. HMS already has developed a contact list of key personnel within each West Virginia hospital.

effective working relationships have been established, a multifaceted program can educate and update providers on the process for each audit.

Prior to conducting audits, HMS will implement a BMS-approved provider orientation initiative that will reach out to West Virginia provider associations as well as individual providers (through association meetings and webinars) and will ensure that providers have a clear understanding of the project objectives and process. With BMS's approval, the HMS orientation process will be ongoing throughout the project, providing a forum for dialogue between providers and HMS staff.

A successful Review program incorporates provider input that is reflected in a decrease in each provider's denial rate for improper documentation and billing and frequently correlates with an increase in the quality of care. This also equates to a greater understanding by the provider community of state rules and regulations involving admissions to acute hospitals and ongoing care in provider facilities, which helps to ensure that a state spends its dollars appropriately and wisely.





HMS has multiple interactions with the provider community each year. Our staff is aware of key resources throughout the large inpatient hospitals, and our database of provider contact information extends beyond Chief Financial Officers to include patient account directors. We will incorporate additional contacts within each facility, such as medical documentation experts. This effort will ensure that our communications are direct and not lost within a large facility mailroom.

Through our experience in West Virginia and across Medicaid programs, HMS understands that positive provider relations are critical in the successful implementation of a large-scale Provider Audit program. Throughout our years of working with BMS, we have successfully worked with providers in West Virginia and the surrounding region.

Please see our draft outreach plan components in **Exhibit A-33** for an overview of how we will provide effective communications, relevant educational events, and informative publications. HMS understands that this will be the basis of discussion about our approach to provider outreach.

HMS proposes to begin Outreach programs to providers and other Medicaid contractors upon award of this engagement. Our proposed plan is to initially reach out to provider associations to describe the HMS business, purpose, and process we will follow to accomplish the objectives set forth by CMS and BMS. The scope of work will be defined by HMS and approved by BMS.

HMS also plans to reach out to provider associations at the end of each audit year and provide trending results to date. We will present an overview of the audits, the results, and plans for the next audits and will answer questions regarding HMS's process; we will refer all other questions to BMS.



Exhibit A-33 > Draft Provider Outreach Plan Co	omponents
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Item	Outreach Activity	Information	Time Frame
1.	Meetings of Introduction	HMS will schedule meetings to introduce our company and discuss the purpose of the RAC and its process	0–90 days
2.	Provider Webinars	HMS will reach out to providers and other stakeholders and offer webinars for introduction prior to any audit activity.	0–90 days and regularly scheduled to provide ongoing information
3.	Newsletter	HMS will produce a stakeholder newsletter to provide continuous information about the RAC and the audit process and to answer questions related to HMS or our process.	0–90 days and every quarter thereafter for the duration of the engagement
4.	Website	HMS will have a public website for all RAC stakeholders that includes educational materials, Frequently Asked Questions (FAQs), and a link to the BMS website.	0–90 days and continuous
5.	Email	HMS will provide a specific email address for providers/stakeholders to submit questions or comments and for an avenue to present additional information to individuals. This email will be continuously monitored and answered by HMS Provider Relations staff.	0–90 days and continuous
6.	Toll-Free Telephone Number	HMS will provide a toll-free telephone number directly to our Provider Relations staff to assist all providers and answer non–policy-related questions; all policy-specific questions will be referred to BMS.	0–90 days and continuous
7.	Special Sessions	HMS will hold special meetings or educational forums on an as-needed basis and will invite all providers/stakeholders; these sessions can be scheduled regionally.	0–90 days and continuous
8.	Provider Portal	HMS will introduce the Provider Portal and educate providers on how to access status/recovery information.	0–90 days and continuous

HMS's Approach to Provider Education

HMS will deploy the following informational and communication tools and materials upon BMS's approval.

Provider Portal

HMS will offer providers access to our Provider Portal, an optional online portal that can serve as the primary point of contact throughout the overpayment identification process. After providers register and supply proper credentials to validate their identity, the portal will give them a broad scope of self-service options. Providers can update contact



More than 28,000 providers currently use HMS's Provider Portal. This access simplifies their enrollment and facilitates their understanding of the RAC by giving providers direct access to knowledgeable staff who can assist them throughout the audit process.



information for Medicaid billing inquiries and requests, download overpaid claims listings, and submit questions to HMS's Provider Outreach and Customer Service team.

The 24/7 portal will also allow providers to elect to go "paperless." By selecting this option, providers will receive an email at their registered email address whenever a new claims listing has been posted on the portal. Once logged in, a provider can download the reports immediately, rather than wait for delivery via postal mail. As an added benefit, HMS will also automatically log which members of a provider's staff accessed a given listing and when it was downloaded. This information has proven extremely valuable for our clients when providers submit an appeal stating that they never received a recovery request.

The Provider Portal is a critical part of HMS's approach to preventing overpayments since it provides a channel for clear communication about the causes of the overpayments. Upon contract award and with BMS's approval, HMS can quickly implement additional modules and RAC-specific functionality for its providers. The portal is a clear example of an in-place tool that will enable HMS's rapid implementation of West Virginia's RAC contract.

Medicaid RAC-Specific Website

HMS is paving the way by being one of the first contractors to provide a website devoted to Medicaid RACs. To help states navigate the many facets of the ACA's requirements for RACs, HMS has established an information and support website at www.medicaid-rac.com. The information accessible at Medicaid-RAC.com ranges from the history of the development of Medicaid RAC requirements to an up-to-date summary of the RAC status of all states. Valuable discussions, FAQs, and online resources are also available on the website. Topics on Medicaid-RAC.com include:

- ▶ "State Activity"—includes an interactive map of state RAC activities
- ▶ "Blog"—RAC blog for related discussions
- "Legislation"—contains up-to-date CMS RAC rules and regulations
- "Considerations"—guide to states concerning RAC vendor requirements and best practices
- ▶ "FAQ"—vehicle for submitting questions and searching previous questions and answers
- ▶ "Resources"—contains useful links to CMS and other related websites
- ▶ "For Providers"—gives information to providers on what to expect from Medicaid RACs
- "Contact HMS"—gives users an avenue for sending comments or questions to HMS

This site is frequently updated with information as it is released. Clients and providers have found Medicaid-RAC.com to be a very useful tool in keeping up with the changing healthcare environment. States that want to keep up to date on new and changing RAC legislation can subscribe to receive alerts to critical posts on the Medicaid-RAC.com blog.

In addition to providing the Medicaid RAC website, HMS will develop a website specifically for West Virginia as we have done for our other Medicaid RAC clients (**Exhibit A-34**). HMS goes far beyond the CMS Final Rule requirement to maintain a website to post audit issues. We will work with West Virginia for content requirements and prior approval before posting any information, and the West Virginia



website will be devoted to RAC activities occurring in the state. We will implement ongoing communication processes that ensure that providers feel that their concerns and ideas are being appropriately considered and addressed. Upon approval, we envision that the West Virginia website will contain such information as:

- ► Issues that have been approved for audit
- An overview of BMS's RAC program and processes
- Links to West Virginia regulations and provider manuals
- ▶ Information about any changes in program operations
- Relevant Medicaid criteria and information about the types of claims, diagnoses, and errors targeted for review
- Schedule of outreach events
- Recordings of webinars and outreach presentations
- Communications regarding any new procedures, system interfaces, and rules pertaining to the review process



Exhibit A-34 > Sample Website Screenshot

Medicaid RACs	
Legislation State Activity Considerations FAQ Resources For Provide	ers Contact HMS Blog
New Jersey Providers	Search
HMS (HMS.com) is under contract with the State of New Jersey Office of the State Comptroller, Medicaid Fraud Division (MFD), and the Department of Human Services (DHS), Division of Medica Assistance and Health Services (DMAHS) as New Jersey's Medicaid Recovery Audit Contractor (RAC), pursuant to Section 6411 of the Patient Protection and Alfordable Care Act of 2010. Accordingly, HMS is authorized to audit provider payments and associated financial records for Fee-For-Service and Medicaid Managed Care claims to identify underpayments and overpaymer and to recover any overpayments made to providers.	Lid You Know?
HMS has identified the following targets to date:	to grow to over 82 million lives by 2019.
COMPLEX REVIEW TARGETS	million lives by 2019.
Frequently miscoded DRGs:	
Ventilator Support of 96 hours or greater	01010100000000000000000000000000000000
Extracorporeal Membrane Oxygenation	01010100000000000000000000000000000000
Tracheostomy	A BANK
Operating Room Procedure Unrelated to Principal Diagnosis	.0.8%
Excision Debridement	
Long Term Care audits:	
Patient Liability Reporting	
Claims Overpayment Review	
AUTOMATED REVIEW TARGETS	
Duplicate Claims Review	
Transfer Cases	
Claims Paid After the Patient Deceased	
Newborn Billing Issues	
This Statement of Work (SOW) document addresses the State of New Jersey's Medicaid Recove Audit Contractor (RAC) requirements.	ry
Frequently asked questions for the Recovery Audit Contractor (RAC).	
Please email njrac@hms.com with any questions.	

By providing this information, we can reduce provider abrasion as well as future improper payments. The website should serve to help providers determine their "RAC risk." Providers should assign a committee or an individual responsible for keeping up with RAC issues, and providers can use the information on the website to prepare cases for review and to make changes to avoid future errors. In addition, by providing specific information about our processes, the site will enhance providers' ability to quickly and accurately respond to RAC requests.



Newsletters

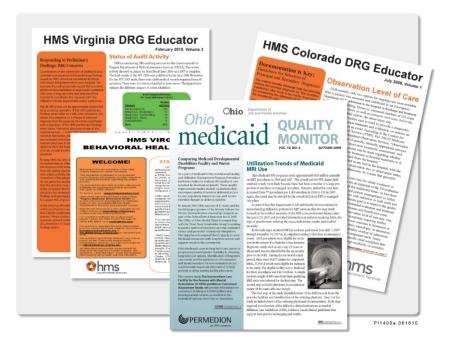
HMS publishes trends and issues encountered in our provider newsletter.

Webinars

HMS webinars reach providers who cannot access training or communication sites. The webinars can be extremely useful in communicating new procedures, system interfaces, and rules and in introducing any facets of a Review program.

Notification Letters

HMS's letters contain specific information regarding errors; they are an effective tool to educate providers regarding proper practices.



Conference Telephone Calls

HMS conducts regular telephone calls and in-person meetings with providers and provider associations to discuss findings.

Provider Relations and Education Success

The HMS team has implemented and led more than 200 provider educational programs. We have developed collaborative provider education opportunities, conducted large-scale seminars and workshops, provided consulting sessions with individual providers to develop quality improvement plans, and convened early quality conferences. Our production of educational materials runs the gamut from clinical, topic-specific educational reference manuals and teaching guides to web-based program information and from newsletters to one-on-one consultation.

Examples of our success in establishing high-quality working relationships with provider communities include the following:

Prior to transition from the incumbent vendor to our team for the recently awarded Massachusetts Medicaid Utilization Management contract, HMS met regularly with the client and the outgoing vendor to discuss implementation activities and obtain guidance. An informational meeting (including officers and members of the Massachusetts Hospital Association) gave the hospitals an opportunity to ask questions about the new contract. By delivering provider education prior to the launch of Utilization Review activity, providers "bought in" to the project transition to allow a



smooth implementation of the new contract. We recently met a second time with the Association and its provider members to discuss the status of the project and opportunities to enhance processes and communications.

The South Carolina Department of Health and Human Services awarded HMS a contract for consulting and audit services for Medicaid overpayments. As part of this contract, we work closely with providers to educate them about best practices in coding and billing Medicaid claims. HMS conducted a comprehensive provider outreach effort to educate the hospitals with respect to this project—including a step-by-step, detailed report of our review process as well as communications regarding specific provider expectations. We accomplished this outreach via a formal presentation to approximately 120 members of the South Carolina Hospital Association; we received ample positive provider comments and feedback regarding this effort.

2.4.2.2 Staffing for outreach and communication including the number and type of Subject Matter Experts (SME) available to directly answer provider questions or concerns;

Provider Relations Representatives

HMS's qualified and experienced Provider Relations representatives will be knowledgeable of HMS's

efforts on behalf of BMS. This knowledge will include potential recovery methods and the appeal process. Representatives will have access to our case management system, thereby enabling them to efficiently access claim-specific data that will support their ability to best respond to callers' needs. All standard answer times, hold times, and telephone message scripts will be followed by HMS and approved by BMS prior to implementation. As necessary, the staff person responsible for an overpayment that prompts a telephone call to the call center will return the call within one business day of receipt.

HMS's call center capabilities include our ability to respond to calls from Spanish and other non-English speakers. The call center can assist callers by way of our translation service, Language Line. When someone who does not

Prompt, Efficient Provider Relations Service via Our Call Center

HMS is proud of the quality and speed of our response to provider inquiries, as illustrated through the following statistics:

- Providers accessing HMS's Provider Portal: more than 28,000.
- Average number of work events processed monthly: 26,000.
- Abandon call rate: 0.5% (compared with industry standard of 3%).
- Percentage of inbound calls sent to voicemail: 0.4%. Messages left prior to 3:00 p.m. are responded to the same day, and those left after 3:00 p.m. are responded to no later than the next day.
- First call resolution rate: 98.9%.

speak English or Spanish calls, our specialist will place him/her on hold, dial the Language Line, select the language, and wait on the line for an interpreter to provide the necessary translation. Our Customer Service Representative, customer, and interpreter then enter a conference call to begin the conversation. We will work with BMS to understand its specific language requirements to ensure that all employees will have access to accurate and comprehensive information associated with our services.



Effective communication is an important part of a successful Post-Payment Review program. Through HMS's provider communication process, we can inform providers about the appropriate utilization of funds and services. The following are some of the processes that HMS has used successfully in other state Medicaid programs and will implement for BMS upon approval:

Provider communication:

- Use overpayment notification letters that contain specific information regarding errors as an effective tool to inform providers about proper practices
- Publish information about trends and issues identified on our website
- Conduct regular conference calls and face-to-face meetings with hospital and provider associations.
- Maintain a HIPAA-compliant website for this entire program, which will enable providers to track project activity, and view trend reports and other identified issues. The website will also include links to educational materials and resources

Provider service:

- Ensure that all Project staff are readily available to discuss the project and/or specific issues
- Communicate clearly with providers
- Respond efficiently and courteously to provider inquiries
- Convey respect for the provider's viewpoint
- Develop and/or modify functionality on the State's Medicaid-specific website to provide added value and utility for the State and its providers, subject to BMS's approval

Our ability to provide information about BMS's program, help providers gain a better understanding of State rules and regulations, and identify common ground for improvement strengthens our credibility and enables us to cultivate an environment of mutual trust and respect.

PIE retains all reviewer documentation related to each case. Medical record documentation and correspondence from/to providers (including notification letters) are also scanned and maintained in the case file. As a result, evidence documentation and rationale are immediately accessible online to support inquiry or appeal processes.

Cornerstones of Customer Service

Excellence

Our culture is based on a commitment to the highest levels of quality, reliability, and proactive levels of service for our clients and their interests. From top to bottom, we operate under the concept of "go the extra mile for results".

Innovation

We proactively partner with our clients to develop leading-edge products and services that address their evolving needs.

People

Our employees represent not only the values of our company, but also those of our clients and their brands – professionalism and integrity are paramount. We work in a team environment where all employees are treated with respect, encouraged to develop their individual skills, and are recognized and rewarded for their efforts. We cultivate open communication, adaptability, and strategic thinking to inspire each team member to excel. Our clients, therfore, benefit from this synergistically derived level of excellence.

Service

Our success hinges on being an indispensable partner to our government, private sector, and commercial clients. That means working seamlessly with our clients to understand and respond to dynamic external environments, manage the demands and challenges of the internal environments, and deliver unmatched industry results.

The success of our clients is our number one priority. More than just a phrase – it is the overarching basis of our culture and business model – our client's success is the way we measure our own success.

QA.1449.011111.MS

At predefined intervals—customizable to meet the needs of the State—HMS Provider Relations specialists contact the providers who have not responded with a friendly, polite reminder of upcoming due



dates for a response. Additionally, Provider Relations specialists produce reports at regular intervals listing the response status of each provider in the recovery queue. These reports are reviewed by the Project Management team to develop tailored strategies, with the guidance of the State, for follow-up with nonresponsive providers.

2.4.2.3 Staffing for the toll-free number during the Bureaus normal business hours from 8:00 a.m. to 5:00 p.m., Eastern Standard Time (EST) excluding observed State holidays; and

HMS Call Center Communications

Supported by state-of-the-art call center technology and proprietary case management tools, our Provider Relations team ensures that the recovery process is as clear, quick, and simple as possible. The team responds to provider inquiries and questions and resolves issues that arise during the recovery period, including the following specific activities:

Communicate with providers to ensure that the requirements and documentation are clear and understood.



- Inform providers about the time frames during which they need to respond to claim review requests.
- ▶ Supply additional information about claim records upon request.

During the response period, our Provider Relations specialists answer providers' questions, provide supplemental data, and manage provider correspondence in a timely manner. The call center will be staffed from 8:00 a.m. through 5:00 p.m. Eastern Standard Time, and the center's toll-free telephone number will be included on all HMS correspondence submitted to providers.

2.4.2.4 Compiling and maintaining provider approved addresses and points of contact including notification to the Bureau's current fiscal agent.

Prior to sending any correspondence to providers, HMS's Provider Relations team verifies the provider address from the BMS Provider File and identifies the appropriate contact at the provider for record requests. This information is maintained in the HMS Provider Portal Provider Database and is updated and reverified if the contact information changes in the BMS file. In addition, providers can update their contact information online through our Provider Portal. Prior to generating record request letters, PIE confirms that the provider information has been verified. If not, PIE generates an exception report and does not print letters for that provider.



2.4.3 The Vendor should propose a staffing plan that includes team members who bring a breadth and depth of data analysis, audit and Medicaid knowledge and experience relevant to the scope of this proposal. In their proposal, the Vendor should describe how their staffing plan provides all the skills needed to fulfill the requirements throughout the life of the contract. The Vendor should supply resumes for staff as the Bureau considers staff resumes as a key indicator of the Vendor's understanding of the skill mixes required for each staffing area.

Staffing

HMS's RAC Project team comprises experts with varied functional backgrounds and skills, including a

project director, deputy project director, Project Management team, Medical Director, Certified Coding Specialists, clinical auditors, IT and Security staff, data analysts, and an Executive Oversight team. We have assigned staff to this RAC engagement based on their healthcare experience, demonstrated knowledge of Medicaid, and RAC expertise. **The staff assigned to BMS bring knowledge of the regulations, laws, and rules that govern West Virginia's Medicaid and RAC programs.** In addition, they bring program integrity expertise across Medicaid agencies and other health plans. HMS has ensured that members of our proposed team are fully qualified and will be trained to meet and even exceed all RFP requirements for this project. All of our Audit staff will be knowledgeable in Medicaid claims payment



For more than 24 years, HMS has applied staff expertise in specialized areas to meet the needs of West Virginia programs. HMS will continue in this same spirit to help BMS meet RAC requirements as defined in CMS' Medicaid RAC Final Rule.

processes, medical record and provider documentation review, and recovery activities.

Our project experts understand both Medicaid and Medicare payment integrity and have years of practical experience in the specific issues pertinent to improper payments. Members of our team have worked sideby-side with CMS, Medicaid agencies, CHIPs, AIDS Drug Assistance Programs, high-risk populations, and State Pharmacy Assistance Programs to interpret policy, design solutions, and consult in areas impacting RACs.

HMS has the Administrative staff and organizational resources required to meet BMS's needs for this engagement. Because many of our staff are already in place, BMS can be assured that we will implement the RAC program by the State-defined contract start date. In addition, HMS has the necessary staff resources to meet CMS' requirements to deliver and measure the accuracy and timeliness of reviews and case deliverables. Our rapid recruitment and training approach ensures that the reviewers whom we have identified and vetted to work on this project will be available, trained, and ready to work on this engagement once a contract is awarded and the implementation timeline is agreed upon.

We closely manage the assignment of claim review types, volumes, and production goals to reviewers so we do not sacrifice the quality of the review. We do not assign specific claim review types to reviewers not specialized in that claim type or set production goals so high that we overload our auditors, risking



poor-quality reviews that are likely to increase provider abrasion and reconsideration/appeals requests. Throughout the contract term, HMS's Project team will leverage the resources of dedicated West Virginia RAC team members as well as the expertise of the SMEs throughout HMS. We will apply expertise and qualifications from a broad range of specialized areas, including:

- Project Management. The HMS Project Management team brings years of payment review and recovery experience across Medicaid programs throughout the United States. This team will ensure that adequate staffing and system resources are devoted to the Medicaid RAC contract and that all contract requirements are met or exceeded.
- Executive. Our Executive team members are recognized experts in their fields who will routinely provide consulting guidance, apply national best practices, share their expertise, and provide program direction and consultative services to our staff and to BMS, as appropriate. HMS team members also serve as educators, advisors, and trusted thought leaders to our clients, helping them stay abreast of and adapt to policy trends that impact them. Because of our extensive experience in working with multiple state Medicaid clients, their provider communities, and their stakeholders, HMS has a thorough understanding of Medicaid programs, pertinent Medicaid policy issues, and reimbursement methodologies.
- Regulatory and Reimbursement Research and Development. Our Regulatory and Reimbursement Research and Development team comprises policy, legal, and data/coding experts who are experienced in researching the West Virginia–specific policy, regulatory, and reimbursement requirements necessary to support the Medicaid RAC services that we propose to BMS.
- Data Analytics. Our experienced Data Analytics team has an in-depth understanding of and experience in coverage, billing, coding, clinical, and reimbursement policies and overpayment issues in Medicaid and the ability to analyze data and develop algorithms to target improper Medicaid payments. Our data analysts will support a host of data routines for BMS that will target and identify improper payments.
- Clinical audit services. Our qualified Medical Director, registered nurses, certified coders, pharmacy auditors, and Clinical Audit staff supported by proprietary systems and operational processes ensure the accurate and efficient validation of inappropriate payments and the notification of overpayment findings to providers within 60 calendar days. HMS's peer review panel includes more than 900 physicians and other healthcare professionals covering more than 70 specialties.
- Coding. The certifications held by our Coding staff ensure that they are proficient in the following areas:
 - Reviewing and assigning accurate medical coding for diagnoses, procedures, and services in a physician office setting
 - Reviewing hospital records and assigning numeric codes for each diagnosis and procedure
 - Possessing expertise in the ICD-9-CM and CPT coding systems
 - Demonstrating proficiency across a wide range of services, including anesthesia, surgical services, radiology, pathology, and medicine



- Medical coding rules and regulations, including compliance and reimbursement
- Anatomy, physiology, and the medical terminology necessary to correctly code provider diagnoses and services
- Ensuring the quality of medical records by verifying their completeness, accuracy, and proper entry into computer systems
- Assembling and analyzing patient data to improve patient care or control costs
- Coding diagnoses and procedures in patient records for reimbursement and research
- Financial audit services. Our Financial Audit team members are experts in reviewing provider Accounts Receivable management systems to identify overpayments, coordinating refunds, and reviewing records for billing errors to validate cases of improper payment that have been identified through data analytics.
- Provider Relations. HMS's toll-free telephone number gives providers direct access to HMS's Provider Relations staff who are experienced in establishing and maintaining effective communication with providers and will promptly respond to all inquiries and questions. Supported by state-of-the-art call center technology and HMS's web-based portal and case management tool, this team will also work with West Virginia providers to ensure appropriate communication and maintain up-to-date address and contact information.
- Information Technology. Our IT staff use state-of-the-art, HIPAA-compliant transfer protocols to transmit, synthesize, analyze, and process data from BMS. Our IT professionals are dedicated to providing innovative and effective solutions for our cost containment and recovery initiatives. We will deploy advanced technology in support of BMS Medicaid RAC services, and our team is well versed in how to implement and manage the case management tools designed specifically to support the services that we provide to state Medicaid agencies.

HMS's expansive, nationwide resources and RAC service experience enable us to assemble a team for BMS that will apply both contract- and State-specific expertise on West Virginia's behalf. We have provided a detailed explanation of personnel roles, responsibilities, and skills in Section 2.4.3.2: Project Management Expertise, RAC Operations Experts, and Executive Oversight Team.

Résumés for Key Personnel

HMS brings BMS extensive experience in the Medicaid arena. Our staff possess the knowledge and expertise to successfully implement the Medicaid RAC engagement. The key staff résumés listed in **Exhibit A-35** are provided in Appendix **3**.



Exhibit A-35 ► HMS's Key Staff for BMS RAC Engagement

- David Dawson, Accountable Executive and Project Advisor
- David Hancock, Regional Executive
- Susan Wells, Project Director
- Richard Levock, Deputy Project Director
- > Joleen Bond-Livingston, Implementation and Audit Operations Director
- Jan Cary Kletter, MD, Contract Medical Director (CMD)
- Joseph Joy, Information Systems Manager
- Rebekah Ocker, RN, CCA, Implementation and Audit Development Director
- Michael Hostetler, Data Analytics Director
- Niki Love, Provider Communications Director
- Christie Watson, CPA, Automated Review Director
- Shelia Green, CPC, CPCH, CHC, Quality Assurance Supervisor
- Lila Holland, RN, Clinical Supervisor
- Cathy Powers, CCS, Coding Specialist
- Michelle Armstrong, CPC, CPC-P, Coding Specialist

The Vendor's proposed staffing plan should address the following components:

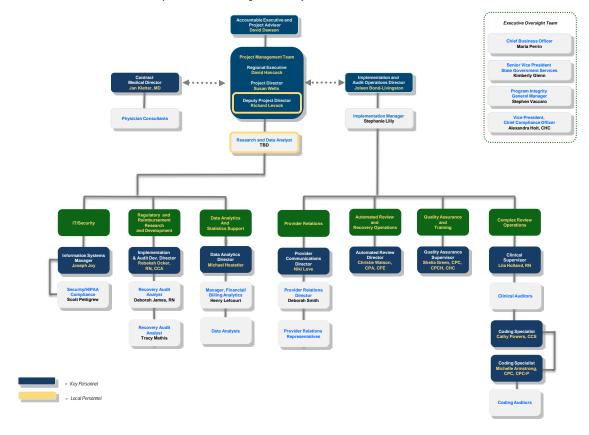
2.4.3.1 Organizational Chart. The organizational chart should show all staff to be used onsite, offsite as well as subcontractor staff. Off-site staff and subcontractor staff should be clearly identified on each organizational chart;

BMS-HMS Project Team

We have provided an organizational chart of the Project team in Exhibit A-36.



Exhibit A-36 ► HMS Project Team and Executive and Advisory Teams Support BMS's RAC Project



HMS Project Team for West Virginia Recovery Audit Contractor Services

2.4.3.2 Description of the roles, responsibilities, and skill sets associated with each position on the organization chart;

2.4.3.3 Brief summary description of the roles and responsibilities of each key staff member and the experience that qualifies them for their role in this project, including work performed off-site and the work of subcontractor(s). The Vendor should further describe the assurance of quality and timeliness of the work performed off-site and by subcontractors;

Project Management Expertise

Our proposed Project Management staff have demonstrated their expertise in applying improper payment identification and recovery best practices in both West Virginia and many other states. HMS offers BMS highly qualified day-to-day project managers led by **Susan Wells** (Proposed Project Director) and **David Hancock** (Proposed Regional Executive). Ms. Wells and Mr. Hancock are experienced project managers who work exclusively on Medicaid program projects in the South, including engagements where we provide audit and recovery services. Ms. Wells currently oversees HMS's contract work for BMS, which includes cost containment and recovery work.

Susan Wells has more than six years of healthcare experience and has extensive knowledge of audit and post-pay recovery projects and other cost containment projects. Ms. Wells has served as a program



director for two years. She provides day-to-day management and oversees contract activities to ensure that project objectives are met. Ms. Wells will leverage her Medicaid and overall healthcare experience in program integrity and revenue maximization as well as her knowledge of West Virginia–specific project development to ensure success in this scope of work.

David Hancock has over 12 years of health industry experience in managing audit and recovery, TPL, and cost containment projects. Mr. Hancock currently provides management oversight for the TPL work that HMS currently performs on behalf of BMS. In addition, he is responsible for overseeing HMS's services in Alabama, Arkansas, Georgia, Kentucky, Mississippi, and West Virginia. At present Mr. Hancock is also responsible for coordinating resources from HMS's operational units to ensure contract performance on behalf of BMS.

David Dawson serves as the Accountable Executive and Project Advisor and supports Ms. Wells and Mr. Hancock in ensuring that all necessary business units within HMS, including Government Services, Program Integrity, Information Systems, Human Resources, and Corporate

Compliance, cooperate to support the engagement with BMS. Mr. Dawson is also responsible for overseeing the project's financial performance and bringing national best practices to this project. Mr. Dawson has 26 years of healthcare experience and provides executive oversight for our current Medicaid RAC contracts in the South region.

Richard Levock has more than 17 years of healthcare experience and will serve as the Deputy Project Director for this engagement. Mr. Levock will support Ms. Wells in all project management functions and will serve as the secondary point of contact. He brings invaluable experience and insight to the various programs and services offered in West Virginia, including experience with Credit Balance Audits at West Virginia hospitals. He has supervised the implementation of Medicare and commercial disallowance projects and has worked closely with providers. Mr. Levock provides a local presence for the BMS-HMS Project team.

Joleen Bond-Livingston, CPC, Implementation and Audit Operations Director, is responsible for implementing HMS's RAC and Audit programs, with operational responsibilities that include development of state/program-specific requirements; creation of audit protocols; development of audit staffing models; hiring and training Audit staff; developing and maintaining audit tools, letters, and reports; and developing and maintaining communication and risk mitigation plans. Ms. Bond-Livingston oversaw HMS's



Operations Expert Joleen Bond-Livingston has nearly 22 years' experience in healthcare revenue management, working with state and federal entities to assure maximum reimbursements.

Susan Wells, Project Director Susan Wells will serve as the

primary point of contact for this engagement. She brings BMS more than six years of healthcare experience, extensive knowledge of West Virginia Medicaid, and BMSspecific project management, including post-payment and recovery services.



Medicaid Integrity Program Medicaid Integrity Contractor (MIC) audit work for CMS' Western Region for three years and participated in meetings between state Medicaid programs and CMS to refine overpayment audit targets.

The Project Management team will expertly manage the BMS Project team, with oversight from executives and support from advisors and operational experts. Team members understand their responsibilities related to overall contract fulfillment. The combination of our Contract Management personnel will help avoid the risks that sometimes hamper new project implementations.

RAC Operations Experts

In addition to the project medical director, our Operations staff includes registered nurses, certified coders, data analysts, clinical and financial auditors, pharmacy auditors, Information Systems personnel, and others.

Our core Operations team has expert knowledge of the audit processes and rules, best practices, and state and federal regulations that pertain to improper payment and recovery projects. In particular, **our team is already adept at working successfully within the Medicaid environment, including the Medicaid-specific rules that define the BMS program**. Several members of our Operations team regularly attend national program integrity educational sessions, including those at National Association for Medicaid Program Integrity conferences.



Our staff's extensive knowledge of Medicaid policy and understanding of Medicaid RAC rules assure BMS that we will correctly interpret relevant policies, rules, regulations, and laws related to the successful operation of BMS's RAC program.

The following experienced RAC personnel will lead our operational initiatives:

- ► Joseph Joy, Information Systems Manager
- Rebekah Ocker, RN, CCA, Implementation and Audit Development Director
- Michael Hostetler, Data Analytics Director
- Niki Love, Provider Communications Director
- Christie Watson, CPA, Automated Review Director
- Shelia Green, CPC, CPCH, CHC, Quality Assurance Supervisor
- Lila Holland, RN, Clinical Supervisor

Through our current contract work for West Virginia's Medicaid program, the following HMS clinical review experts bring a strong understanding of BMS's program goals and expectations, stakeholders, and provider community:



- Joseph Joy, Information Systems Manager, has more than 19 years of experience in managing information systems and projects. He is currently responsible for IT functions for HMS's existing engagements. He will oversee all staff performing IT activities under the RAC contract from his Irving, TX, location. Mr. Joy has extensive experience in managing data warehouses/data marts, office automation systems, and document imaging and workflows.
- Rebekah Ocker, RN, CCA, Implementation and Audit Development Director, has over 23 years of expert knowledge of healthcare review and audit functions. Ms. Ocker has extensive experience in coordinating large project activities with government regulatory and oversight agencies. In addition, she oversees the development of HMS's recovery audit capabilities and processes.
- Michael Hostetler, Data Analytics Director, will be leading the development of our data analytics and algorithms. Mr. Hostetler has 20 years of experience in implementation and recovery projects, most notably for Medicaid programs in New York, Massachusetts, and New Jersey, and has improper payment experience across all benefit areas.
- Niki Love, Provider Communications Director, has more than 19 years of experience in client and provider education. Ms. Love will ensure HMS's compliance with BMS's provider information requirements and implement all communication requirements.
- Christie Watson, CPA, CFE, Automated Review Director, is responsible for managing our Retrospective Audit programs, with operational responsibilities that include managing Audit staff, serving as key liaison with various internal departments, managing contract deliverables, maintaining client relationships, and overseeing the audit QA process. Ms. Watson has 16 years of Generally Accepted Auditing Standards and GAGAS audit experience.
- Shelia Green, CPC, CPCH, CHC, Quality Assurance Supervisor, is responsible for all aspects of HMS's internal RAC program quality. She will develop the QA policies and procedures related to clinical reviews performed by our nurses and coders. Ms. Green has extensive experience in quality and risk management in healthcare settings.
- Lila Holland, RN, Clinical Supervisor, is responsible for oversight of nurse clinical review functions and ensures timeliness of case deliverables and QA activities. She brings 20 years of healthcare experience and a strong background in quality management and compliance, with 10 years of Medicaid knowledge. The reviewers under her direction will review medical records to collect data, ensure appropriate billing of data, and follow up on questions or concerns raised by nurse and physician reviewers or healthcare providers.

Executive Oversight Team

In addition to the direct service personnel and managers listed above, we will designate executive-level advisors who will lend their unique expertise to this engagement (**Exhibit A-37**).



HMS Executive Team Member	HMS Title	Years of Health-Related Experience
Maria Perrin	Chief Business Officer	8
Kimberly Glenn	Senior Vice President, State Government Services	21
Stephen Vaccaro	Senior Vice President and General Manager of Program Integrity	21
Alexandra Holt, CHC	Vice President of Corporate Compliance	27

HMS's structure supports our corporate goal of maintaining our leadership position as a provider of best

practices and innovation that fulfills the evolving service needs of our clients. Our organization enables us to interact effectively with BMS as well as the legislative and regulatory processes that influence its operations. We are also able to efficiently develop and implement new products and services that leverage our expertise to maximize the value of our robust resources. Members of the Executive Oversight team possess specific expertise in Medicare RAC, and all executives have multiple years of experience in Medicaid overpayment and recovery. These executives will ensure that all necessary business units within HMS, including Government Services, Program Integrity, Information Systems, HR, and Corporate Compliance, cooperate to support this engagement. HMS understands the importance of implementing Medicaid RACs in accordance with federal rules



Executive Advisor

Maria Perrin, HMS's Executive Advisor, brings significant Medicaid experience and was responsible for the operation of three successful Medicare RAC pilot programs.

and individual state requirements as set forth by the Affordable Care Act (ACA). We currently serve as the Medicaid RAC for 16 states. Our executive advisors will provide high-level oversight and advisory functions relating to the improper payment audit services that we propose as part of this response. Their résumés are included in Appendix 3.

2.4.3.3 Brief summary description of the roles and responsibilities of each key staff member and the experience that qualifies them for their role in this project, including work performed off-site and the work of subcontractor(s). The Vendor should further describe the assurance of quality and timeliness of the work performed off-site and by subcontractors;

We have provided a brief summary description of the roles and responsibilities of each key staff member and the experience that qualifies them for their project role in **Response 2.4.3.2** for the following key staff:

► Jan Cary Kletter, MD, FACS, MS, our West Virginia–licensed Contract Medical Director, will lead our Clinical staff and oversee their audit activity. Dr. Kletter has more than 31 years of experience in healthcare as a general surgeon. He is board certified in General Surgery and has been in good standing with the West Virginia Medical Board since 2000. In 1997, Dr. Kletter received certification from The American Board of Quality Assurance and Utilization Review



Physicians, and in 1999, he earned a degree in Health Administration. As the CMD for the BMS RAC project, Dr. Kletter will:

- Participate in provider outreach for presentations
- Serve as a readily available source of medical information to guide questionable claim review situations for complex claim reviews
- Recommend when State regulations, provider education, system edits, or other corrective actions are needed or must be revised to address RAC vulnerabilities
- Brief and educate reviewers on the correct application of policy during claims adjudication, including through written IRGs
- Interact with other contractors to share information on potential problem areas
- Be available to discuss the RAC program and/or specific claims or initiatives with the West Virginia provider community
- Cathy Powers, CCS, Coding Specialist, has more than 19 years of experience in performing billing and documentation reviews to ensure appropriate billing and coding of services rendered. Ms. Powers is also responsible for maintaining HMS's coding resource files, manuals, and documentation.
- Michelle Armstrong, CPC, CPC-P, Coding Specialist, has more than 28 years of experience in performing inpatient and outpatient hospital coding and professional services coding of healthcare claims. She will perform billing and documentation reviews to ensure appropriate billing and coding of services rendered. Additionally, Ms. Armstrong will help to maintain HMS's coding resource files, manuals, coding policies, and documentation.

Quality Assurance

HMS Delivers High-Quality Services to BMS

A key issue in a RAC program is the quality of findings identified by the contractor and sent to providers. For automated, semi-automated, and complex reviews, it is critical that the contractor ensure the quality of results at both the identification and the finding level. Failure to do so results in false positives and a high level of appeals, which would impose a burden on BMS staff as well as providers.

As with our operational QA, HMS uses a multilevel approach to ensure quality in our audit targets and findings and to avoid false positives. We use internal checklists, supervisor/internal review, and QA review at key checkpoints in the implementation and audit/review process. In addition, we incorporate the following features into our development and ongoing audit process to ensure the overall quality of our targets and findings:

- Accurate data
- Exclusion and integration of prior work and work in progress
- Effective analytics



- Accurate automated, semi-automated, and complex reviews
- ► Interrater reliability

Accurate Data

Inaccurate data is a key cause of false positives in healthcare recovery audits. Because audit targets are based on data analysis and algorithms, data must accurately reflect each claim that was billed and the amount paid. Even a 1% data error will result in thousands of false findings/unnecessary requests for medical records being sent to providers. HMS invests heavily in our Medicaid data process and expertise to ensure that we accurately reformat and understand claim, recipient, and provider data. Our analysts have many years of experience in working with Medicaid data, and we have developed specific checkpoints that enable us to verify the accuracy of our data, including:

- ▶ Immediate and accurate processing of all MMIS voids and adjustments
- Metrics-based benchmarks
- > Periodic checks against MMIS/data warehouse to ensure referential integrity
- MMIS data validation of all initial findings

Exclusions and Integration with Prior Work and Work in Progress

A key issue in the quality of recovery audit populations is ensuring that the findings have not been found before. Nothing irritates providers more than having a claim/record reviewed more than once. Avoiding such duplicated effort is conceptually easy but operationally difficult. Unfortunately, not all prior work is documented in detail at the claim level. For instance, when extrapolation or settlement has occurred, no claim level detail will exist. Since multiple audit entities conduct audits, (e.g., State Program Integrity, Surveillance and Utilization Review Sections, Audit MIC, OIG, and CMS), tracking prior work is difficult. HMS has designed our process so we can perform exclusion processing at multiple levels. Our PIE application includes built-in Exclusion Tables that enable us to "match off" at various levels, which allows HMS to clearly exclude "off limit" populations by:

- Provider type/provider/date of service
- Provider/date of service
- ► Procedure
- ► Issue type
- ► Claim

During the implementation and development of each improper payment concept, HMS will work with BMS to identify these populations and incorporate them into both our system and our QA process:

Audit issue development. A key focus of the development process is to ensure that our findings for automated review and our targets for complex review are accurate. This occurs on multiple levels:



- Our Policy Research team conducts exhaustive research on State coverage, coding, and reimbursement policy, searching for prior guidance, bulletins, legal activity, and even news items related to the issue.
- Our Data Mining team carefully tests and vets the findings of each algorithm. We check findings against the MMIS (assuming that access is available) to ensure that the claims data is accurate and that claims have not been adjusted in some way. We review findings with our Medical Director and clinical experts/SMEs to ensure that the magnitude and scope of findings is within the expected range, and we look at date of service, provider, and paid date distributions to identify any anomalies that might indicate a data or policy change issue.
- In our Audit Issue Proposal to and discussion with BMS, we attempt to review any unforeseen policies, prior work, or other obstacles that could cause issues in the audit process. We will ask about any unwritten policies or court cases, double-check that the issue was not already audited, and even inquire about the political landscape related to the provider type. We may propose talking with one of the providers or with the provider association.
- Pilot approach. Despite our exhaustive research and testing, as HMS identifies and proposes potential automated improper payments and targets for complex review, we will propose to BMS a pilot implementation approach for each concept. A pilot approach allows us to test each concept on a limited scale prior to full-scale audit implementation, which enables us to test for nonpublished policies, nondisclosed prior audit work, and other "submerged" obstacles that could impact the overall success of the audits. Although this approach can delay revenue to HMS, we believe that caution is appropriate as new concepts are being implemented.
- Multilevel QA. In the development and generation of each audit population, HMS uses the multiple checkpoint QA process discussed above, which reviews audit populations at different points before information is sent to providers.
- Ongoing results and trend evaluation. HMS closely monitors the results (acceptance rate, appeal rate) of all concepts at both the identification and audit level, reviewing them on a weekly basis. If we see acceptance rates dropping or appeal rates rising, we will immediately discuss with BMS the possibility of suspending that concept until we can review it to determine if there is a quality issue or if the concept has run its course (typically, providers improve/modify billing practices after several audits). This process ensures that findings/targets remain at a high level of quality while avoiding provider abrasion resulting from false positives.

Maintaining Effective Analytics

An example of our ongoing commitment to improving outcomes can be seen in how we routinely monitor the effectiveness of each data algorithm that we use to identify payment errors. HMS ensures that we continue to be effective in identifying improper payments and avoiding false positives.

We devote significant effort to the initial load and validation of data and the ongoing QA of that data and the analytical processes used to review it. Before new data is loaded into our system, we run automated



validation routines that check specific fields and values for expected ranges. If the validation routines identify an anomaly, a claims data analyst is paged, and immediate review of the data is initiated.

In addition, HMS carefully reviews the results of each data analysis algorithm and carefully validates them to ensure proof of concept for each scenario. We understand that each client processes claims according to its own payment rules. Unlike other vendors who may overly rely on national coding and clinical standard practices, HMS invests significant resources in developing client-specific analyses and benchmarking to differentiate our clients' accepted standards of practice. Our internal process and practice reviews incorporate project-specific criteria when evaluating quality and performance.

We use a multistage approach to ensuring that our data analysis results are targeting improperly paid claims with a high degree of accuracy. HMS also has teams of analysts who focus on specific areas, including claim billing errors, outpatient/medical coding errors, pharmacy issues, financial/COB issues, and LTC/hospice scenarios, to test the concept. **Our ability to apply clinical and functional expertise to the focused development of analysis related to each service area is a key differentiator for HMS.**

Accurate Automated, Semi-automated, and Complex Reviews

HMS has implemented a QA and Improvement program that addresses all aspects of the payment error analysis process and provides for continuous improvement. Internal Program Integrity business units will implement a Quality program for BMS based on the following principles:

- ► Training and continued education
- Accuracy
- Consistency
- Proper use of data
- Correct interpretation and application of Medicaid legal, regulatory, and policy documents
- Clarity and accuracy of communication (evidenced by legibility and correct spelling, grammar, punctuation, capitalization, and use of medical terminology)
- Promotion of continuous improvement and process reengineering
- Root cause analysis



In the last year, HMS staff performed complex record review for more than 500,000 claims, resulting in more than 100,000 claim level determinations. This level of experience has enabled us to become skilled at producing determinations and provider-level audit reports that are accurate, specific, consistent, and supportable, with specific reasons for determination, appropriate policy and regulatory criteria citations, and consistent and approved terminology. This is enforced through supervisory review and QA of all reports.



Design of the deliverable preparation process incorporates quality checks at critical points, usually associated with movement from one activity to the next. Overlaid on this quality design, the Quality team is required to review all contract deliverables prior to release based on checks of significant and quantifiable client requirements. To conduct a QA deliverable review, a Be Sure document is prepared that outlines the client requirements for the deliverable and how to check that the requirements are met; the document is maintained throughout the contract period to ensure that it is in alignment with requirements and clarifications.

Each Operational team will have a Training and Quality program dealing with processes, audit policies, metrics, and audit tools. The Quality team will initially, and ongoing on a regular schedule, review each unit's QA program and provide feedback and input.

Automated Review Quality

Each identified overpayment goes through our proprietary data validation process to ensure that each claim for which the auditor identified an overpayment was at one point paid by Medicaid. The first (automated) portion of the validation runs against the paid claims data that we receive from BMS to identify the exact claim. If a perfect match is not found, our validation system locates potential matches. Our staff manually review these results to determine if the match is accurate.

Complex and Semi-automated Review Determination Quality

HMS understands that the determinations made by our Audit/Review staff must be consistent on both an individual and group level for our findings to be supportable. Through careful research/planning and reviewing as well as a multilevel QA process that continually tests the quality and consistency of results on an audit and individual basis, HMS ensures that we are applying Medicaid program rules appropriately in our determinations.

Our multilevel approach for ensuring the quality of determinations includes the following:

- During the audit issue research process, HMS's Policy Research team documents all policies and issues related to an issue. They then work with clinical/subject matter supervisors to develop IRGs and/or audit protocols that detail step-by-step processes for the complex review of claims and the determination of errors related to each concept. Our IRGs help to ensure consistent and accurate review processes and determinations.
- Auditors, review nurses, and coders receive initial and ongoing training related to specific concepts. In addition to ongoing professional development training, our Audit staff receive specific instructions on the policy, criteria, and issues related to each concept approved by the client. This training (and the corresponding reference material) enables our auditors to make accurate, consistent decisions.
- ► A percentage of each auditor's results on a per audit basis (depending on Internal Quality Control [IQC] guidelines) are re-reviewed by independent Audit staff to ensure the overall quality of review/determinations (Exhibit A-38). This Independent Sample Review (ISR) helps validate the



quality of each audit and on an ongoing basis enables HMS to conduct ongoing IRR review for each auditor.

- As with all work products and deliverables, audit findings, determinations, and related audit reports are reviewed by the supervisor through a formal QA review prior to being presented to clients.
- HMS's processes and systems help ensure that determination/report formats and language are consistent and supportable. Formats are based on templates and protocols approved by each client. Wherever possible, preapproved error matrixes and templates that contain contract-specific language and policy citations are incorporated into PIE and used by our auditors. This procedure helps ensure standardization of language and citations and consistency in the work product. Through multiple contracts with CMS and state Medicaid agencies and our interaction with the Program Integrity divisions within each state, we understand the importance of accurately and appropriately formatted/worded audit reports (at both the provider and the claim level) in the program integrity process in reducing provider appeals and in the support of audit findings through the appeal process.

Exhibit A-38 HMS's Approach to Conducting Internal Quality Control for Complex Reviews

HMS Review Audit: Clinical/Coding Internal Quality Control (IQC) Guidelines

Coding audit accuracy: ISR/IRR required accuracy—95%

- 1. Criteria:
 - The principal diagnosis is accurately assessed to the highest level of specificity.
 - The principal procedure is assessed and coded.
 - The DRG or other derived code is accurate.
 - The reason for denial is relevant and accurate, and supporting concerns are clear, accurate, and concise.
 - Determination text is clear, accurate, and professional and includes appropriate references.

Coding audit accuracy: ISR/IRR required accuracy—95%

- 2. Criteria:
 - The clinical narrative clearly documents the clinical indications for the assigned DRG.
 - The clinical indications for the DRG are accurately assessed.
 - Clinical criteria such as InterQual or Milliman are used accurately and documented.

HMS Review Audit: IQC Process

- 3. Prior to approving determinations for a cycle, the Senior Nurse Manager (SNM) will select a random sample of 15% (minimum 5) of each auditor's findings and assign to an independent senior coder/nurse reviewer for an ISR.
- 4. If minimum IQC levels are not found for an auditor, all of the auditor's findings will be re-reviewed, and the auditor will be referred for training.
- 5. If minimum IQC levels are found, but some discrepancies exist, the SNM will review the case(s) and as appropriate assign a second independent coder/clinician to review and resolve any related discrepancies.



- 6. Following an ISR review, the SNM will conduct a final quality review of all determinations.
- 7. ISR results for each audit/auditor are maintained and used to conduct a quarterly IRR for each auditor.

For new auditors, there is a 100% ISR/IRR for the first 90 days.

Interrater Reliability

We understand that the findings made by our review staff must be consistent on both an individual and group level for our findings to be justifiable. By reviewing and continually testing the uniformity of reviewers and consistency of results, HMS ensures BMS that we are achieving IRR and applying West Virginia Medicaid program rules in a defensible way.

We use a bimonthly IRR review process to ensure that our reviewers and Clinical/Coding staff are achieving results of the highest quality and consistency. For these reviews, a panel of selected peers independently checks each reviewer's decisions and/or determinations.

Our IRR review process:

- Consists of reviews of three separate issues, at a minimum one claim per issue
- ▶ Is a group exercise separate from the individual reviewer audit
- Examines compliance with the IRGs provided and evaluates auditor consistency with those guidelines as well as adherence to established review time frames, timeliness of disseminating determinations, and data collection methodologies
- Can be performed on adjudicated and not yet adjudicated cases
- Can be performed on randomly selected case files, referred cases, topics with previous quality issues, and case types overturned during the appeals chain, especially at the hearings level
- Compares individual reviewers' decisions with those reached by a selected panel

HMS Standard Quality Control Policies

Ownership

It is the responsibility of the quality manager, the RAC Quality team, and HMS Process Engineering & Quality department to ensure that the ongoing program is designed to promote accuracy and consistency of the overpayment review process for BMS.

The quality control manager reports directly to the HMS Medical Director and audit manager responsible for all audit activities including preparation for and conduct of the audit and preparation of the Final Audit Report. The quality manager also indirectly



Our quality control policies draw on our extensive industry experience, allowing us to identify and resolve potential issues further upstream than less experienced vendors.



reports into the HMS Process Engineering & Quality department, which houses Corporate QA, to ensure consistent application of ADMAIC processes and roll-up for enterprisewide reporting and quality administration. Together these groups comprise the Quality team.

The Quality team ensures that all quality standards are met and that continuous improvement principles are applied. HMS believes that each person is responsible and accountable for the quality of his/her work and for ensuring, to the extent possible, that work completed in a prior activity meets quality requirements. This includes, for some deliverable types, utilization and review of cross-functional checklists to ensure that control activities designed to validate quality specifications have been completed.

Documentation

All procedures for deliverable quality review are required to be documented using the standard HMS procedure and process flow templates. Documents should be in lay terms and able to be interpreted and applied easily to obtain a quality measure. Review guidelines and/or procedures are developed for each review type and refined as aspects of the review require clarification.

Accuracy

A deliverable with an identified error is returned for correction to the point of origination of the defect. An audit deliverable with an identified quality defect or inaccuracy will receive an independent secondary review following its correction and will be re-reviewed through completion of the normal quality activities.

Any quality issue that cannot be remedied by reissuance of the deliverable will be logged for follow-up with a written root cause analysis, including both corrective and preventive actions with detailed remedial steps and timelines.

To ensure that Audit staff individual quality targets are maintained within HMS's policy guidelines, Corrective Action Plans are established for auditors who have error rates that are out of tolerance to internal quality service levels. All auditors are expected to achieve and maintain the established performance standards and level of competency as indicated in our complex review QA procedure.

Timeliness

HMS is committed to meeting all of the project timelines requested or required by BMS. Although deliverable quality will generally take precedence over "on-time" delivery, timeliness and cycle time metrics are measured and included in our internal quality control assessment. When delays occur, HMS Project staff will notify BMS promptly and will keep it informed of issues and resolutions. As has been noted elsewhere, "Quality is the first thing seen; Service is the first thing felt; and Speed is the first thing forgotten if Quality is

HMS's Quality Assurance Tool provides a longitudinal perspective of reviewer performance that allows our QA team to monitor and assess auditor knowledge, accuracy, and consistency.



sacrificed." HMS makes all effort possible to avoid delays in meeting our clients' expected deadlines.

Measurement

The Quality team is required to maintain reporting on reviews and payment error analyses conducted for BMS. HMS uses these metrics for deficiency reporting and process improvement purposes. Transparency in quality processes is a priority, and management by fact drives our decision making. Key Performance Indicators of quality are used to measure quality, timeliness, and volumes and to identify opportunities for improvement. Quality metrics underscore our approach to achieving and maintaining deliverable quality.

HMS monitors quality through several external and internal listening posts, including annual Voice of the Customer surveys, feedback from internal stakeholders, dashboard reporting, individual performance reporting, pre- and postdelivery assessment of deliverables, and success of the review against projected results.

Training and Auditor Measurement

At least one person is cross-trained on all quality review procedures. HMS has defined the criteria/metrics for quality auditing in our "Quality Assurance Tool." This tool is a comprehensive score sheet for all components of review and audit findings, including examining the correct application of judgment in analysis of supporting reference materials provided for audit and continuous education regarding review guidelines and/or procedures. The intention of the Quality Assurance Tool is to assess auditors' knowledge, accuracy, and consistency of findings.

2.4.3.4 Staff skill matrix in Vendor's own format to summarize the roles, responsibilities, and relevant experience of the proposed staff;

In addition to our core staffing plan, HMS taps into national resources on an as-needed basis. HMS does not rely solely on the staff dedicated to each project. A key advantage that HMS brings is that our broad base of Medicaid clients has allowed us to develop significant subject matter expertise; a cross-contract Advisory team; and significant clinical, audit, technical, and operational resources. Upon award of the West Virginia RAC project to HMS, BMS will continue to gain significant advantage and input from these expert resources. In addition, HMS will commit to ensuring that the appropriate level of resources is available to BMS. Staff who will be directly involved in RAC implementation and operations will:

- Understand BMS-specific regulations, data, and issues
- Receive ongoing input, guidance, training, and support from the West Virginia RAC Advisory team and program integrity-dedicated subject analysts
- Support the development of audit procedures and project protocols as needed

Exhibit A-39 identifies these members and their areas of responsibilities under the contract. Résumés for all Project team members are included in Appendix 3.



Exhibit A-39 > HMS's Project Team

HMS Team Member/ Title	Area of Responsibility/Role	Years of Related Experience
PROJECT MANAGEMENT		
David Dawson Vice President, Government Services South	 Accountable Executive and Project Advisor Provides executive contract oversight and guidance Ensures that all required company resources are available and that the right level of staffing is maintained through the engagement with BMS Oversees contract performance and introduces national best practices to BMS 	26
David Hancock Regional Vice President	 Regional Executive Serves as the senior manager and back-up project director for this engagement and will work closely with BMS, HMS's Project team, and other stakeholders during the implementation and operations phases Provides project oversight to ensure that we achieve project goals, meet all contractual objectives, and the services provided by HMS continue to bring high value to BMS Identifies areas to improve contract activities and increase value to BMS 	12
Susan Wells Program Director	 Project Director Oversees contract activities and serves as BMS's primary point of contact Provides day-to-day management and monitors quality control activities to ensure that projects are delivered on time and meet or exceed requirements. Ensures that appropriate resources are assigned to each contract functional area Works with various Audit teams to ensure that BMS's regulations, guidelines, policies, and procedures are met With HMS IT staff, facilitates successful data exchanges and interfaces between BMS, its Fiscal Intermediary, and other resources as required Identifies areas to improve contract efficiencies and increase value to BMS 	6



HMS Team Member/ Title	Area of Responsibility/Role	Years of Related Experience
Richard Levock Program Specialist	 Deputy Project Director Oversees contract activities and serves as BMS's secondary point of contact Provides day-to-day management and monitors quality control activities to ensure that projects are delivered on time and meet or exceed requirements. Ensures that appropriate resources are assigned to each contract functional area Works with various Audit teams to ensure that BMS's regulations, guidelines, policies, and procedures are met With HMS IT staff, facilitates successful data exchanges and interfaces between BMS, its Fiscal Intermediary, and other resources as required Identifies areas to improve contract efficiencies and increase value to BMS 	17
TBD Research and Data Analyst	 Research and Data Analyst Performs monthly/quarterly data mining projects, such as over/underpayment reviews Provides strict adherence to quality control for all claim reviews and audits Provides technical and client support for our PIE case management system Serves as provider education contact Responsible for reviewing provider billing manual Creates algorithms as BMS's needs change or special projects are needed 	TBD
IMPLEMENTATION AND AU	DIT MANAGEMENT	
Joleen Bond- Livingston, CPC Implementation and Audit Operations Director	 Implementation and Audit Operations Director Assists in implementation of Audit programs, with operational responsibilities that include development of state/program-specific requirements Creates, maintains, and revises audit protocols to ensure compliance with all state, federal, and program-specific requirements Oversees the hiring and training of Audit staff Develops and maintains audit tools, letters, and reports Creates, implements, and monitors formal communication and risk mitigation plans 	23



HMS Team Member/ Title	Area of Responsibility/Role	Years of Related Experience
Stephanie Lilly Audit Manager	 Implementation Manager Assists in implementation of Audit programs, with operational responsibilities that include development of state/program-specific requirements Creates, maintains, and revises audit protocols to ensure compliance with all state, federal, and program-specific requirements Oversees the hiring and training of Audit staff Develops and maintains audit tools, letters, and reports Creates, implements, and monitors formal communication and risk mitigation plans 	24
IT/SECURITY		
Joseph Joy Senior Vice President and Chief Information Officer	 Information Systems Manager Serves as the point of contact for IT activities Directs all Information Systems staff assigned to the RAC contract Manages multiple information systems and projects, including data warehouses/data marts, document imaging and workflow, web-deployed applications, and other office automation systems Coordinates, facilitates, and consults with contract management staff on information systems, application development and support, and IT project initiatives 	23
Scott Pettigrew Chief Security Officer	 Security and HIPAA Compliance Oversees HMS's technical and physical security policies and procedures, controls, and audits Coordinates with business units to implement best practices Develops educational programs Leads refinement of corporate risk assessment, business continuity, and disaster recovery planning Chairs the HMS Security committee and serves as member of the internal Corporate Compliance committee Works closely with technical and operational groups to improve internal structures and service deliveries 	20
REGULATORY AND REIMBU	RSEMENT RESEARCH AND DEVELOPMENT	
Rebekah Ocker, RN, CCA Manager, Recovery Audit Development	 Implementation and Audit Development Director Guides development of HMS's recovery audit capabilities and process Ensures program compliance with CMS Medicaid RAC guidance 	23
Deborah James, RN Recovery Audit Analyst	 Recovery Audit Analyst Leads claim targeting for clinical reviews Conducts statistical and epidemiological analysis of healthcare data Prepares clinical review reports 	15



HMS Team Member/ Title	Area of Responsibility/Role	Years of Related Experience
Tracy Mathis Recovery Audit Analyst	 Recovery Audit Analyst Leads claim targeting for clinical reviews Conducts statistical and epidemiological analysis of healthcare data Prepares clinical review reports 	15
Michael Hostetler* Vice President of Program Integrity	 Data Analytics Director Leads the development and ongoing enhancement of our data analytics and algorithms Explores new opportunities based on improper payment findings in other states 	20
Henry Lefcourt Director of Improper Payment Recovery Services	Manager of Financial/Billing Analytics Provides data mining, investigations, and analytics support, with focus on financial audits	15
Data Analysts	Data Analysts Provide sampling analysis to identify potential improper payments across multiple provider types	5+
PROVIDER RELATIONS		
Niki Love Provider Relations Director	 Provider Communications Director Oversees Provider Relations department, ensuring compliance with contract requirements and provider information needs Implements state/program-specific requirements, including provider inquiry response, provider webbased portal training, call center protocols, document-handling procedures, and provider education and communications 	20
Deborah Smith Provider Relations Director	 Provider Relations Director Oversees all provider relations efforts Handles escalated provider complaints/issues 	5
Director	 Ensures that representatives are knowledgeable of BMS's regulations, procedures, and audit issues 	



HMS Team Member/ Title	Area of Responsibility/Role	Years of Related Experience		
AUTOMATED REVIEW AND I	AUTOMATED REVIEW AND RECOVERY OPERATIONS			
Christie Watson, CPA, CFE* Program Audit Manager	 Automated Review Director Develops and manages operational structure of overpayment and audit processes Develops and maintains audit tools, letters, and reports Creates, implements, and monitors formal communication and risk mitigation plans Responsible for monitoring all contractual activities Oversees all operational aspects of the project, including QA, communication with the client, and reporting Guides Contract Management team during project implementation Provides oversight of automated audit services and 	16		
	resources			
QUALITY ASSURANCE AND	TRAINING			
Shelia Green, CPC, CPCH, CHC* Implementation Manager	 Quality Assurance Supervisor Responsible for monitoring all contractual activities Oversees all operational aspects of the project, including QA, communication with BMS, and reporting 	13		
MEDICAL REVIEW/UTILIZAT				
Jan Cary Kletter, MD* Project Medical Director	 Project Medical Director Provides clinical leadership and medical oversight Performs clinical reviews and coordinates physician clinical review activities Advises on clinical issues including utilization review, quality of care, and broader healthcare trends 	31		
Physician Panel	 Physician Reviewers Perform medical record review regarding issues of medical necessity, resource utilization, standard of care, and overall quality Provide guidance on clinical issues 	40+		
Lila Holland, RN, CPHQ* Senior Nurse Manager	 Clinical Supervisor Oversees nurse clinical review activities and ensures timeliness and high quality Coordinates with Medical Director and physician review panel Participates in provider hearings as needed Oversees the hiring and training of Audit staff Ensures that Quality program is followed by all Audit staff Monitors and ensures quality standards 	29		



HMS Team Member/ Title	Area of Responsibility/Role	Years of Related Experience
Clinical Auditors	Clinical Auditors Perform retrospective chart review; collect additional data as necessary to evaluate requests; apply appropriate criteria; use clinical expertise to approve services or refer requests to a physician for review; prepare letters to summarize retrospective review activity; and evaluate, identify, and report on quality-of-care issues	10+
Cathy Powers, CCS Coding Reviewer	 Coding Specialist Reviews billing and medical record documentation to ensure appropriate billing and coding of services rendered Keeps all coding resource files/manuals/documents used by HMS up to date 	19
Michelle Armstrong, CPC, CPC-C Project Manager	 Coding Specialist Performs coding analysis validation of selected review targets Performs coding documentation reviews for automated reviews for which the provider requests a reconsideration Performs QA reviews on coding-related findings Coordinates with Medical Director on reconsideration and appeals as appropriate 	28
Various Coding Specialists	Various Coding Specialists Coding specialists perform medical record reviews to ensure appropriate billing and coding of Medicaid accounts	5+

* Key personnel



2.4.3.5 Approach to staff retention and ensuring continuity of staff; and

Maintaining Appropriate Staffing Levels

HMS is committed to assigning the appropriate number of qualified and appropriately licensed personnel to this engagement, and we understand that the staffing level may fluctuate based on the number of claims and types of providers that BMS requests and approves for audits. We have a pool of experienced and talented employees from which to draw should the scope of work expand or if an assigned Project team member is unavailable to meet his/her responsibilities in support of this contract. As needed, we will quickly and efficiently realign our staffing resources in order to meet the needs of the RAC project.

As indicated in the project staffing tables provided in **Response 2.4.3.4**, we have assembled a core team to fulfill all project requirements, and we are aggressively seeking highly qualified candidates for the positions marked on the project organization chart as "In Recruitment."

As a large organization that operates successfully in many states, HMS has established successful processes to recruit qualified local personnel, minimize employee attrition, train both new and long-term employees, and quickly and efficiently adjust personnel resources so no engagement suffers if a Project team member leaves the company or is otherwise unavailable to meet his/her project responsibilities. We are a national organization with a national reach, and we have established a reputation as a fair employer offering competitive wages, an exciting and challenging work environment, and advancement opportunities. Our reputation considerably assists our efforts to attract highly qualified new talent. HMS is committed to providing equal employment and individual advancement opportunity to all job applicants and employees without regard to race, creed, color, national origin, sex, age, medical condition, disability, veteran or marital status, sexual orientation, citizenship status, or any other unlawful criteria.

2.4.3.6 Approach to personnel management, including a process for transitioning essential knowledge to BMS' staff.

Orientation, Training, and Monitoring of Review Staff

HMS employs quality review measures to ensure the overall quality and effectiveness of our review process and results, including the work of our Review and Audit teams. HMS maintains multilayered quality control procedures to ensure that our reviewers/auditors conduct onsite and desk reviews in an appropriate and compliant manner and to verify that the findings from each review are and remain consistent, complete, accurate, and defensible.



Orientation of HMS Review Staff

Newly hired HMS staff undergo a comprehensive orientation, including training on HIPAA security and compliance, Medicaid policy, West Virginia and federal regulations, HMS's corporate business philosophy, job-specific policies and procedures, and the use of HMS proprietary tools and applications. HMS evaluates newly hired or newly promoted employees as they undergo training, measuring their job performance based on qualitative and quantitative metrics and providing feedback. Depending on the job training process for a particular position, Review staff often shadow a more experienced team member as they receive formal training on procedures and protocols.

To ensure that Review staff can deliver top-quality results for BMS, initial and ongoing training efforts focus on:

- Knowledge training
- ► Skills training and practice
- ► Testing to ensure skills/knowledge mastery
- Performance feedback
- Individual coaching
- Mentoring program

After the initial training, supervisors monitor work closely to ensure that quality standards continue to be met. After the orientation period, we continue to monitor the performance of Review staff and refer them for retraining and improvement planning when deficiencies are noted.



HMS Review staff must consistently meet our high quality standards, ensuring that we deliver excellent results to our clients. We know that a well-trained staff will produce high-quality results for BMS.

Training of HMS Review Staff

All of our staff, including new hires and experienced staff, have the expertise required to deliver exceptional service to BMS. HMS will tailor our training curriculum to meet BMS's project requirements, emphasizing best practices and knowledge acquisition at every stage, to keep our staff current with West Virginia and national Medicaid program, process, and policy changes.

HMS has years of experience in creating effective and comprehensive Training programs. We offer an effective and targeted Training program to new and experienced staff to ensure that they remain current on industry practices. Upon hire, we assess learning needs, and experienced staff train newer employees regarding company policies and procedures, contract requirements, regulations, and rules as well as position-specific duties. HMS provides comprehensive training to all staff as their duties change or new services are offered. Staff receive specific job-related training on a continual basis to ensure that they can adequately perform all job requirements.

For example, we thoroughly train nurse reviewers in data abstraction, a goal that is supported in part by use of a nurse reviewer Training Manual. HMS's project managers will ensure that this training is



adequate. Upon hire, all initial work completed by a nurse reviewer and/or coder will be monitored by an experienced reviewer to ensure that the new employee is performing his/her work duties correctly.

Job specific training is two-pronged, focusing on both project- and job-specific knowledge. Clinical and Coding Review staff are trained in West Virginia coverage policies, rules and/or regulations, and coding policies; West Virginia health practitioner regulations; and the tools and systems that support quality decisions. In addition, they receive ongoing training on accessing information needed to review claims, including:

- ICD-9/ICD-10/CPT/HCPCS coding references
- CPT Assistant (online)
- ► HHS WinStrat (online)
- Coding Clinic Online
- ► InterQual and/or Milliman Online
- ► 3M Grouper
- ► APC Grouper (HMS proprietary)
- 3M coding/coverage tools; and various commercial coding publications (e.g., DRG Desk Reference, Coding Desk References, Uniform Billing Editor, and Facility Guide to Interventional Radiology)

HMS routinely monitors changes in industry standards, updates manuals and procedure documentation, and provides timely information to Review staff to ensure that they stay current with guidelines, annual updates, and relevant coding and practice issues.

In addition to monthly publications to support training for the Complex Review team on new coding updates and CMS guidelines, self-assessment exams evaluate comprehension and competency. Team members attend local and national coding organization conferences (e.g., American Academy of Professional Coders, American Health Information Management Association, and AMA) to stay up to date on guidelines, annual updates, and relevant coding issues.

Financial Audit staff also receive specialized training targeting West Virginia rules and regulations, documentation, HMS's audit procedures, and financial reporting requirements. Training also addresses maximizing the identification of credit balance dollars owed to Medicaid agencies, expediting refunds, and identifying additional recovery targets.

Monitoring of HMS Review Staff

HMS's practice is to assign individuals the role of evaluating and monitoring staff performance. Our project management, data analysts, clinical and coding professionals, and other Audit staff all must meet HMS standards of practice and are evaluated periodically based on the nature of their work. In all cases, a



supervisor or the quality control manager provides feedback about quality improvement immediately and clearly either verbally or in writing, depending on the issue, required response, and whether the issue is a repeat of a prior issue.

HMS evaluates **Project Management staff** through a protocoled PeopleSoft process on at least an annual basis to review project and professional performance, set new performance measures and goals, and provide meaningful feedback on performance and career development. The employee's direct supervisor performs these reviews. Evaluation of our **Project Data Analysis staff** occurs frequently and regularly by direct supervisors. Based on the frequency and scope of reviews, Analytical staff are measured against HMS internal benchmarks and quality standards, including the validity of results and appropriateness of targets. Because of the nature of their work, **Clinical, Coding, and other Audit staff** are evaluated more frequently, receiving input from peer review committees, interrater reviews, and Clinical staff. Our process for monitoring project Review staff is described below.

To ensure that all reviewers continue to meet appropriate quality standards, HMS will deploy at least two types of internal staff performance audits.

Individual Reviewer Audit

Reviewer audits are an examination of the work of each medical review professional:

- We employ a rigorous Training program to educate new staff on HMS review and audit protocols.
- New hires are tested on reviews until satisfactory performance metrics are met.
- Reviewers with identified quality problems are placed on review until acceptable standards are met.



Each auditor undergoes monthly random sample reviews during ongoing operations.

Interrater Reliability Audit

As noted above, HMS IRR audits are used to comparatively assess professional reviewer decisions and to achieve a high rate of consistency.

The most important component of our quality control process is the day-to-day QA checks that we perform on our reviewers' findings. Our internal QA staff audit the determinations made by the reviewers to ensure that they are consistent with BMS reimbursement policy and that the identified overpayment amount is accurate. A failed finding is sent back to the reviewer with a clear explanation of why it failed the QA check. The responsible reviewer is required to review the claim again and, if appropriate, to contact the provider to obtain additional information. We maintain ongoing work quality data for each

HMS's thorough quality control process ensures that Review staff maintain individual and group consistency to ensure that our findings are defensible, thus reducing appeals.



auditor and monitor both short- and long-term trends to ensure that error rates are within an acceptable range.

In addition to the ongoing quality control procedures described above, our senior reviewers accompany auditors to onsite reviews on an intermittent basis to ensure that the reviews are conducted according to established HMS protocols. This layer of quality control focuses on the professional conduct of auditors and their interactions with stakeholders, a component of the process that cannot be assessed solely through a review of work product. In addition, the senior reviewer assesses the accuracy and thoroughness of the review to ensure that reviews are conducted in full, maximizing the results for BMS Medicaid.

HMS collects and reports reviewer activity statistics to our Quality Management committee. Quarterly reports document the percentage of cases that we refer to a physician reviewer and the resulting approval and denial rates for each physician. This helps us determine the reviewer's effectiveness in selecting cases for physician review and that appropriate procedures and admissions are being selected for review.

In addition, we have a comprehensive IQC program to ensure that all physician reviewers are performing above expectations. HMS pulls a randomly selected sample of physician review cases every six months for peer review. We identify and address any training needs at this time. We also review every record that a physician reviewer returns to us against measure quality indicators. If we identify a performance deficiency, we develop, initiate, and reevaluate a quality improvement plan with direction from our Medical Director to correct the problem. HMS removes from the panel physicians who are either unwilling or unable to correct deficiencies.

Finally, we require that each HMS clinical or coding QA auditor be a Certified Patient Account Technician in order to ensure a basic level of competency in each auditor's understanding of provider patient accounting, which we view as the foundation for effective onsite and desk reviews.

Training BMS Staff

HMS will extend training sessions to designated BMS staff, as appropriate, to ensure that they have the information and training required to access and operate HMS's proprietary tools and systems related to this RAC engagement. HMS can provide training on how to maximize the value of our online tools, such as how to access and generate claims status and recovery reports through eCenter, how to determine the status of cases relating to improper payment identification and recovery, and how to use the systems.

Additionally, HMS has training materials and programs for HMS and BMS personnel that will improve MMIS, properly adjudicating the claims resulting from our RAC audit findings.

We provide training at an introductory level or more advanced level at which we explain in detail how to maximize the value of our technology resources and how they benefit all program stakeholders. All training will be conducted by qualified and experienced trainers who understand the material as well as the HMS services provided to BMS.



2.4.4 The Vendor should provide examples of reports produced for similar overpayment recovery and underpayment identification projects.

Reporting

HMS offers BMS a robust solution for tracking and managing the improper payment identification process, carefully and accurately documenting audit tasks and results throughout the contract term. We have worked extensively with state government clients and have a clear understanding of the types of reporting that the West Virginia Medicaid program needs to manage the process, participate in the process as desired, and comply with federal reporting requirements.

We can customize our reports. In addition to the menu of standardized and client-specific reports available on demand, HMS can create other reports in accordance with BMS's needs on an ad hoc basis and run them when required or incorporate them into our standard reporting menu.

HMS will submit reports to BMS in accordance with Section 6411(c) of the Affordable Care Act (ACA), which requires CMS to report to Congress on the effectiveness of the new state Medicaid RAC programs. The reports that we will provide are described in **Exhibit A-40**. HMS's reporting plan complies with CMS' recent guidance on performance measurement reporting, which includes:

- Number of audits by provider type
- Number of claims
- Dollar value of overpayments identified by provider type and total
- Number of overpayment notifications made to providers
- Dollar value of overpayments collected
- Dollar value of underpayments identified by provider type and total
- Number of overpayment notifications made to providers
- **Dollar value of underpayments restored**
- Number of appeals
- Dollar value of claims appealed
- Number of appeals decided in the provider's favor
- Dollar value of overpayments overturned
- Administrative cost
- Number of fraud referrals from RAC work



Rec	quirement	Description	HMS Complies
(1) Monthly Reports	The Vendor should submit monthly reports outlining work accomplished during the previous month. Monthly reporting formats are to be approved by BMS. These reports should include the following:		
		Identification of the number of cases with overpayments by review name, i.e., upcoding office visits to include total dollar amount identified, number of claims involved, number of providers involved, amounts to be refunded, and percentages	
		 Reports of underpayments to include total dollar amount identified, number of claims involved, number of providers involved, amounts to be refunded, and percentages 	
		 Identification of the number and type of letters sent to providers (e.g., demand letters and record requests) 	
		 Identification of number of new appeals by review name and update outcomes of appeals for month 	\checkmark
		Ad hoc reports as needed by BMS staff at no additional cost	
		 Identification of the number of providers submitted to BMS for fraud/abuse referral 	
		 Meeting summaries for all meetings conducted between Contract and BMS staff for approval. 	
		 Type of approved provider education referred to Fiscal Agent for completion and issue 	
		 Number of pending reviews awaiting approval at BMS 	
		 Numbers of provider address changes and confirmation of notification to Fiscal Agent for update. 	
(2)	Quarterly Reports	The Vendor should submit quarterly reports summarizing work accomplished during the previous quarter. Quarterly reporting formats are to be approved by BMS. These reports should include the following:	
		 Quarterly Work Plan Progress Reports. These are narrative reports specifying benchmarks, problems, and proposed solutions. 	\checkmark
		Status report containing summarized data from the monthly reports as well as any aberrant issues identified. This report should be presented and discussed at scheduled in-person meetings or telephonically, depending upon the urgency or the issue.	
(3)	Annual Reports	The Vendor should submit annual reports summarizing work accomplished during the previous State Fiscal Year. Annual reporting formats are to be approved by BMS. These reports should include all audits (by agreed-upon name/issue) in process and completed during the previous year and consist of an aggregate of all quarterly reports as well as any recommendations by the contractor for future reviews, changes in the review process, potential system or policy vulnerability, or any other findings related to the review of claims for fraud, waste, or abuse.	~
(4)	Final Executive Summary Report	The Vendor is to submit a final report consisting of an aggregate compilation of the data received in the quarterly reports as well as a narrative describing the following:	
		 Recommended changes to internal controls and/or policy modifications to minimize erroneous payments; 	\checkmark
		 Results of each approved audit work plan 	
		Monies recovered to date and the contractor share of those recoveries	



Requirement	Description	HMS Complies
(5) Weekly Project Status Conference Calls	Select members of the Vendor's key staff (as approved by BMS) are to participate in weekly strategy/problem-solving conference calls with the BMS OQPI director or designee(s). These calls are to commence upon contract execution and will be held on a BMS/Vendor mutually agreed- upon schedule. The Vendor is to be responsible for setting up and facilitating the conference calls, preparing the agenda, documenting the minutes of the meeting, and preparing any other supporting materials as needed.	\checkmark
(6) Monthly Project Status Conference Calls	Select members of the Vendor's key staff (as approved by BMS) are to participate in monthly project status conference calls with the BMS OQPI director or designees(s). This monthly meeting will be facilitated by the Vendor to present the Monthly Reports (Deliverable No. 1, described above). The calls will commence upon contract execution and will be held on a BMS/Vendor mutually agreed-upon schedule. The Vendor is to be responsible for setting up and facilitating the conference calls, preparing the agenda, documenting the minutes of the meeting, and preparing any other supporting materials as needed.	\checkmark
(7) Quarterly Meetings	Select members of the Vendor's key staff (as approved by BMS) are to participate in quarterly meetings with the BMS OQPI director or designee(s). This meeting will be held to present the Quarterly Reports (Deliverable No. 2, described above) and is to include, but not be limited to, the following topics: review of tracking activities and discussion of issues, problems, suggested solutions, relevant findings, trends, special study projects, and enforcement challenges due to regulation or policy weaknesses. The Quarterly Meetings will commence upon contract execution and will be held on a BMS/Vendor mutually agreed-upon schedule. The Vendor is to be responsible for setting up and facilitating the meetings, preparing the agenda, documenting the minutes of the meeting, and preparing any other supporting materials as needed.	✓
(8) Operational Letters	The Vendor is to produce provider notification letters, such as RRLs, draft demand letters, final demand letters, and notifications of findings and documentation of support of appeal. The Vendor is to bear the cost of the production and mailing of all operational letters.	\checkmark
(9) Turnover and Close-Out Management Plan	The Vendor is to provide a plan detailing the approach to transitioning systems and operational responsibilities to a successor RAC vendor.	\checkmark

As a data-driven company, we know how to develop the specialized, tailored reports required to manage the improper payment and recovery process. We currently provide accurate, detailed, and timely reports to state, federal, and commercial clients across the nation. Our reporting capabilities are robust, meeting end-to-end requirements and reporting all case-related elements. Comprehensive sets of standard reports are part of each Audit Identification and Recovery program. Additionally, upon contract award, we can discuss customizing reporting needs to meet BMS's requirements. Reports can be generated at many different time intervals along with summary reports based on contract year or fiscal year time horizons.

HMS will deliver detailed transaction level reports on all recoveries and outstanding overpayments and on underpayments at the frequency and in the media required by BMS. **Our experience in operating under contingency fee-based recovery contracts sets us apart from other vendors who may not have**



experience in processing and reporting collections from providers. HMS understands the unique data requirements of Medicaid programs, how Medicaid recoveries are accounted for, and the types of information that may be needed for not only updating the MMIS but also reporting to CMS and state accounting systems.

Our customizable reports capture all of the data elements necessary to update claims in the MMIS and provide documentation for state and federal auditors. Itemized claim reports can be made available on demand through the HMS system or as a separate deliverable in a format specified by BMS. Our client-driven recovery reports provide detailed and accurate payment and adjustment information at the claim-line level. HMS can report the full history of payments and adjustments applied to claims in the data set received from BMS.

HMS status and results reporting is anchored by PIE, our claims tracking and case management database. PIE contains all of the claims identified by the project, and for each claim, we maintain extensive data elements that enable tracking and reporting on status, results, event status and dates, and virtually all activity/information related to the identification, verification, and recovery process. **Exhibit A-41** lists some of the data elements in PIE that facilitate tracking and reporting.

Project Code	Type of Over/Underpayment Data Routine
Select Reason	Reason the claim was selected for review/recovery
Select Detail Code	Detail reason code that provides specificity as to why the claim was selected and is used to assign text and regulatory references to letters and reports
Select Amount	Estimated over/underpayment amount at the time of selection
Review Type	Automatic or complex review
Workflow ID	Code designating the workflow to be applied to the case
Case Status/Date	Open, Closed, Suspend and date
Case Result/Date	Current result and date
Last Stage Completed/Date	Last workflow step completed and date
Current Stage/Date	Current workflow step and due date
Next Stage/Date	Next workflow step and date
Over/Underpay Amount	Over/underpayment amount
Appeal Status/Date	Status of appeal and date
Appeal Stage/Date	Stage of appeal and date
Appeal Amount	Amount after appeal
Collection Type	Type of collection (check or recoupment)
Collection Status/Date	Status of collection effort and date
Collection Stage/Date	Stage of collection effort and date
Collection Amount	Amount collected
Collection ID Number	Check number or other ID related to recovery

Exhibit A-41 > Data Elements Tracked in PIE



Project Code	Type of Over/Underpayment Data Routine
Invoice Status/Date	Status of the invoice related to recovery and date
Invoice Stage/Date	Stage of the invoice related to recovery and date
Invoice Amount	Amount invoiced/received
Invoice Transaction ID	Check number or other ID related to recovery

In addition to reporting through PIE, HMS can transmit electronic versions of each report to BMS via secure email or other transmission protocol. We provide reporting details that we produce for other clients below. Samples are shown at the end of this section.

Sample HMS RAC Reports

HMS will provide all reports requested by BMS during the contract period. The reports that we produce for Medicaid clients are generally custom reports since each program often needs different data elements or even report titles. As a result, HMS has developed the ability to easily customize and generate both production and ad hoc reports. **Exhibit A-42** describes some of our standard activity, status, and claims tracking reports. Sample reports are included following the exhibit.

Report Name	Content	Value to BMS	Frequency of Generation/ Delivery
Summary Activity	Describes the activities for the month, including analyses performed, reviews conducted, and appeals processed	Enables summary review of all audit/review activity for the month, including the volume of claims/ charts reviewed and resources expended	Monthly
Recoveries Detected	Identifies the quantity of claims identified during the month along with the source/ process of identification	Monitors the quantity of recoveries identified and the processes used to identify them	Monthly
Fraud and Abuse Issues	Identifies the specific cases, along with facility-, provider-, or member-related information, that may indicate patterns of fraud/abuse	Tracks cases in which data analysis and/or review indicate fraud/ abuse and need further follow-up from State personnel	Monthly
Overpayments/ Underpayments by Provider	Identifies the specific payments, along with facility-, provider-, or member-related information, where either an overpayment has occurred and BMS can expect a recoupment or an underpayment has occurred and correction is required	Allows the State to examine the details related to specific over/ underpayments that have been identified	Monthly

Exhibit A-42 > Sample RAC Activity, Status, and Recovery Reports



Report Name	Content	Value to BMS	Frequency of Generation/ Delivery
Activities Requiring Department Action	Identifies specific cases in which HMS is requesting action by the State	Highlights cases for which State resources or actions are needed to resolve issues found during audit activity	Monthly
Appeals Summary	Identifies cases that have been submitted by providers for appeal; includes case identification and financial impact	Tracks provider appeals	Monthly
Facility/Provider Education	Summary of provider education activities for the month	Assists BMS in tracking outreach efforts to provider community to mitigate and prevent future billing/coding and payment issues	Monthly
Trends Observed/ Miscellaneous Issues	Identifies any other issues or concerns that HMS has identified that should be brought to BMS's attention; documents any emerging trends or patterns that HMS has observed during the month	Provides process reporting and tracking of any items that do not fit easily into other reporting sections	Monthly
Regulatory	Assists BMS in generating regulatory reports for other state or federal government agencies	Fulfills regulatory reporting requirements	As needed

RAC Service Reports

HMS will provide draft samples of all proposed reports to BMS for review and comment during the implementation phase of the contract term. New reports can be requested at any time by BMS.

Sample report content appears in Exhibits A-43 through A-50:

- **Exhibit A-43:** Summary Activity
- **Exhibit A-44:** Recoveries Detected
- **Exhibit A-45:** Fraud and Abuse Issues
- **Exhibit A-46:** Overpayments/Underpayments by Provider
- **Exhibit A-47:** Activities Requiring Department Action
- **Exhibit A-48:** Appeals Summary
- **Exhibit A-49:** Facility/Provider Education
- **Exhibit A-50:** Trends Observed/Miscellaneous Issues

















2.4.5 The Vendor should describe their data validation processes including acceptance of electronic medical records from providers.

Ensuring Data Validation

HMS has a long history of data interaction with BMS. Because HMS currently receives and processes data from BMS on a regular basis, we anticipate few modifications to our base system; our systems are flexible enough to ensure a smooth transition with any MMIS vendor.

Throughout our process, we review and validate the quality of the data received, including verifying that:

- ▶ All of the required data elements are included
- ► All of the required fields are populated with expected values
- ▶ The values in each required data field are valid

HMS reviews the data transmission process to ensure that it functions appropriately. For this engagement, we will validate the following:

- Electronic Data Interchange protocols were correctly set up in terms of the State's requirements
- ▶ The data loaded into the appropriate directory
- ► All components of the transmission were completed

At HMS, the validation, mapping, and testing of data is an ongoing process since data is so crucial to our business. We receive more than 150 million claims per month from more than 170 different payer programs. Accurate intake and understanding of claims data is a central component of our business processes, and we have developed extensive systemic and operational processes that efficiently and accurately control the request, receipt, copying, validation, processing, organization, and QA of client data. We have invested tens of millions of dollars developing and enhancing HIPAA-compliant, SSAE 16 (formerly Statement on Auditing Standards 70)–audited technology and infrastructure that enables us to effectively secure, store, back up, and access that data. HMS takes great pains to ensure the integrity and validity of the data that we use to identify improper payments because we know how incorrect or incomplete data can lead to inferior results.

Acceptance of Medical Records and Quality Control

Our quality control process reviews all scanning and indexing results to ensure that documents are appropriately indexed to each case. Quality control is an ongoing process that is performed in near real-time while the documents are being scanned and indexed. Because our imaging system, ImageNow, can distribute the output of the capture/index process to multiple machines, quality control can occur immediately after, or even simultaneously with, the scanning and indexing process. Thus, HMS Quality Control staff can check a batch of documents that has been scanned while the next batch is being scanned and indexed.



2.4.6 The Vendor should describe the proposed approach to the completion of the project turn-over and close out phase. Components should address the following:

2.4.6.1 Turn-over and close-out management plan; and

2.4.6.2 Relationship management plan with successor.

Turnover and Closeout Management Plan

HMS's approach to project turnover enables flexibility and the ability to accommodate BMS and other affected stakeholders. HMS assures BMS that we will make the turnover process as professional and efficient as possible. The HMS Project Management team and senior Operations staff will take the lead on the transition to ensure that we appropriately handle all aspects of the effort at the end of the contract.

HMS has experience in transitioning operational units, methodologies, files, and processes back to state Medicaid agencies after the HMS contract period. In order to expedite BMS's ability to continue generating results for its programs, HMS staff will turn over all relevant procedural, systems, and operations manuals and provide training sessions as part of the turnover process. Further, we will meet with State-designated staff to ensure that all processes are fully transitioned.

Upon receipt of notification of BMS's intent to transfer contract functions, HMS will provide a turnover plan that will include the following:

- ► A schedule of the transition timeline and meetings with BMS
- A list of action items from the turnover planning meeting
- ► The necessary turnover documentation
- ▶ Transfer of Medicaid documents to BMS or its designated agent

HMS will produce deliverables in an organized manner according to reasonable and customary standards and to ensure a thorough and smooth transition with limited interruption. Upon turnover, the deliverables will be in a form and condition satisfactory to BMS and submitted within the time frames specified by BMS staff.

Transition and Relationship Management Plan

HMS has had the privilege of sustaining a beneficial relationship with BMS and the vast majority of our clients. However, we have occasionally transitioned projects back to our clients or to new vendors at the end of a contract period while minimizing the disruption of service to our clients. Our team consists of operations professionals who will ensure that the operations of this project will migrate seamlessly from us to BMS or a new contractor. Members of our team will also actively communicate with all stakeholders to facilitate the transition.

We will create a transition plan in accordance with the requirements of this RFP and submit it to BMS within 120 days of contract award. The plan will address the items in **Exhibit A-55**. After contract award, we will review our transition plan activities with BMS and make any modifications to the plan as directed.



Exhibit A-55		HMS's	Transition	Plan	Components
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Transition Plan Components	Included in HMS Transition Plan
Coordination of RAC services including how services will be maintained throughout the transition process	✓
Tasks and subtasks for transition	✓
Schedule for transition	✓
Operational resource requirements	✓
Training requirements for transition including how and when training will be provided	✓
Staff identified for the transition process including their qualifications	✓
Data conversion requirements from the Contractor to BMS or a new contractor	✓
Transfer of data to BMS or a new contractor	✓
Transfer of documentation, files, or other records	✓
Provide for the transfer of any current comprehensive policy and procedures manuals, and all other written materials developed in support of contract activity to BMS	✓
Plan for cooperation during transition with BMS and a new vendor	\checkmark
Release and transfer the toll-free telephone number(s) to BMS or a successor contractor upon termination of the Contract	✓

Ensuring That Services Continue with Minimal Interruption

HMS assures BMS that it will continue to receive the superior service, qualified support, and exceptional recovery efforts that we have already demonstrated during any project transition. Effective coordination is critical to any successful transition.

It has been HMS's experience that performing a transition in a phased manner, rather than all at once, can ensure that services and recoveries are maintained during the switchover. HMS will work closely with BMS and any designated new vendor during the transition period to help minimize any potential service interruptions. Furthermore, it is HMS's position that BMS or the new vendor should have input into this coordination effort, which would better provide HMS with guidance about the volume of work that they can handle and further ensure a smooth transition.



Attachment B: Mandatory Specification Checklist

List mandatory specifications contained in Section 2.5:

Mandatory Requirements

2.5.1 The Vendor must comply with requirements listed in Attachment D: Special Terms and Conditions.

HMS affirms that we will comply with all of the requirements listed in Request for Proposal (RFP) Attachment D: Special Terms and Conditions.

2.5.2 The Vendor must supply all deliverables as described in Attachment E: Deliverables, comply with reporting requirements listed in Attachment F: Medicaid RAC Performance Metrics and perform according to approved Service Level Agreements (SLAs) listed in Attachment G: Service Level Agreements of this RFP.

HMS will supply all of the deliverables described in RFP Attachment E: Deliverables and will comply with the reporting requirements listed in Attachment F: Medicaid RAC Performance Metrics. We will also provide services based on the approved Service Level Agreements listed in Attachment G: Service Level Agreements.

2.5.3 The Vendor must agree that all written material, including reports and letters must be approved by the Bureau in advance of planned distribution. The Vendor shall provide copies of all findings to the BMS Office of Quality and Program Integrity (OQPI), coordinate with case development and attend regularly scheduled presentations occurring at a minimum on a monthly basis with BMS staff or any other related meetings as requested including requests to attend a minimum of two (2) face to face meetings per contract year.

HMS agrees that all written material must be approved by BMS prior to distribution. We will provide copies of all finding to the BMS Office of Quality and Program Integrity, coordinate with case development, and attend regularly scheduled presentations occurring at a minimum on a monthly basis with BMS staff or any other related meetings as requested, including requests to attend a minimum of two face-to-face meetings per contract year.

2.5.4 The Vendor must furnish all necessary services, personnel, materials, equipment, and facilities, as needed to perform the work of the resulting contract within the continental United States.

HMS will furnish all services, personnel, materials, equipment, and facilities required to perform the work of the contract within the continental United States.

West Virginia Department of Health and Human Bureau for Resources Medical Services / Request for Proposal MED13001 Attachment B: Mandatory Specification Checklist



2.5.5 The Vendor must comply with all current and future State and Federal regulations relating to the Medicaid Recovery Audit Contractors Program including performance metrics not yet finalized by CMS and all reporting necessary for Federal claiming. A copy of the Federal Regulation is provided in Attachment H.

HMS will comply with all current and future state and federal regulations related to the Medicaid Recovery Audit Contractor (RAC) program, including performance metrics not yet finalized by CMS and all reporting necessary for federal claiming. HMS has read the Federal Regulation in RFP Attachment H, and it is our practice to stay abreast of the laws and regulations related to the services that we provide.

2.5.6 The Vendor must hire a minimum of 1.0 Full Time Equivalent (FTE) Contractor Medical Director who is a Doctor of Medicine or Doctor of Osteopathy in good standing with the State licensing authority in which their license is issued and provide a copy of the license with the proposal response.

Jan Cary Kletter, MD, FACS, MS, our West Virginia–licensed Project Medical Director, will lead our Clinical staff and oversee their audit activity. Dr. Kletter has more than 31 years of experience in healthcare as a general surgeon. He is board certified in General Surgery and has been in good standing with the West Virginia Medical Board since 2000. In 1997, Dr. Kletter received certification from The American Board of Quality Assurance and Utilization Review Physicians, and in 1999, he earned a degree in Health Administration. As the Project Medical Director for the BMS RAC project, Dr. Kletter will:

- Participate in provider outreach for presentations
- Serve as a readily available source of medical information to guide questionable claim review situations for complex claim reviews
- Recommend when State regulations, provider education, system edits, or other corrective actions are needed or must be revised to address RAC vulnerabilities
- Brief and educate reviewers on the correct application of policy during claims adjudication, including through written Internal Review Guidelines
- ▶ Interact with other contractors to share information on potential problem areas
- Be available to discuss the RAC program and/or specific claims or initiatives with the West Virginia provider community

Dr. Kletter is in good standing with the West Virginia licensing board, and a copy of his license is provided in **Appendix 2** of this proposal.

2.5.7 The Vendor must hire a minimum of 2.0 FTE Contractor certified coders and provide proof of certification.

HMS has named the following certified coders as key staff members for this engagement. Coding certifications for Ms. Powers and Ms. Armstrong are provided in **Appendix 2**:



- Cathy Powers, CCS, Coding Specialist, has more than 19 years of experience in performing billing and documentation reviews to ensure appropriate billing and coding of services rendered. Ms. Powers will also perform retrospective chart reviews; collect additional data as necessary to evaluate requests; apply appropriate criteria; use clinical expertise to approve services or refer requests to a physician for review; prepare letters summarizing retrospective review activity; and evaluate, identify, and report on quality of care issues.
- Michelle Armstrong, CPC, CPC-P, Coding Specialist, has more than 28 years of experience in performing inpatient and outpatient hospital coding and professional services coding of healthcare claims. She will perform billing and documentation reviews to ensure appropriate billing and coding of services rendered. Additionally, Ms. Armstrong will help to maintain HMS's coding resource files, manuals, coding policies, and documentation.

2.5.8 The Vendor shall assist the Bureau in defense of findings at any provider hearing and/or appeals held in connection with recovery efforts. The Vendor shall have in their possession written documentation that supports the basis for the recoupment. This material along with SMEs will be made available for defense of findings at any level of the administrative appeals process.

Reconsiderations and Appeals

HMS recognizes that BMS has a legal requirement to provide due process to providers when they are notified of improper payments and related negative determinations and will work with BMS to adhere to required time frames for giving those providers an opportunity to appeal and provide additional documentation regarding an IPN letter.

HMS brings 27 years of experience with appeals for many Medicaid agencies, managed care organizations (MCOs), health plans, and other clients, including attending or providing support through the various fair hearing, administrative hearing,



presettlement, and preappeals processes. HMS will comply with all provider appeal processes defined by the State as described in the West Virginia Provider Policy Manual. We will work closely with the State to ensure that we execute the process per BMS requirements.

HMS Provides Support throughout the Appeal Process

HMS will provide support to the Bureau or its authorized representatives throughout all levels of an appeal. We will also provide comprehensive support to the State in response to any other litigation or dispute resolution associated with our Medicaid RAC services. Appeal support will include, as appropriate:

> Preparation and submission of all supporting documentation

West Virginia Department of Health and Human Bureau for Resources Medical Services / Request for Proposal MED13001 Attachment B: Mandatory Specification Checklist



- Organization and presentation of references to applicable Medicaid statutes, regulations, manuals, and instructions
- Court appearances
- Hearing appearances

To comprehensively support appeals submitted from providers, HMS will apply our extensive audit finding appeal experience and resources. We understand that the goal of the appeals process is to efficiently allow an opportunity for reconsideration when a provider disagrees with the results of our overpayment analyses. We fully support providers' right to appeal our findings if they believe that HMS has erred when reviewing submitted documentation. As appropriate, we will apply our appeals response processes and resources to support those established by BMS.

Our review managers and clinical reviewers routinely participate in hearings as required. HMS is accustomed to contributing to prehearing conferences as well and will work with BMS and its attorney to meet all requirements relating to our participation in the hearing process for this contract. In addition, HMS has experience in providing witness testimony services for our clients. Our staff resources will be available to answer questions, explain the review process and rationale for the determination, and otherwise defend the determination that we made.

We recognize that providers may appeal decisions that have an adverse financial impact on their business, especially when they believe that they are in compliance with regulations. HMS agrees that a case is not closed until either the time to appeal has expired or the appeal has been finalized. We will provide ongoing to support to BMS throughout the reconsideration/appeal and fair hearing processes.

HMS works to forestall and/or resolve provider reconsiderations and/or appeals prior to fair hearings by identifying all discrepancies at the claim level. We make it easy for providers to review every claim for which we identify a recovery.

HMS has achieved a low number of reconsideration and appeal requests by providing sufficient information to support our decisions and corroborating that qualified experienced personnel conducted a thorough review. Furthermore, HMS ensures that state-specific rules and regulations were applied correctly. We work with state licensure boards, State Attorneys General, and other state Legal staff and know the necessity of maintaining professional clinician and coder support throughout the lifetime of a case. Our thoroughness is a major factor contributing to our low appeal rate for all of our clients, setting us apart from our competitors and limiting the impact of recovery activities on State staff.

In conducting improper payment reviews, our professional staff provide accurate and detailed review determinations, including clinical summaries and other documentation to show why the decision was made. In cases of clinical or coding reviews, each determination letter includes the decision rationale based on nationally recognized guidelines; state-specific rules, regulations, and practice patterns; and the best treatment evidence available. Determinations are written in clear terms that are understandable to both professional and administrative provider contacts.



Low Appeal Volume and Low Overturn Rate

HMS's low appeal rates set us apart from our competitors. Our RAC audit approach results in less work for providers since our decision rationale is clearly reported and less work for the State since there are fewer issues with providers. Even in cases in which a state requests that we implement more aggressive appeal strategies and "denial management" initiatives with providers, our appeal rate remains low.

- In Fiscal Year (FY) 2010, we reviewed more than 12,000 records for Ohio Medicaid, with only a 16.6% reconsideration rate. About 29% of those reconsiderations were reversed because the provider submitted additional information. In State FY 2010, only 138 (1.2%) of our reviews were appealed to the State, and 80% of those decisions were upheld.
- For our Virginia Department of Medical Assistance Services Medicaid program, we received only 7 appeal requests to our more than 7,000 review decisions over a 2-year period. We also have seen a low rate of State overturn decisions, which demonstrates that we are in line with our clients' goals and review processes.
- As a subcontractor to HealthDataInsights in support of CMS' RAC pilot project to perform Medicare postpayment reviews, only 10% of our overpayment decisions were rebutted, and the majority of the rebuttal decisions were upheld following further review. These statistics were superior to those attained by the other RAC vendors. Over the two-year span of our contract, we reviewed approximately 1,250 Florida Medicare inpatient medical records monthly for Diagnosis-Related Group error, the medical necessity of services, and the need for an inpatient stay.

Key aspects of the appeals process include the following:

- Stated requirements in clear language of what forms and types of documentation the provider must submit to be considered for appeal.
- Review of documentation submitted by the provider to determine if newly acquired documentation validates the claim being audited.
- Submission of a response letter to the provider, including notification of the results of the appeal.
- ▶ Working with the provider to reach a resolution of the appeal through an informal process prior to escalation to a fair hearing.
- Escalation of appeals that cannot be resolved through an informal process. HMS's staff will be available to assist BMS with the resolution of these appeals.

2.5.9 The Vendor shall limit their frequency of record requests to no more than 5% of the total claims submitted annually. Percentage will be based upon claims submitted the prior year.

HMS affirms that we will limit the frequency of record requests to no more than 5% of the total claims submitted annually per provider.



2.5.10 The Vendor shall maintain a database with three (3) years claims data. The database will consist of, at a minimum, claim related data, member eligibility data, and related fee with reference tables. The database will include professional claim forms CMS-1500, Standard UB-04 claim forms for inpatient/outpatient services and proprietary claim formats.

HMS's Claims Control Data Base Data Warehouse

HMS has extensive experience in the intake, netting, and warehousing of state Medicaid data. HMS loads all claims data into our Claims Control Data Base (CCDB), which is a secure proprietary DB2-based data warehouse on which our analytics are based that was built by HMS specifically to store Medicaid claims data. The CCDB schema can support all standard claim types (e.g., UB-04, professional CMS 1500, pharmacy, and dental) and Medicaid-specific claim types and data elements required for LTC; Home and Community-Based Waiver services; Early and Periodic Screening, Diagnosis, and Treatment; Medicare crossovers; and MCO premium payments and proprietary claim formats as required or needed by BMS. Our CCDB data warehouse maintains claims at the line level, and for institutional claims, we maintain full revenue charge data for each claim. We can apply both lines and claim-level analytics to the claims.

In addition to standard claim data elements, CCDB supports the storage of adjudication information that is critical to the validation and calculation of improper payments and overpayment amounts, including COB and other third party payment information, reimbursement-related data, prior authorization information, and adjustment/void data elements necessary to appropriately account for rate adjustments and voided claims. HMS fully processes all adjustments and void transactions against prior history, ensuring that claims identified as potential improper payments and/or selected for audit are current and in Paid status. Within our CCDB, HMS can also define state-specific codes that are important to analysis and reporting.

West Virginia will maintain our database for at least three years of claims data including claim related data, member eligibility data, and related fees with reference tables.

Recipient demographics and eligibility data will be loaded to our Eligibility Master File, a database designed to store Medicaid recipient information, including eligibility category, program enrollment dates, managed care plan and enrollment dates, and date of death.

Provider data will be loaded to our Provider Database, which can track multiple IDs, addresses, and contacts for each provider. We can also match provider information in our Provider Database to external files for enhancement or validation of information, to identify excluded providers, and so on.

2.5.11 The vendor shall maintain and preserve all records of recovery effort for a period of five (5) years from the date of final recovery. At the conclusion of the contract all files and records shall be returned to the Bureau within thirty (30) days following close of contract. The Vendor shall be responsible for managing the entire recovery process including the initiation of collection of all identified overpayments, management of all A/R processes and reporting with minimal staff resources required by the Bureau.

HMS will maintain and preserve all records of recovery efforts for a period of five years from the date of final recovery. At the conclusion of the contract, all files and records will be returned to the Bureau within 30 days of the close of the contract. HMS will be responsible for managing the entire recovery process



including the initiation of collection of all identified overpayments, management of all Accounts Receivable processes and reporting with minimal staff resources required by the bureau.

2.5.12 The vendor shall be responsible for the identification, dispute resolution, collection processes and reporting for all RAC recovery and underpayment RAC activities specified in the scope of this contract.

Our solution for BMS is based on robust systems, algorithms, and audit procedures backed by our talented team's understanding of the Medicaid claim environment and ability to validate improper payment scenarios—including those not covered under Medicare RAC programs, such as home health, LTC, hospice, and home and community-based waiver services. Exhibit B-1 summarizes our approach to designing and deploying BMS's RAC program.

HMS's Medicaid RAC solution has helped the State of New York to recover more than \$100 million.

Exhibit B-1, BMS Will Maximize Its RAC Program by Relying on HMS's Customized Solution

The HMS Solution	
	HMS performs a complete review of BMS's scope of work and program components, including systems; state requirements; program data; regulations, policies, and manuals; state codes, administrative rules, provider manuals, and bulletins; Medicaid publications; Code of Federal Regulations (CFR) 42; OIG Exclusion Database; and plans. In addition, we will meet with the various internal and external stakeholders to ensure that we meet BMS's program goals, provide BMS-specific education on program requirements/ processes, and coordinate with other audit efforts.
Detection of Medicaid Improper Payments	HMS already accurately and securely performs intake of BMS's claims, program eligibility, provider, reference, and other MMIS data. This current activity provides a significant advantage and will allow HMS to expedite the implementation process for BMS. HMS has a well-established, secured method of transmission of all BMS data. In addition, HMS already has data receipt protocols and reformatting in place for BMS's data files, including BMS paid claims. If needed, we will customize these mechanisms for this engagement.
	Working with BMS, we have already interpreted West Virginia's policy, billing rules, and State Plan into our rules engine, and that information is readily available for this engagement.
	While we bring to BMS a standard set of data mining algorithms, we do not stop at the standard list. Using our library of improper payment algorithms, HMS will develop and configure data routines specifically for this engagement. HMS's Regulatory and Reimbursement Research and Development department reviews state and plan regulations and policies to ensure the applicability of each algorithm to the program and to set the appropriate parameters for each algorithm. HMS will seek BMS's approval for the data routines that we will implement for this engagement.



The HMS Solution		
	HMS has the tools and personnel necessary to determine if an over/underpayment occurred. Our experienced staff have years of in-the-field training. Relying on this experience, team members not only review documentation and assess if an improper payment occurred but also identify additional target referrals for other improper payments.	
Automated, Semi- automated, or Complex Reviews: Confirmation of Medicaid Improper Payments	We identify improper payments by conducting automated reviews (no review of documentation) or complex reviews (review of medical record or other documentation). An automated review is used for improper payment claims identified through data analysis routines approved for producing clearly improper payments. For complex reviews, we conduct a thorough review of medical records and other documentation using nationally recognized and West Virginia–specific criteria. A semi-automated review is used when either some additional documentation or information is required from the provider but the full medical record is not needed or the provider is not required to submit the full record. HMS auditors review the documentation to ensure that the claim was appropriately billed. Our reviews are performed through a combination of desk and onsite audits. Our staff, who are trained to identify suspected fraud and abuse, will report any suspected fraud directly to BMS monthly.	
Tracking and Reporting Medicaid Improper Payments	HMS's state-of-the-art case tracking system, Program Integrity Enterprise (PIE), documents the activities of each identified improper payment and generates detailed reports to our clients. BMS will have direct access to PIE. PIE specifically supports the efficient administration of RAC program activities, which eliminates the need to be retrofitted to accommodate evolving Affordable Care Act and CMS requirements.	
Recoupment and Recovery of Medicaid Improper Payments	HMS will work with providers to maximize BMS's collection of improper payments. Our effective approach minimizes administrative burden on providers, and our experienced Provider Relations team is available to communicate with providers throughout the recovery process, address their concerns, and resolve disputes. Our collaborative approach to working with the provider community has been a key component of our ability to consistently achieve a high level of recovery for our clients.	



West Virginia Department of Health and Human Resources Bureau for Medical Services / Request for Proposal MED13001 Attachment B: Mandatory Specification Checklist

I certify that the proposal submitted meets or exceeds all the mandatory specifications of this Request for Proposal. Additionally, I agree to provide any additional documentation deemed necessary by the State of West Virginia to demonstrate compliance with said mandatory specifications.

Health Management Systems, Inc.	
(Company)	(A)
David Dawson, Vice President Government Services Sc	outh hand
(Representative Name, Title)	
214.453.3112 / 469.359.4413	
(Contact Phone/Fax Number)	
_July 23, 2012	

(Date)

West Virginia Department of Health and Human Bureau for Resources Medical Services / Request for Proposal MED13001 Attachment B: Mandatory Specification Checklist



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Attachment D: Special Terms and Conditions

If a Vendor's proposal includes proprietary language and/or personally identifiable information (PII) Vendor employees or subcontractors within the technical proposal, an electronic copy omitting any proprietary language and/or PII, shall be submitted for publishing to the DHHR and BMS web-sites.

Vendor agrees that BMS retains ownership of all data, procedures, programs, work papers, and all materials developed and/or gathered under the contract with BMS.

Compensation Structure

- 1. Fees paid to RACs must be made only from amounts recovered. If the provider enters into a repayment agreement, the RAC payment will be based on the amount of monthly withholdings or collections.
- 2. If a provider appeals a Medicaid RAC overpayment determination and the determination is reversed, at any level, then the Medicaid RAC must return the contingency fees associated with that payment.
- 3. The contingency fee may not exceed that of the highest Medicare RAC, as specified by CMS in the *Federal Register*.
- 4. The highest Medicare RAC as specified by CMS in the CPI-B 12-01 Information Bulletin issued 12/30/11 for the recovery of improper payments made for "medical supplies, equipment and appliances suitable for use in the home" found within the home health services benefit authorized by section 1905(a)(7) of the Social Security Act.

Vendors are to propose their compensation rates using the Cost Proposal Form provided in Attachment C of this RFP

I certify that I have read and acknowledge the additional contract provisions contained in Attachment D and that the proposal meets or exceeds all additional requirements as listed.

 Health Management Systems, Inc.

 (Company)

 William C. Lucia, Chief Executive Officer

 (Representative Name, Title)

214.453.3140 (Contact Phone/Fax Number)

07/19/12

(Date)

Bureau for Medical Services

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 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. 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:	Signed:
Date:	Title:

"Check any combination of preference consideration(s) indicated above, which you are entitled to receive

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

I to alite Management Overlagen Inc.

Vendor's Name: Health Management Systems, Inc.	
Authorized Signature: Date: Date:	6/19/12
State of TEXOS	
County of Dallas, to-wit:	
Taken, subscribed, and sworn to before me this play of Une	, 20 <u>[</u>]
My Commission expires Decembre 10, 2014.	
AFFIX SEAL HERE NOTORY PUBLIC	teller)
WHITLEY L NINO My Commission Expires December 6, 2014	

Purchasing Affidavit (Revised 12/15/09)



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

HEALTH MANAGEMENT SYSTEMS, INC.

a corporation formed under the laws of New York filed an application to be registered as a foreign corporation authorizing it to transact business in West Virginia. The application was found to conform to law and a "Certificate of Authority" was issued by the West Virginia Secretary of State on March 27, 1991.

I further certify that the corporation has not been revoked by the State of West Virginia nor has a Certificate of Withdrawal been issued to the corporation by the West Virginia Secretary of State.

Accordingly, I hereby issue this

CERTIFICATE OF AUTHORIZATION



Validation ID:7WV0W_R8QC5

Given under my hand and the Great Seal of the State of West Virginia on this day of June 01, 2012

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.businessentity.search.validate.appx entering the validate of the secretary of State's Web site. https://apps.wv.gov.sos.businessentity.search.validate.appx entering the validate of the valid and effective issuance of a certificate.

WV.GOV - WVBOM





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West Virginia Board of Medicine Licensee Search

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To determine if a physician is Board Certified in a particular specialty, you may call the American Board of Medical Specialties toll-free at 866.275.2267, or you may visit their website at www.abms.org.

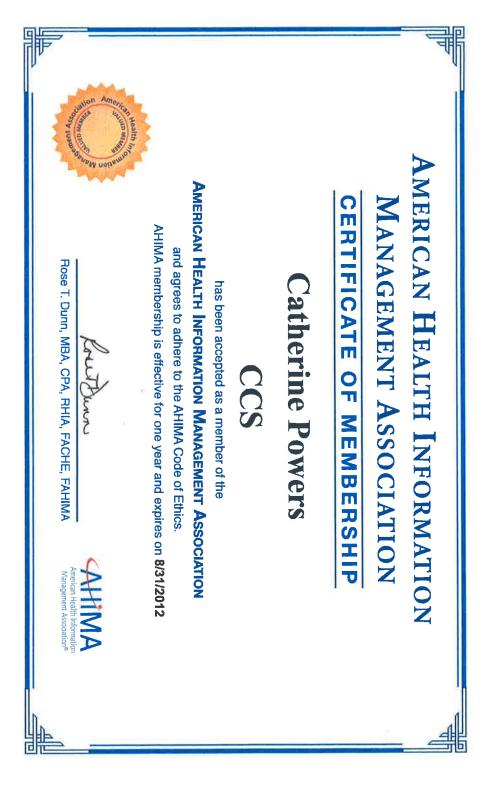
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Full Name:	JAN CARY KLETTER, M.D.	
Born:	1957	
Preferred Mailing Address:	WVU MEDICAL OFFICE BUILDING 203 EAST FOURTH AVENUE RANSON, WV 25438	
-	WVU MEDICAL OFFICE BUILDING 203 EAST FOURTH AVENUE RANSON, WV 25438 (JEFFERSON C	· ·
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Originally Granted:	7/10/2007	
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Post-Graduate Training:	NEW ROCHELLE HOSPITAL/MC, NEV /1986)	W ROCHELLE, NY (06/30
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KLETTER, JAN CARY	MD	RANSON, WV
New Search		

Phone: (304) 558-2921 Fax: (304) 558-2084

This licensee search was developed by Tygart Technology, Inc. Please send any questions, comments or suggestions to our Web Administrator.



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Note to credentialed members: Please ensure you provide your last name and member ID as it is recorded in your account.



Please enter a member ID and last name to validate a member's credential(s):

Member ID:	Last Name:	
01069939	Armstrong	Validate

Verification Results

member's ID# and last name.

Medical Auditing Certification

Medical Compliance Certification

Practice Manager Certification

Locate Exam Prepare for Exam

Exam Tips

FAQ

Credential Verification

Credential	Certification Date	Renewal Date
CPC®	11/17/2007	04/30/2013
CPC-P®	10/24/2008	04/30/2013

Terms of Use

The AAPC provides this online system as a service to employers in the health care industry, and users of the system are granted access on the strict condition of their willingness to agree to and abide by these terms. The use of this system for any purpose other than the verification of an individual's credentials, including compilations of data or other commercial purposes, is prohibited.

The AAPC will make every effort to ensure that the information provided through this system is accurate and current. It cannot, however, guarantee the absolute accuracy of the information, and all persons using the system do so at their own risk. In addition, each user assumes the responsibility to ensure that any information is applicable to the correct individual for whom verification is sought. Users acknowledge that the AAPC shall not be liable to users or to any other party for any decision made or action taken in reliance upon such information obtained through this service. It is the responsibility of the user to confirm the last name and member ID of the individual whose credentials are being verified before using this tool.

By using this tool, you agree to these terms.



http://www.aapc.com/certification/credential-verification.aspx



Appendix 3: Resumes

Resumes for Key Personnel

HMS brings BMS extensive experience in the Medicaid arena. Our staff possess the knowledge and expertise to successfully implement the Medicaid RAC engagement. The key staff résumés listed in **Exhibit 3-1** are provided below.

Exhibit 3-1 " HMS's I	Key Staff for BMS RAC Engagement
Key Staff	David Dawson, Accountable Executive and Project Advisor
	 David Hancock, Regional Executive
	 Susan Wells, Project Director
	 Richard Levock, Deputy Project Director
	Joleen Bond-Livingston, Implementation and Audit Operations Director
	 Jan Kletter, Contract Medical Director
	Joseph Joy, Information Systems Manager
	 Rebekah Ocker, RN, Implementation and Audit Development Director
	 Michael Hostetler, Data Analytics Director
	Niki Love, Provider Communications Director
	 Christie Watson, CPA, Automated Review Director
	Shelia Green, CPC, CPCH, CHC, Quality Assurance Supervisor
	 Lila Holland, RN, Clinical Supervisor
	 Cathy Powers, CCS, Coding Specialist
	 Michelle Armstrong, CPC, Coding Specialist

West Virginia Department of Health and Human Bureau for Resources Bureau for Medical Services / Request for Proposal MED13001 Appendix 3: Resumes



David Dawson

Accountable Executive and Project Advisor

Current Practice

HMS

Vice President, Government Services South, 2011–Present

- Senior accountability for state agency contracts throughout the Southern region of the U.S., including those in Florida, West Virginia, Kentucky, Tennessee, Georgia, Alabama, Mississippi, Louisiana, Arkansas, Texas, Oklahoma, Kansas, and Missouri
- Responsible for sales and operations of HMS's service offerings including Third Party Liability billing and recovery, cost avoidance, casualty, estate recovery, Medicare identification, credit balance and provider auditing, pharmacy auditing, and program integrity services
- Manages teams dedicated to servicing Southern clients and coordinates the efforts of teams in New York City; Atlanta, GA; Jackson, MS; Charleston, WV; Tallahassee, FL; Topeka, KS; Austin, TX; and Irving, TX, supporting HMS's client base

Vice President, Government Services Midwest, 2007–2010

- Senior accountability for state agency contracts throughout the Midwestern region of the U.S., including those in Michigan, Indiana, Illinois, Iowa, Minnesota, Wisconsin, and Ohio
- Responsible for sales and operations of HMS's service offerings including Third Party Liability billing and recovery, cost avoidance, casualty, estate recovery, Medicare identification, credit balance and provider auditing, pharmacy auditing, and program integrity services
- Managed teams dedicated to servicing Midwest clients and coordinates the efforts of teams in New York City, Westerville, OH; Indianapolis, IN; East Lansing, MI; Des Moines, IA; and Irving, TX, supporting HMS's client base.

Career History

Perot Systems, Healthcare Division

Director, 2002–2007

- Provided senior leadership support for multiple clients within the Healthcare Payor Services Group; services provided in an onshore/offshore leveraged model include ASP application support, system migration and implementation services, claims processing support (imaging, OCR, data entry, claims examination, auditing, print center and mailroom services), customer service, premium billing, and enrollment support.
- Within eight months of assuming responsibility for a new client, customer satisfaction scores improved by 94%.
- Led teams that implemented system enhancements and claims processing re-engineering efficiencies for several healthcare clients that resulted in: reducing inventories by more than 50%, streamlining workflows that increased productivity and reduced expenses, improving quality that increased customer satisfaction, and reducing customer service calls.
- Represented the Healthcare Division on a cross-functional team reporting to the CEO to develop a corporate business process outsourcing strategy.



David Dawson

Accountable Executive and Project Advisor

Senior Client Executive, 1999–2002

- Led a team of more than 150 professionals in providing data center infrastructure, networking, desktop, help desk, security, asset management, change and problem management, project management, and consulting services to a major pharmaceutical contract research organization
- ▶ Responsible for international delivery of these services in six locations in the US and UK
- Implemented numerous technical projects and instilled best practices to strengthen and standardize the infrastructure at the client's major business locations

Client Executive, 1998–1999

- Responsible for leading a team of more than 50 professionals providing IT and business services for a leading nursing home provider in support of the client's acquisition of more than 180 nursing homes; all associates were new hires to Perot Systems, requiring that Mr. Dawson hire, recruit, and coordinate training for all associates and implement account start-up activities.
- Directed a team in providing onsite training and implementation services for the rollout of a new financial and clinical application to approximately 180 facilities over a 15-month period.

Project Manager, 1996–1998

Led a team in the contract negotiations, budgeting, hardware and software acquisition, and implementation of a practice management system for a major behavioral healthcare provider; in addition, coordinated the installation of a new managed care/claims processing system for three of the client's managed care sites.

EDS-State Government

Director of Operations, 1996–1998

- Directed the activities of 150 claims processing and technical support employees in support of the Georgia Medicaid program
- Served as the primary contact with the customer regarding account operations

Implementation Manager, 1991–1992

Led a business support team in implementing major system modifications related to a successful contract reprocurement for fiscal agent services associated with the Georgia Medicaid program and served as primary contact with the customer for the definition of system modifications

Claims Manager, 1998–1991

- Assumed responsibility for a 100-employee claims operations team in support of the Connecticut Medicaid program that was experiencing a high turnover rate, low morale, quality assurance issues, and a backlogged inventory
- Dramatically improved customer satisfaction through attracting and retaining quality people, improving productivity through process reengineering, and implementing a quality assurance program.

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David Dawson

Accountable Executive and Project Advisor

Systems Engineer, 1986–1988

Created and modified programs related to claims payment. In addition, led a technical support team in the implementation of a new eligibility system for the Georgia Medicaid program and served as the primary contact between the customer and the technical team on system modification issues.

Education

Carson-Newman College, B.S., Business Data Processing, 1986



David Hancock, Project Manager

Regional Executive

Current Practice

HMS

Regional Vice President, 2008–Present

- Manages all aspects of program integrity and Third Party Liability recovery contracts in the southern region, including Mississippi, Kentucky, Georgia, Arkansas, Alabama, and West Virginia
- Supervises project operations including Program Integrity, Overpayment Identification, Credit Balance Audits, Estates, Subrogation, Medicare Premium Management, Medicare Crossover Analysis, Medicaid Buy-In, cost avoidance, and Health Insurance Premium Program (HIPP)
- Assists project managers and State agencies in implementing TPL and program integrity best practices
- Manages subcontractor and strategic partner relationships in program integrity / recovery audit contractor engagements
- Identifies methods of improving efficiencies within HMS payment integrity reviews, billing and cost avoidance processes, enhancing recoveries, and developing cost saving initiatives
- Manages the recovery of payments from third party resources including Medicare, commercial insurance, and CHAMPUS, which requires the coordination of multiple business functions including data matching, verification and A/R management

Director, Program Integrity Development 2007–2008

- Assisted with the design and implementation of a Diagnosis-Related Group (DRG) project that sought recovery from providers following data analysis and medical records review
- Developed algorithms for pricing of Medicare crossover claims to minimize state expenditures
- Managed casualty, health insurance verification, TPL billing, and credit balance review projects
- Assisted in the development of business systems to reprice Medicare Crossover Claims; the system includes management of electronic claims, data entry of paper claims into State mainframe system, and reporting
- Assisted in the development of a system to capture Medicaid and Medicare fraud

Senior Consultant & Consultant 2000–2007

- Established policies and procedures to fulfill all contractual obligations to North Carolina, West Virginia, New Jersey Revenue Maximization, Illinois, and Wisconsin engagements
- Assisted in the development of a Correct Coding Initiative in West Virginia that garnered \$4 million in recoveries
- Conducted training sessions with staff on routine basis to update on project requirements
- Developed and coordinated presentation activities with providers, attorneys, and clients
- ▶ Instituted automated online carrier eligibility lookup capability



David Hancock, Project Manager

Regional Executive

▶ Implemented privatization of TPL units for claims review and TPR Suspect

Business Analyst, 1999–2000

- Led identification and validation of health insurance information for the covered lives in two states on behalf of a managed care organization client
- Developed and implemented MAPP web-enabled system to automate a Medicare Part A/B Premium Purchasing Function on behalf of West Virginia
- Directed the Insurance Verification Unit for West Virginia responsible for researching and verifying third party coverage on behalf of the state's Medicaid program
- Assisted in the development of in-house programs to enable efficient insurance verification
- Conducted onsite provider audits to recover Medicaid overpayments
- Conducted daily quality assurance activities regarding HIPP case management work, including extensive internal management reporting to flag problem cases

Career History

Stevens Furniture

Chief Operations Officer, 1996–1999

- ▶ Instituted cost cutting measures that resulted in a 68% reduction in monthly expenses
- ▶ Streamlined operations with affiliated store to increase operating margins from 11% to 23%.
- Restructured accounts payable department to generate better terms with key vendors
- Reengineered the finance office to prepare/respond to managerial needs and produce more timely monthly financial statements
- ▶ Led the migration from a general accounting system to furniture-specific accounting software
- Developed database applications for pricing and order entry
- > Created an intranet to display sales progress and distribute data company-wide

National Policy Forum

Policy Council Assistant, 1993–1994

- Provided advance onsite setup of three national town-hall meetings. Organized 20 community forums with national political representatives
- Assisted in the writing and layout of "Issues for Candidates 1994."

Education

- University of Pittsburgh, MBA., 1996
- ▶ University of Pittsburgh, M.P.I.A., 1996
- Boston University, B.A., 1990



Susan L. Wells, MBA, CTP

Project Director

Health Care Delivery Systems Programs Specialist

Project Development / Implementation & Management / TPL Recovery / Revenue Maximization / Cost Avoidance / Medicare & Commercial Insurance Recovery / Data Matching / Provider & Employer Relations / Strategic Planning / Business Solutions / Claims Processing

Current Practice

HMS

Program Director, July 2010 - Present

- Maintains senior accountability for state Medicaid agency contracts including Kentucky and West Virginia.
- Initiates special data mining recovery projects to drive increased audit collections and maximize revenues, such as a \$5 Million recovery project for KY Medicaid involving a specific provider type of audit.
- Identifies underpayments and overpayments through audit detection processes, and strategically aligns recovery/collection efforts according to results found to achieve greatest impact on client savings.
- Contacts and initiates data exchange of eligibility information between West Virginia and Kentuckyspecific commercial insurance carriers and the Medicaid agency clients to improve the coordination of benefits.
- Manages local operational staff in West Virginia and Kentucky and all related P & L budgets.
- Provides new lead sources through data mining and data matching projects for the identification of health insurance for Medicaid recipients in an effort to reduce costs for Medicaid.
- Manages and quality assures the West Virginia and Kentucky MMIS TPL upload process and all related Financial and Management reports.
- Manages the relationship with the WV CHIP program which includes COB verifications, trauma recovery and credit balance audits.

Career History

Frontier Nursing Service, Inc.

Director of Reporting and Treasury Management, 2006 - 2010

- Managed \$52 Million annual budget for all FNS companies and related benefits plans, including selffunded health insurance, section 125 health, long term disability, and dependent savings plans.
- Completed major bank conversion saving company over \$30,000 in annual fees and earned excellent annual performance reviews.
- Worked closely with various team members to help further the mission of FNS to provide quality health care to rural Southeast KY.
- Managed 72 accounts within multi-bank relationships daily to ensure access to short-term and longterm liquidity.



Susan L. Wells, MBA, CTP

Project Director

Coordinated all company insurance plan negotiations and subsequent renewals of policies, including health, medical malpractice, general liability, auto, etc.

BB&T

Assistant Vice President, Business Services Officer III, 2005 – 2006

- ▶ Fostered positive relationships with over 100 new nonprofit prospects.
- ▶ Won company wide sales award for selling 200+ purchasing cards issued to new bank client.
- **b** Brought in six new relationships totaling over \$20 million in new deposits.
- Coordinated joint calling efforts across a ten-county territory for maximum territory penetration.

Fifth Third Bank

Assistant Vice President, Commercial Lending, 2001 – 2005

- Grew client base to 51 clients over a multi-year timeframe.
- Surpassed relationship manager sales goals in an eight-county territory, including demand deposits, loans and treasury management products.
- Successfully generated new \$113 Million client base while managing established customer base of \$26 Million+ book of business.
- Profitably deep-sold existing client base and strengthened customer relations. Improved networking and time management skills.

Merchant Account Manager, Commercial Division, 1999-2001

- Developed customer database and profiling system that facilitated the targeting of top sales opportunities.
- Managed relationships with new and existing merchants.
- ▶ Retained 99% of 500+ customer base, and deep-sold relationships.
- Effectively coordinated contract renewals.

Chase Manhattan Mortgage Corporation

Assistant Vice President, Account Executive, 1998 – 1999

- Expanded Kentucky customer/ broker base from 6 to 130+.
- Achieved established sales goals with a 90% market penetration rate.
- ▶ Effectively cross-sold products with other Chase team members.

Education

- Master of Healthcare Administration Candidate, Sullivan University
- Master of Business Administration, Sullivan University
- Bachelor of Arts, Boston University



Susan L. Wells, MBA, CTP

Project Director

Certifications / Accreditations

- > 2008 Named to AFP Honors Program for Treasury achievements
- 2008 Earned Certified Treasury Professional certification
- ▶ 2006 Lexarts Workplace Giving Coordinator at BB&T/ 25% increase in annual giving realized
- ► KTMA: KY Treasury Management Association, Board Member 2009-2010 Vice President
- ► AFP: Association For Financial Professionals: Member since 2001
- ▶ HFMA: Healthcare Financial Management Association: Member since 2006
- KRHA: KY Rural Health Association: Member since 2006



Rick Levock

Deputy Project Director

Project Management Specialist

Medicaid and TPL Recovery / Credit Balance Audits / Project Implementation and Project Management/ Provider & Employer Relations / Claims Processing and Recoveries / Trauma/Tort Recovery / Estate and Trust Recovery / Medicaid Buy-In / Client Satisfaction / Business Solutions / Quality Assurance

Current Practice

HMS

Project Specialist/Manager, 2006 - Present

- ▶ Worked credit balance audits in largest hospitals in the state of WV
- Managed claim analysis that identified half a million dollars' worth of Medicaid duplicate payments, nursing home/hospice duplication and Medicare/Medicaid primary payment analysis.
- Presentations to WV Healthcare Association, West Virginia Medical Institute, WV Senior Services and various social services organizations
- Manage daily operations of TPL recovery units including A/R, Trauma, Estates, HIPP, Medicaid Buy In, Disallowances.
- Supervise a staff of 4 and responsible for meeting strict operational deadlines.
- ▶ Directly communicate with client regarding daily issues that arise.
- Manage invoicing & Quality Assurance of Trauma, Estates, Credit Balances, Disallowances, Medicaid Buy In & CHIP projects.
- Operate statewide Medicaid third party recovery effort generating over \$9 million per year in recoveries

Career History

HMS, Inc.

Case Director, Trauma/Tort Recovery Unit, 2001 - 2006

- Manage the Third Party Liability (TPL) Trauma/Tort recovery project for the State of West Virginia, including Medicaid and CHIP.
- Case management for General Torts or Personal injuries; Medical negligence and malpractice, auto accidents, and Workers' Compensation, valued at over \$10.4M.
- Enforced the state's Assignment Rights to recover Medicaid expenditures from trauma/tort TPL.
- ▶ Identified potential recoveries through various referral methods and investigated all leads.
- Valued claims and establish lien.
- ► CY 2006, \$3.1M worth of cases were negotiated, compromised and settled.
- Prepare required recovery and referral reports.

Case Director, West Virginia Medicaid Estate Recovery Unit, 2001 - 2010

Manage the Third Party Liability (TPL) Estates recovery project.



Rick Levock

Deputy Project Director

- Seek recovery for Medicaid assistance from estates through the use of claims.
- ▶ Responded to recovery questions from interested parties.
- ▶ Negotiate claim and lien cases with attorneys and executors.
- > Prepare statistical reports for client. Oversee all statistical data and participate in client status meetings.
- ► Represented department's right of recovery.

City Mortgage Services

Loan Counselor, 1999 - 2001

Responsible for back-end loan collection on accounts 60, 90, 120+ days past due.

Bowles, Rice, McDavid, Graff & Love

Legal Assistant, 1996 - 1999

• Workers' Compensation legal assistant for defense firm.

State of West Virginia, Workers' Compensation Office of Judges

Legal Assistant-Paralegal Writing Team, 1992 - 1996

Adjudicated and prepared written decisions on cases involving compensability, medical treatment and temporary and permanent disability benefits.

Education

> Paralegal Certificate, University of Charleston



Joleen Bond-Livingston, RMA, CPC

Implementation and Audit Operations Director

Divisional Vice President, Recovery Audit

Government Services /Revenue Cycle Management/Audit & Recovery / Regulatory Compliance with Government and State Agencies / Operations Design & Management / Client Relationships / Strategic Planning / Program Implementation / Contract Negotiation & Administration / Business Development Support / Financial Management

Current Practice

HMS

Division Vice President, Program Integrity, Recovery Audit, 2011 – Present

- Responsible for the operation staff performing all aspects of provider audits for the detection of improper payments. Develop and maintain operational infrastructure from startup through on-going operation for Recovery Audit. Direct involvement and oversight in the audit operation implementation of state Medicaid Recovery Audit Contractor or other audit & recovery contracts in the states of Oregon, Utah, New Jersey, New York, South Carolina, Tennessee, Connecticut and New Mexico.
- Operational responsibilities include: RAC contract implementation, develop state/program specific audit requirements, create audit protocols, develop audit staffing model, hire and train staff, develop and maintain audit tools, letters, reports, develop client reports and develop and create and maintain provider communication plans.

Career History HMS

Division Vice President, Federal Market, 2009 - 2011

- Division oversight of federal contract for the Medicaid Integrity Program Audit MIC Task Order 3, San Francisco jurisdiction. Developed and ensured state specific audit protocols were followed and implemented a Quality Assurance Surveillance Plan and Quality Assurance Process for all audit activities
- Responsible for client management/account management of the Medicaid Integrity Program across the states of California, Washington, Oregon, Idaho, Arizona, Hawaii, Nevada and Alaska. In addition, served as a subject matter expert and oversight for the key development efforts for the CMS/State Collaborative Audit program with the states of California, Washington, Arkansas and Texas.

Regional Vice President, Government Services West, 2008 - 2009

Regional oversight of the State of California Third Party Liability Identification and Recovery and Worker's Compensation contracts through the DHCS. Direct contract management with State of CA DHCS and Pharmacy Division. Oversight of the contract and business development activities in six Western states to include Washington, Oregon, Nebraska, Hawaii, Montana and North Dakota. Strategic vision and execution for regional revenue growth.



Joleen Bond-Livingston, RMA, CPC

Implementation and Audit Operations Director

Adaptis, Inc.

Director, Healthcare Operations - Short Term Consulting, 2007 - 2008

- Oversight for all operational functions within the organization to include: claims operations for Medicaid Managed Care and Medicare Advantage plans, coding & configuration for all claims adjudication functions, member and provider call center, provider maintenance, production support (software releases), project management and all client pertinent operational concerns.
- > Provide overall management for multiple regional operation centers within the State of Washington.
- Responsible of the hiring and training of Operations Manager, Project Manager, Certified Coders and Claims Adjudicators and Provider Service Representatives.

Perot Systems (ARS)

Client Executive, 2006 - 2007

Executive oversight of the successful operational management of Perot Systems Revenue Cycle Outsourcing contract. Through contract responsibility, reporting directly to the CFO of a 250 bed hospital with oversight of patient financial services operations, delivery, client satisfaction, and financial performance. Work across client delivery support units to resolve project issues.

Group Health Cooperative

Associate Director Revenue Cycle Operations, 2000 - 2006

Oversee and direct operational management of all reimbursement cycle and provider billing and compliance activities statewide generating more than \$100,000,000 annually in non-dues revenue in a centralized business model. Responsible for Medicaid, Medicare, Commercial, State Industrial Insurance, Group Health Plan (HMO) billing and collections across 2 hospitals and 23 outpatient clinics across the state of Washington

Senior Coding Consultant, 1997 - 2000

Certified Professional Coder (CPC) providing coding support to business operation coders and providers. Conduct classroom training for physician groups on documentation requirements and coding principles. Provided consultative recommendations for administering Medicare, Medicaid and Commercial billing/coding regulations as new line of business.

Advantage Healthcare Consultants

Co-founder/President, 1998 - 2001

- Provide consulting services to physician practices on coding and documentation requirements of reimbursement by government agencies. Orchestrated appeals for Medicare and Medicaid denials based upon coding documentation. Evaluate compliance risk based upon random coding audits while recommending corrective actions.
- Recognized speaker on Coding Principles for Optimal Reimbursement by the American College of Internal Medicine – Washington State Chapter

Education

Executive Leadership Certification, University of Washington, Seattle, WA, May 2004



Joleen Bond-Livingston, RMA, CPC

Implementation and Audit Operations Director

- Biological Science, Pierce College, Tacoma, WA, June 1991
- ▶ Registered Medical Assistant, San Antonio College, El Paso, TX, July 1987

Certifications/Accreditations

- ▶ Healthcare Financial Management Association, 2000
- American Academy of Professional Coders, 1995
- American Association of Health Care Administrative Management, 2001
- America's Health Insurance Plans, 2007
- Registered Medical Assistant (RMA), 1987



Jan Cary Kletter, M.D., F.A.C.S., M.S.

Contract Medical Director

Medical Director, West Virginia-based

Utilization Management Review / Program Management and Development / Physician Review Panels / Quality of Care Review Outcome Measurement Programs / Medicaid Managed Care / Strategic Planning / HIPAA Compliance / Quality Assurance

Current Practice

Eastern West Virginia Rural Health Education Consortium Surgery Preceptor, Present

Jefferson memorial Hospital

Attending Surgeon, 2001 - Present

West Virginia University Hospitals Assistant Professor of Surgery, 2004 - Present

Career History

Endless Mountain Health Systems (EMHS)/Montrose General Hospital *Attending Surgeon*, 1987 - 2001

Tyler Memorial Hospital Consulting Surgeon, 1992 - 2000

Barnes-Kasson Hospital Attending Surgeon, 1992 - 2000

College of Medicine, Health Science Center, State University of New York

Clinical Instructor of Surgery, 1993 - 2001

Education

- M.S., Health Administration, King College-McGowan School of Business, 1999
- M.D., University of Medicine and Dentistry of New Jersey, 1981
- ▶ A.B., Rutgers University The College of Arts and Sciences, 1977

Certifications/Accreditations

- ▶ Diplomate, American Board of Quality Assurance and Utilization Review Physicians, 1997
- ▶ Diplomate, American Board of Surgery, 1987, recertification 1995
- Member, West Virginia University Hospital-East CEO Selection and Board Nominating Committee, 2004 -Present
- ▶ President of Medical Staff, Jefferson Memorial Hospital, 2004 Present
- ▶ Vice President of Medical Staff, Jefferson Memorial Hospital, 2003 2004
- Member of Credentials and Peer Review Committees, Jefferson Memorial Hospital, 2002 Present
- Medical Director, part-time, Eastern Panhandle Integrated Delivery System, 2001 Present
- ▶ Chair, Surgical Committee, Jefferson Memorial Hospital, 2001 Present



Jan Cary Kletter, M.D., F.A.C.S., M.S.

Contract Medical Director

- Chair, ICU Committee, Jefferson Memorial Hospital, 2004 Present
- Co-Chairman, Utilization Review Management Committee EMHS/Montrose General Hospital, 1997 -2001
- President of Medical Staff, EMHS/Montrose General Hospital, 1995 2001
- ▶ Chairman of Quality Assurance, EMHS/Montrose General Hospital, 1995 2001
- Chief of Surgery, EMHS/Montrose General Hospital, 1988 2001
- ▶ Chairman, Blood Transfusion and Tissue Committees, EMHS/Montrose General Hospital, 1988 2001
- Member, American College of Physician Executives, 2004
- ▶ International Who's Who of Professionals, 1996 Present
- ▶ Fellow, The American College of Surgeons, 1991 Present
- Pennsylvania Medical Society, 1986 2001



Joseph Joy

Information Systems Manager

Current Practice HMS

Senior Vice President and Chief Information Officer, 2003 - Present

- Manages HMS's data center operations.
- Provides technical support in tailoring HMS's software applications to serve the needs of the Program Integrity and other business lines.
- Manages multiple information systems and projects—including customer service/call center systems, legacy mainframe applications, data warehouse/data marts, document imaging and workflow, Webdeployed applications (including TRAC case management system used for program integrity projects) and other office automation systems.
- Directs information systems staff.
- Coordinates, facilitates, and consults with all senior management staff on information systems, application development and support, and IT project initiatives.
- Ensures corporate compliance with system standards and security requirements.
- Develops and executes strategic plans to optimize the use of information technology in support of business objectives.
- Manages overall resource allocation and future direction and control of proposed information systems.

Career History

Health Network Systems

Application Development Manager, 2002 - 2003

- Maintained and enhanced internal medical provider pricing claim system.
- ▶ Implemented the systemic loading and maintenance of client network contacts and fee schedules.
- Developed technological application resulting in the automated determination of the provider claim reimbursement.
- Managed staff of 16 java developers.

The Prevision Group, LLC

Managing Director/Senior Project Management Consultant, 2002 - 2003

- ► Founding contributor to healthcare IT consulting organization.
- Implemented business model and grew organization from zero to over \$1K in revenue in first year of operation.
- Coordinated corporate associations with four healthcare organizations.
- Performed HIPAA-related consulting, maintenance support for claim systems, and performed claim system product evaluations.



Joseph Joy

Information Systems Manager

Health Management Systems, Inc.

Vice President General Manager, 2001 - 2002

- Completed the successful closing of the Health Care Division of Health Management Systems.
- Completed all existing contracts/work orders with customers fulfilling all outstanding client obligations.
- Terminated multiple contracts early, which resulted in a savings of over one million dollars in expenses.

Vice President - Client Services/Product Development, 1997 - 2001

- Managed the client service division that included a staff of more than 250.
- Managed eight project managers who were responsible for all consulting services.
- ▶ Recruited and trained business, technical, and management positions.
- ▶ Responsible for meeting top/bottom line budgets.
- Managed the product development division that included a staff of more than 50.
- Managed effort to re-engineer an enterprise managed care mainframe-based product suite to a distributed, Java/Web-based product suite.
- Utilized Rational Rose for object-oriented analysis and design.

Assistant Vice President, 1994 - 1997

- Managed majority of client services organization which included a staff of almost 150.
- Managed five project managers and was responsible for business development and client relationships.
- Direct responsibility for meeting top/bottom line estimates for clients including BCBS (Ohio, Western New York, South Carolina, Nebraska, Oklahoma, Maine, and Minnesota) and commercial carriers (Great West Life and General American Life).

Product/Account Manager, 1990 - 1994

- Project manager for multiple, concurrent customers.
- Managed a large scale membership and billing implementation for BCBS of the National Capital Area, Pierce County Medical Bureau, and Wisconsin Physicians Services.
- Responsible for completing base product functionality, as well as new modifications and customizations.

Programming Supervisor/Manager, 1988 - 1990

Managed programming resources for BCBS Georgia Claim System implementation and implemented the entire system on time, in nine months.



Joseph Joy

Information Systems Manager

Programmer/Analyst and Senior P/A, 1985 - 1988

Developed, enhanced, and maintained a medical claim payment system for a client roster which included BCBS of the National Capital Area, BCBS Ohio, and BCBS Virginia.

Education

- Java Programming I, II and III, College of DuPage, Glen Ellyn, IL, 2002
- ▶ X-Technologies Developers Program, DePaul University, Chicago, IL, 2002
- B.S., Applied Computer Science, Illinois State University, Normal, IL, 1984

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Rebekah Ocker, RN

Implementation & Audit Development Director

Client-Oriented Recovery Management and Medicaid Program Integrity Project and Product Development Leader

Clinical Recovery Audit / Program Integrity Project Development and Implementation / Claim Data Analytics Design / Recovery Audit Process Design / Clinical Review Design and Management / CMS RAC Interface Management / Medicaid State Plan and Provider Reimbursement Analysis / Appeal Management

Current Practice

HMS

Manager, Recovery Audit Development, Program Integrity, 2010 - Present

- > Project Manager for development of HMS's recovery audit capabilities and process.
- Ensures program compliance with CMS Medicaid RAC guidance.
- > Development/enhancement of clinical audit/review process.
- > Development/enhancement of new data analysis issues.
- > Development/enhancement of case management system capabilities.
- ► Coordinates stakeholder initiatives and opportunities.
- Consults with clients and HMS client service teams to identify and implement new program integrity opportunities and enhancements.

Diversified Collection Services, Inc.

Project Deputy Director, Audit Manager, CMS RAC 2005 - 2010

- ▶ Developed and managed all production aspects of DCS CMS Recovery Audit Contracts.
- Staff training and management of 70 medical review nurses, certified coders, and customer service representatives performing RAC activities.
- Managed clinical staff conducting chart audits to ensure that all services were accurately coded and documented.
- ▶ Reviewed all claims under review for potential fraud.
- Maintained knowledgebase and database of billing trends for providers under review for questionable practices.
- Coordinated and conducted extensive provider outreach sessions for CMS RAC.
- Coordinated project activities with government regulatory and oversight agencies.
- Primary clinical contact with CMS.
- Coordinated and chaired biweekly clinical meetings with the 4 regional MACs.
- > Primary point of contact and coordinator for RAC subcontractors.
- Developed data algorithms for identification of improper payments.



Rebekah Ocker, RN

Implementation & Audit Development Director

GM&A

Medical Auditor, 2003 - 2005

- Conducted desk and onsite chart audits of claims to ensure that services were billed, documented, and paid correctly.
- Reviewed medical records for up-coding, unbundling, and other coding issues and to ensure adherence to CPT/HCPCS documentation and coding guidelines.
- ▶ Identified average 15-20% overpayment per claim reviewed.
- Coordinated and conducted entrance and exit conferences with providers.
- Reviewed policies and procedures of facilities undergoing audits.
- Monitored and presented audit findings and trends to payor clients.

Blue Cross Blue Shield of Texas

Medical Reviewer, 2000 - 2003

- > Primary contact and reviewer for all provider appeals for the HMO BCBS division of Texas.
- Analyzed data to determine validity of claim payment.
- Reviewed Medical Records to determine that coding, documentation, and payment had been performed in accordance with policy.
- Developed improper payment reports.

San Angelo Community Medical Center

Maternal Child Track Charge Nurse, 1988 - 2000

- Obstetrics/Gynecology Charge Nurse
- Pediatric Charge Nurse
- Newborn Nursery Charge Nurse

Education

Associate Degree, Nursing, Angelo State University

Certifications/Accreditations

- Registered Nurse
- FDCPA Certified
- ▶ Pediatric ALS Certified, Chemo Certified, Bio Terrorism for Texas Nurses Certified
- Managed Care I and Managed Care II Certified
- Member American Association of Clinical Coders and Auditors
- Member Board of Directors Arc of San Angelo
- Ist Lieutenant Civil Air Patrol
- ▶ CMS Common Working File, FISS, MCS, VMS, CMS CICS Region, ECRS, REMIS System
- ▶ InterQual

West Virginia Department of Health and Human Bureau for Resources Bureau for Medical Services / Request for Proposal MED13001 Appendix 3: Resumes



Rebekah Ocker, RN

Implementation & Audit Development Director

Milliman



Michael Hostetler

Data Analytics Director

Client-Oriented Recovery Management and Medicaid Program Integrity Project and Product Development Leader

Program Integrity Project Development and Implementation / Data Analytics Design and Development / Audit Program Design / Medicare/Medicaid Coordination of Benefits / Medicaid Third Party Identification and Recovery / Medicaid State Plan and Provider Reimbursement Analysis and Consulting / State FFP Revenue Maximization / Systems Design and Systems Application Reengineering / Recovery Yield Management

Current Practice

HMS

Vice President of Analytics, Program Integrity, 2006 - Present

- ▶ Leads research, development and implementation of HMS's Program Integrity Service offerings.
- Leads operational development and implementation of key HMS Program Integrity engagements.
- Facilitates the efforts of data analysts, review staff, and operations support staff in the execution of payment integrity project requirements and deliverables.
- Responsible for the development of innovative, supplemental methodologies to enhance government agency program integrity and SURS functionality; leads the development and piloting of systems error identification and overpayment recovery projects, including integration of clinical review
- Consults with clients and HMS client service teams to identify and implement new program integrity opportunities and enhancements
- Develops and implements new methodologies and process for increasing client recoveries and results, including:
 - n Overpayment targeting analysis and recovery process development
 - n Cross State utilization analytics development
 - n Development of HMS data analytics and recovery capabilities for:
 - ► Hospital Overpayments
 - ► LTC Facility Overpayments
 - Renal Dialysis Facility Overpayments
 - Pharmacy Overpayments
 - Behavioral Health utilization issues and overpayments
 - DME overpayments
 - ► HMO premium overpayments
 - Medicare crossover overpayments
 - n Development/expansion of HMS's Medicare COB capabilities including:
 - ▶ Pharmacy/DME (Medicare Part B and Medicare Part D)
 - ► DME (Medicare)
 - Medicare home health appeals
 - Medicare SNF COB
 - ► SSI Retro Identification and recovery issues
 - n Development of HMS's PI-Track database

West Virginia Department of Health and Human Bureau for Resources Bureau for Medical Services / Request for Proposal MED13001 Appendix 3: Resumes



Michael Hostetler

Data Analytics Director

- n Development of HMS's Online Provider COB Interface
- n Development of HMS's J-Code Drug Rebate product
- n MMIS analysis and edit development consulting

Career History

HMS

Vice President, Product Development, 2003 - 2006

Responsible for the development of new opportunities and methodologies for increasing client recoveries and results, including:

- Program Integrity
- Clinical and DRG Review
- Medicare COB, Part A, Part B, Part D, including: Home Health, Nursing Facility, and DME
- Medicaid HMO Premium audits
- Medicare Crossover Overpayment Identification and Re-pricing
- Medicaid Rebate Maximization
- Program Analysis and Revenue Maximization

Vice President, Operations, 2001 - 2003

- Managed all NY based development, operational, and Yield Management teams.
- Ensured quality and effectiveness of HMS's recovery and cost avoidance results.

Director of TPL Operations, 1999 - 2001

Directed Yield Management and Contract Operations units.

Director of Yield Management, 1998 - 1999

- Managed the unit responsible for acquiring third party eligibility data, developing electronic claims billing interfaces, resolving carrier adjudication issues, and billed claim follow-up.
- Developed processes and protocols for identifying and addressing pockets of opportunities in billed claims populations.
- Reengineered HMS's Group Capture System, which enables HMS to track commercial insurance coverage and benefits for hundreds of thousands of employer groups.

Director, Business Development, 1997 - 1998

- Expanded HMS TPL recovery products and processes that resulted in over \$100 million in HMS client recoveries.
- Led reengineering of the HMS claims data staging process, which now enables HMS to process, organize, and provide ready access to more than 7 billion Medicaid claims.
- > Developed utilization of Medicare Adjudicated Claims history data to ensure accurate coordination of



Michael Hostetler

Data Analytics Director

benefits for dual eligibles and identify Medicaid overpayments to providers. Recovered over \$80 million for HMS clients.

- Expanded HMS Medicare recovery projects to include renal dialysis, CMHC, DME, ambulance, and, most recently, pharmacy services.
- Developed Medicare maximization processes that use claim and recipient attributes to identify and validate Medicare "leads" which has recovered more than \$30 million for HMS clients.

Development Project Manager, 1993 - 1997

> Developed and implemented contracts for seven HMS clients.

Project Manager, 1991 - 1993

• Executed contracts for five TPL clients.

Drexel Burnham Lambert

Lead Programmer, 1988 - 1990

> Developed systems and software to support brokerage's regulatory reporting activities.

Coopers & Lybrand

Senior Programmer, 1984 - 1987

Developed PC-based auditing software.

Education

▶ B.S,. St. Lawrence University



Provider Communications Director

Customer Care Specialist

Business Solutions & Contract Development / Claims Processing / Contract Negotiation Strategic Planning / HIPAA Compliance / Information Systems Development / Process Automation Emerging Technology Planning & Development / General Third Party Revenue Recovery Project Management / Systems Reengineering / Research & Product Development

Current Practice

HMS

Director, Provider Relations, 2009 - Present

- Directs the activities of Provider Relations staff to ensure prompt, friendly, and valuable customer service to government-sponsored health and human service programs across the nation
- Responsible for the development and implementation of operational plans in support of HMS business with state Medicaid agencies and Medicaid managed care organizations
- Establishes contract compliance policies and procedures for the fulfillment of all contractual obligations related to Provider Relations
- Conducts quality assurance activities to include extensive internal management reporting to enhance quality
- Monitors performance metrics to guarantee service levels of the highest quality
- Conducts outreach to clients and providers to educate on the roles and responsibilities of Provider Relations
- Oversight responsibility for the State of Maryland to notify Medicaid providers of other health coverage to include Medicare and commercial insurance under federal and state requirements for Third Party Liability

Career History

HMS, Inc.

Vice President, 2007 - 2008

- Executive accountability for state agency contracts across the western U.S., including California, Alaska, Colorado, Idaho, Nevada, and South Dakota
- Directs the activities of Program Directors within the western region of HMS's client base
- Manages project operations of the Sacramento-based staff servicing California's Department of Health Care Services
- Direct project management oversight of comprehensive project components including health insurance recoveries, provider-based recoveries, cost avoidance and cost savings initiatives, casualty and estate recoveries, provider credit balance reviews, DRG post-payment audits, and program integrity initiatives
- Responsible for the development and implementation of strategic and operational plans to enhance Medicaid recoveries and cost avoidance on behalf of state Medicaid agencies



Provider Communications Director

- Establishes contract compliance policies and procedures for the fulfillment of all contractual obligations
- Conducts quality assurance activities for all recovery, cost avoidance, and case management work to include extensive internal management reporting to enhance quality
- Responsible for the development of individual recovery program work plans, technical requirements, analysis, and training of project teams to fulfill contract requirements
- Oversee the implementation of new projects, technology solutions, and program enhancements

Regional Director, 2006

- Senior accountability for state agency contracts across the Western US, including those in California, New Mexico, Colorado, Idaho, Oklahoma, Missouri, and Kansas
- Supervises program directors within Western region of HMS's client base

Senior Program Director, 2003 - 2005

- > Oversaw client relations and supervise TPL and revenue maximization projects in California
- Reviewed and recommended revenue maximization projects
- > Streamlined process and communications to improve productivity for HMS and state employees
- Revised and implemented more effective project reports for California
- Managed effective working relationships with California to the extent that they view HMS as a business partner, not just a vendor, engendering a high level of trust, such that the state allowed HMS to implement innovative enhancements to in-scope projects

Senior Account Executive, 1998 - 1999

- Provided onsite client service and technical support for two of HMS's largest accounts
- Responsible for client collections in excess of \$100 million annually from Medicaid, Medicare, and Commercial payers
- Directed an onsite project management team; responsible for the overall success of the client relationship and the project
- Receipt of account/charge data from the client's patient accounting system for reformatting and custom filtering into the appropriate carrier or payer's billing format
- ▶ Third party billing, both electronic and hardcopy, to Medicaid, Medicare, and Commercial payers
- Automated remit posting of payments, contractual adjustments, and write-offs to the patient accounting system



Provider Communications Director

Accordis, Inc.

Senior Account Executive, 2001 - 2003

- Provided account management services to two of California's public healthcare networks: San Francisco County and Los Angeles County
- Improved cash collections by 39% with the development and implementation of new projects as well as process improvements to existing projects
- Ensured timely delivery and customer satisfaction of products and services (e.g., installations, conversions, version updates, training, hardware and software support)

Argent Financial Health Services

Senior Project Director, 1999 - 2001

- Directed the operational activity of fourteen California public hospitals
- Provided onsite support to hospitals to interview patients that may qualify for the Medi-Cal Program; services included the interview, completing the required Medi-Cal application forms, and monitoring the outcome to completion.
- ▶ Managed a staff of 30 providing direct patient contact.
- ▶ Increased revenue and client satisfaction to Argent while serving as Senior Project Director

QMA (An HMS Company)

Director, Account Management & Product Support, 1996 - 1998

- Directed the activity of more than 25 employees organized into three teams: Account Management, Help Desk Operations, and Application Support
- Responsible for all client-related activity for more than 70 acute care hospitals and physician groups.
- Ensured timely delivery and customer satisfaction of products and services (e.g. installations, conversions, version updates, training, hardware and software support)
- Directed the activity of help desk operations to provide telephone support to end-users (e.g. medical billing questions, hardware problems, billing platform user questions)
- Account management responsibilities for revenue retention, revenue generation through add-on sales, and the overall success of more than 70 accounts

Director of Operations, 1990 - 1996

- Directed the activity of more than 45 employees organized into four teams: Production, Follow-Up, Business Office Outsourcing, and Data Processing
- Accomplished the quantity and quality of work expected in a production environment
- > Defined and enforced productivity and error standards
- > Performed quality assurance review of output to ensure standards were met



Provider Communications Director

- Ensured timely submission of claims, both original and follow-up submissions, in excess of 4 million claims annually
- Produced productivity/error reports, production schedules, trend analyses, statistical reports, and monthly activity reports.

Education

B.A., Canisius College

Certifications/Accreditations

America's Health Insurance Plans (AHIP)

West Virginia Department of Health and Human Bureau for Resources Bureau for Medical Services / Request for Proposal MED13001 Appendix 3: Resumes



Christie Watson, CPA

Automated Review Director

Current Practice

HMS

Program Audit Manager, 2010 – Present

- Manages department of 25 staff across multiple audits in accordance with GAAS and GAGAS principles including developing training programs for new audits and auditors.
- Serves as key liaison with various internal departments to ensure quality audits on behalf of HMS clients.
- **•** Establishes and maintains client relationships including management of contract deliverables.
- Oversees quality assurance program on behalf of audit clients.
- > Provided expert testimony in formal appeal of Medicaid provider.

Career History

Cherry, Bekaert & Holland, CPA

Government Audit Manager, 2007 – 2008

- Managed \$1 million in audit revenues across multiple governmental clients.
- ▶ Performed and managed audits in accordance with GAAS and GAGAS.
- ► Trained and supervised 10 staff members
- > Provided regional expertise for federal compliance audits (Single Audit).

Haran, Watson & Company, CPA

Partner, 2000 – 2008

- Managed audit practice and participated in Medicaid provider audits.
- > Developed and managed government consulting practice.
- ▶ Performed audits in compliance with GAAS and GAGAS.

Auditor of State of Ohio

Director of Audit Administration/Deputy Director of Finance, 1996 – 2000

- Supervised staff of 15 people in addition to monitoring performance of CPAs in 9 regional offices including productivity and work flow.
- Developed and managed audit of Title IVE foster care at State, County and Provider level including development of audit approach, audit programs and audit process.

Education

Ohio Northern University, BSBA, Accounting and Management, 1994



Shelia Green, B.B.A., C.P.C., C.P.C.H., C.H.C

Quality Assurance Supervisor

Current Practice

HMS

Audit Manager

- Serves as key liaison with various internal departments to ensure quality audits on behalf of HMS clients.
- Establishes and maintains client relationships including management of contract deliverables.
- Oversees quality assurance program on behalf of audit clients.
- > Provided expert testimony in formal appeal of Medicaid provider.

Career History

Parkland Health & Hospital System – Corporate Compliance

Senior Billing Compliance Consultant, 2010 - Present

- > Planning & conducting department billing compliance risk assessments & audits
- > Development & deployment of training & education based on audit findings
- Compliance & HIPAA training/education for new employee orientation
- Yearly Compliance education(face-to-face) for 300-400 new resident physicians
- ▶ Implementing audit plans, writing & updating department policies and procedures
- Staying abreast of regulatory/compliance changes that impact Medicaid, Medicare, managed care & commercial payors

Ernst & Young

Finance & Revenue Management - Charge Capture, 2008 - 2009

- Charge Capture/Revenue Cycle, Coding & CDM Standardization engagements to maximize revenue & accelerate cash flow. Responsibilities included conducting medical records reviews/claim audits, department interviews, presentation of findings, education/training, preparation of project dashboards & working documents, OPPS & CPT/HCPCS Updates
- > Data analysis, report preparation, designing implementation plans & tracking methodologies
- Marketing Analytical Assessment for major automobile manufacturer

Tenet Corporate Headquarters - Patient Financial Services - Revenue Integrity Senior CDM Analyst, 1999 - 2008

- Charge Description Master (CDM) corporate liaison in the following specialty areas--Physical, Occupational, & Speech Therapy, Rehab, Behavioral Medicine, Emergency Room, Materials Management--DME (prosthetics/orthotics) HBOT & Wound Care for 62 hospitals
- Providing expertise/guidance regarding charge capture, pricing & billing guidelines to ensure appropriate reimbursement and compliance with government, managed care and third party billing regulations



Shelia Green, B.B.A., C.P.C., C.P.C.H., C.H.C

Quality Assurance Supervisor

- Collaborating with the Tenet's National Medicare Center, Regional Offices and Hospital Compliance Officers to resolve APC edits, billing errors, claim audits, denials and to integrate CDM related functions to the charging process
- CDM Reviews--includes conducting meetings with hospital CFOs, directors & managers, evaluating current charging structures, charge forms, charge screens/order entry systems and auditing hospital chargemaster files to ensure proper billing. Prepare written reports & financial reports of audit findings with recommendations to hospital management
- Develop, maintain and implement CDM tools and materials such as memos and training/education training courses
- Leading and managing complex projects, coordinating use of consultants/vendors related to revenue cycle/charge capture initiatives
- Staying abreast of CDM related issues through monitoring of the regulatory environment, review of literature & participation in professional healthcare organizations
- Participating in LCD/NCD committee meetings to monitor changes & updates to the Local Coverage Determinations(LCD) & National Coverage Determinations(NCD) that may affect Tenet Hospitals

Synergistic Systems

Physician Coder, 1999

Responsibilities included medical record reviews to capture Emergency Room physician charges using CPT-4 and ICD-9 coding resources.

Baylor Health Network

Healthcare Coding Auditor, 1998 - 1999

Responsibilities included conducting on-site audits for 31 outpatient facilities, yearly charge form reviews, maintained database of current procedures and diagnoses, notifying facilities of upcoming CPT-4 & ICD-9 changes.

University of Arkansas for Medical Sciences (UAMS)

Clinical Services Administrator, UAMS Radiation Oncology, 1997 - 1998

Responsibilities in this new department included patient coordination of care, billing for physician services, tracking reimbursement, supervising staff, maintaining database of all patients seen, preparing monthly financial reports, and chart audits.

Accounts Supervisor, UAMS Obstetrics & Gynecology, 1989 - 1997

Responsible for providing financial and benefit counseling to patients, collections, batching charges/cash payments, supervising staff, training new employees, handling referrals & appeals from insurance payers and medical record audits for a multi-physician office.

Receptionist, Obstetrics & Gynecology, 1988 - 1989

Responsible for providing administrative support to the Accounts Supervisor, coordinating office functions such as greeting patients & visitors, answering phones, coordinating appointments & various clerical duties.



Shelia Green, B.B.A., C.P.C., C.P.C.H., C.H.C

Quality Assurance Supervisor

Education

B.B.A., Marketing, Southern Arkansas University

Certifications/Accreditations

► HITECH Program Certification - Trainer, Midland College

Memberships/Associations:

- ► Health Care Compliance Association
- American Academy of Professional Coders
- Southern Arkansas University Alumni



Lila B. Holland, R.N., M.S., B.S.N., C.P.H.Q.

Clinical Supervisor

Current Practice

HMS

Senior Nurse Manager, 2011-Present

- Management oversight of the clinical review process for Recovery Audit. Oversees the operational process for all clinical medical and coding reviews.
- > Supervises a review team consisting of Nurse Reviewers, Coding Specialists, and Project Specialists.
- Works with physician review panel to perform medical necessity reviews and oversight. Also works closely with Chief Medical Director on audit criteria and review findings to support review determinations and appeals.
- Develops clinical review guidelines to train coding and nursing staff on approved audit scenarios by contract. Develops audit tools necessary to aid in audit review training
- > Develops and monitors Quality Assurance protocol and guidelines on all medical reviews.

Career History

Tenet Healthcare Corporation

Quality Manager (all 4 regions), 2011

- Clinical expert supporting the Compliance, Ethics, and Law Departments when allegations, concerns, or issues are identified by conducting clinical reviews to determine compliance with The Joint Commission Standards, State Regulations, CMS, FDA, etc.
- Performs chart audit and analysis, interviews, process/systems reviews, and regulatory review across multiple hospital departments.
- Performed and provided oversight on One Day Stay reviews, Kyphoplasty reviews, Sepsis reviews and reviewed Pepper data for the hospitals and presentation of information.

Parkland Health and Hospital System

Compliance Manager for Case Management (Compliance Department), 7/6/2010–12/31/2010

- Responsibility for Utilization Management, Case Management, Denials Management, Emergency Department throughput and Observation departments.
- > Performed medical reviews for One Day Stays and all RAC high risk diagnoses

Community Health System (CHS)

Regional Quality Director, Oklahoma and New Mexico, 2008–2010

- Responsible for The Joint Commission continual readiness for 8 hospitals across Oklahoma and New Mexico, Texas and Georgia
- Responsible for Case Management, Utilization Review, Denials Management, and appeals
- ▶ Responsible for the Quality Departments in all of the 8 hospitals. (Core Measures compliance)



Lila B. Holland, R.N., M.S., B.S.N., C.P.H.Q.

Clinical Supervisor

Clinical Manager, 2007-2008

 Supervised Clinical Staff of Invitro Clinic and developed and maintained ongoing Performance Improvement Program

Tenet Healthcare Corporation

Quality Manager (Texas - LA Region and North/South Region & Florida), 2004–2007

- Clinical expert supporting the Compliance, Ethics, and Law Departments when allegations, concerns, or issues are identified by conducting clinical reviews.
- Review chart analysis, interviews, and process/systems reviews across Texas, Louisiana, Florida, Missouri, California, Pennsylvania, Georgia, South Carolina, North Carolina and Nebraska
- Performed Skilled Nursing Facility (SNF's) semi-annual audits, wound care audits and Bariatric audits

Parkland Health & Hospital System

Associate Director of Regulatory and Accreditation, 2001-2004

- Responsible for EMTALA, HIPAA, TDH complaints, Continual Readiness Education for JCAHO, CMS & TDH guideline interpretations.
- Performed and provided oversight on clinical reviews for Medicaid Denials and performed investigations of Ethics Action Line Calls.

Cypress Basin Hospice

Director of Performance Improvement, Patient Coordination, Community Education, 2000–2001

- > Assessed Hospice standards and implemented new Performance Improvement initiative.
- Monitored their P.I. plan, identified areas for improvement & developed indicators and reviewed patient charts, transfers, deaths, and re-certifications - 30, 60, 90 days.
- Reviewed, rewrote and prepared Hospice policies and procedures to meet TDH, Chaps and NHO standards.

Henderson Memorial Hospital

Director of Patient Education & Community Wellness Institute, Director of Diabetes Outreach Program, 1997–2000

Managed overall teaching coordination of both inpatients & outpatients.

Panola General Hospital

Director of Home Health Department, (started the program and department), 1993–1996

Responsible for oversight and compliance with State, Federal, and JCAHO Standards, Accountable for staffing, Budgeting, strategic objectives, coding, and providing general oversight for 55 employees.

Education

- Master of Science, Amberton University (Human Resources & Training and Development), 2004
- Bachelor of Science in Nursing, University of Texas at Tyler, 1996
- Associate Degree of Nursing, Kilgore College, 1976



Lila B. Holland, R.N., M.S., B.S.N., C.P.H.Q.

Clinical Supervisor

Certifications/Accreditations

• Certified Professional in Healthcare Quality (CPHQ) 2006



Cathy Powers, CCS

Coding Specialist

Certified Coding Specialist

DRG Validation / Medical Record Audit / Hospital and Outpatient Audit

Current Practice

HMS

RAP Coding/Auditor Specialist, 2011 - Present

Assisting in the implementation process of Coding Review for the RAP team; DRG validation and medical record audits for code abstraction, including all hospital and outpatient services

Career History

HMS

IntegriGuard Federal Unit/Coder Auditor, 2010 - 2011

Coding Auditor for the Federal Unit of HMS under CMS. Adherence to strict GAGAS guidelines of auditing standards for medical records and documentation. Scope of position included Coding QA review ; assisted in implementation of code education for staff coders including hospital and inpatient diagnosis and procedures

North Texas Hospital

Certified Coding Specialist, CCS, AHIMA, 2010

Inpatient/Outpatient/Emergency Room, auditing, abstracting

Pinnacle Anesthesia/EMCare

Certified Coding Specialist, 2009 - 2010

Anesthesia coding, all specialties, ICD-9 and CPT with ASA crosswalk

Outcomes Source/Remote Coding

Certified Coding Specialist (Contract) 2009-2010

Inpatients/Outpatients and auditing clinicals

CPR Provider

Clinical Cardiology/Certified Coding Specialist 2008-2009

▶ Coding Operative notes, interventional radiology, outpatient, office cardiac procedures

Collin College

Coding Instructor/Substitute 2009-Present

▶ Teaching courses in ICD-9, CPT, HCPCS, DRGS, APCS & coding practices

Baylor Specialty Hospital

Clinical Respiratory Therapist 2008-2009

> All aspects of RT clinical care: Including ventilators, blood gases, transport

Wellness Care Center

Program Coordinator 2007-2008

 Contracted position for RT exercise program, responsible for all patient care, documentation, auditing, billing, and revenue integrity



Cathy Powers, CCS

Coding Specialist

Texas Therapy Centers

Clinical Program Coordinator 2004-2007

- Coding CPT/ICD-9 concurrent with daily documentation for financials
- ▶ Audited all records and maintained coding compliance for facility

Cor Management

Clinical Cardiology Code/Certified Coding Specialist 2003-2004

Medical coding of cardiac procedures for large physician group practice

St. Vincent Hospital

Coder/Abstractor 1998-2003

▶ Coder/abstractor for inpatient , emergency room, and outpatient medical records

Waveny Care Center

Director Medical Records /Coder Abstractor 1993-1998

- Coordination of all medical records, auditing , chart compilation, abstraction of codes
- Adherence to JACHO and state regulatory statutes for medical records

Nassau Chest Physicians, PC

Director Pulmonary Lab/ Rehabilitative Services 1981-1993

Education

Respiratory Care Practitioner, RCP, Licensed State of Texas, Adelphi University, Post Baccalaureate Gerontology, 1985

Certifications/Accreditations

Certified Coding Specialist, CCS/AHIMA



Michelle R. Armstrong

Coding Specialist

Certified Coding Specialist

DRG Validation / Medical Record Audit / Hospital and Outpatient Audit

Current Practice

Permedion, an HMS Company

Project Manager, 2009 - Present

- Analyze Medicare/Medicaid claims data for clients; create reports with recommendations based on findings from the data.
- Managing SIU projects for Medicare/Medicaid clients who are looking for trends in fraud, waste and abuse with various healthcare providers.
- Prepares outcome reports that show findings from project/contract activities which ensure compliance with all regulatory requirements. Effectively communicates project findings to internal and external clients
- > Performs quality assurance checks on client deliverables.
- Works with DRG Review Manager and Bill Audit Manager to train, review and audit staff to the specifications of assigned contract(s).
- Assist data miners as need in the developing of targeting algorithms for clinical reviews.
- Serves as a resource to participants in project/contract activities.
- Maintains professional competencies and knowledge for project. Prepares presentations and reports in concert with contract deliverables.
- > Supports business development efforts through contribution to presentations and proposals.
- Monitors and fulfills contract requirements. Meets with clients regularly.
- Works closely with the Program Integrity department to review data mining efforts.

Harrison College

Adjunct Professor, 2010 - Present

Conduct classroom teaching students working towards their bachelor degree in Allied Health. The classes are Hospital Medical Billing & Healthcare Coder.

Career History

Anthem Blue Cross and Blue Shield

Contract Compliance Auditor, 2006 - 2009

- Audited Hospitals in Central and Northern Ohio, Kentucky & Indiana based on contracts between provider and Anthem.
- Communicated with providers concerning any issues that arose as a result of audit findings.
- ▶ Responded to all appeals concerning audit.



Michelle R. Armstrong

Coding Specialist

- Produced audit findings utilizing extrapolated data.
- Conducted exit interviews with facilities giving a high level over-view of audit findings.
- Reviewed claims system for processed, paid, pended and voided claims
- ▶ Researched eligibility of patients of audited claims
- Reviewed provider databases for effective dates, amended policies and termination specifications
- Reviewed patients out of pocket expenses paid, outstanding, deductibles and coinsurances
- Researched overpayments and underpayments to determine the source and provided solutions for amending the issue.

Associated Plan Administrators TPA

Manager of Operations/HIPAA Officer, 1999 - 2005

- Managed the day-to-day activities of 46 employees serving 50,000 customer lives.
- Managed contracts and administered medical and dental benefits for employees of CMACHO. Negotiated provider contracts on behalf of the client.
- Built and maintained databases for regional health care providers.
- Developed and delivered customized and creative proposals for potential clients.
- ▶ Implemented a state-of-the-art phone system and improved routing capabilities.
- Responsible for implementation of new clients from Ohio and Nevada.
- Developed and led training of employees in three locations for the HIPAA standards.
- Managed call center, claim examiners, auditing, enrollment and mail room associates.
- ▶ Negotiated direct contracts between PPO providers and self-funded employer groups.
- Project Manager for system conversion of medical system.
- ▶ Handled all Department of Insurance complaints ensuring resolutions for all outstanding claims.
- Conducted interviews with potential employees for job vacancies.
- ▶ Responsible for yearly reviews and administering corrective action plans for employees.

R.E. Harrington

Supervisor/Claims Examiner, 1990 - 1998

- Managed staff of medical claims examiners
- Medical and Dental Claims examiner responsible for processing and paying high dollar hospital, dental and physician claims.
- Maintained a 98% accuracy rate on all lines of business
- Required to handle calls for all appeals



Michelle R. Armstrong

Coding Specialist

- Repriced certain claims based on contracted information
- > Coded hospital and physician claims based on medical records submitted
- Conducted interviews with potential employees for job vacancies
- Administered yearly reviews and corrective action plans

United Insurance Company of America

Supervisor/Claims Examiner/Coding Specialist, 1985 - 1989

- Managed staff of medical and dental claims examiners and support staff
- Performed as an experienced coding specialist in Inpatient, Outpatient, ER and Specialty Coding Areas, coding cases on a daily basis
- Performed coding audits and analysis on all patient disciplines inpatient and outpatient, facility and physician.
- In-depth professional and technical knowledge of DRG/MS-DRG, APC, ICD-(-CM, CPT-4 and HCPCS coding conventions, DRG/MS-DRG and APC assignment, clinical documentation, and overall documentation improvement processes
- Provided exit summary's, education and analysis and comparisons as requested and needed to complete audits and revenue cycle processes
- > Processed inpatient, outpatient, physician and dental claims based on the various contracts
- Conducted interviews with potential employees for job vacancies
- Administered yearly reviews and corrective action plans

Education

- M.A., Ohio Dominican University, 2008
- B.A., The Ohio State University, 2005

Certifications/Accreditations

- CPC
- CPC-P



Resumes for Executive Oversight Team and Operations Personnel

The Executive Oversight Team and Operations staff résumés listed in Exhibit 3-2 are provided below.

Exhibit 3-2 " HMS's Operations Staff for DMS RAC Engagement	
Operations Staff	Maria Perrin, Executive Oversight Team Advisor
	 Kimberly Glenn, Executive Oversight Team Advisor
	 Stephen Vaccaro, Executive Oversight Team Advisor
	 Alexandra Holt, CHC, Executive Oversight Team Advisor
	 Stephanie Lilly, Implementation Manager
	 Scott Pettigrew, Security/HIPAA Compliance
	 Deborah James, RN, Recovery Audit Analyst
	 Tracy Mathis, Recovery Audit Analyst
	 Henry Lefcourt, Financial/Billing Analytics Manager
	 Deborah Smith, Provider Relations Director



Maria Perrin

Executive Oversight Team Advisor

Chief Business Officer

Medicaid and Medicare RAC Contract Management / Medicaid TPL Recovery / Data Matching / Commercial Insurance Recovery / Technical Support / Medicaid & TPL Recovery / Provider Relations / Client Satisfaction / Training / Claims Processing / Audits / Contract Compliance / Strategic Planning / Partnership Development / Operations Management / Federal Contract Administration / P&L Management / Growth & Change Management / Process Enhancement / Best Practice Development and Implementation

Current Practice

HMS

Chief Business Officer, 2008 - Present

- Executive responsible for all HMS Government clients and markets, including 80 Medicaid, CHIP and Child Support Agencies, as well as the Centers for Medicare & Medicaid Services, and the Veteran's Administration.
- Executive responsible for the successful implementation and execution of over 14 Medicaid RAC contracts
- ▶ Leads 800 person client management and service delivery team.
- In conjunction with HMS government clients, develops national and state level legislative platforms to further the objectives and efficiencies of government healthcare agencies.
- Works with federal agencies, Congress, and public policy firms to assist in development of appropriate policy and regulatory frameworks.
- Leads product development, mergers and acquisitions, and service enhancement initiatives to ensure HMS delivers clients the most innovative, effective product/service solutions.
- ▶ Responsible for the development of the Program Integrity product line.
- Develops training, leadership and mentor programs to enhance HMS staff development and ensure contract resources are appropriate skilled.

Senior Vice President, Government Relations, 2007 - 2008

- Executive responsible for managing 2 Medicare Recovery Audit pilot contracts for the CMS Medicare RAC program.
- Managed state government affairs efforts to support government clients in analyzing legislation and implementing compliant solutions with federal and state laws and regulations.
- Served as key executive and business manager on HMS's contracts with federal agencies ensuring delivery of high performance, excellent customer service, and partnership with the agency to advance cost containment programs.
- Identified technology and service partners, particularly small and disadvantaged companies, who can assist HMS with expanding their scope of service and delivering high value to their clients.



Maria Perrin

Executive Oversight Team Advisor

Performant Financial Corporation

Senior Vice President, 2005 - 2007

- Led sales, marketing, and business development teams across all divisions of the company including DCS (collections), PAR (healthcare audit and recovery), PHS (software licensing and systems hosted services), and VFI (student loan marketing and call center sales).
- Managed Contract Administration department facilitating 30+ federal and state government contracts including contracts with the U.S. Department of Education, U.S. Department of the Treasury, the Centers for Medicare & Medicaid Services, eight state Departments of Revenue, and other government agencies.
- Implemented and managed the Medicare Recovery Audit pilot program for two CMS Medicare RAC contracts.

Vice President, Business Development and Marketing, 2004 - 2005

- Launched re-brand of 30 year firm and its subsidiaries, including renaming Parent Company and two subsidiaries, launching new websites and all external communication, creating corporate identity guides, and templates, training of brand usage.
- Established Public Relations Program including press release development and distribution, crisis communication plan, media and key messaging training for executives and sales staff.
- Launched two subsidiary businesses to expand product offerings, including student loan marketing, call center sales, and medical eligibility audit and recovery of overpayments.

Bestfoods / George Weston, LTD., 1998 - 2004

Region Manager

Led sales, marketing, and distribution functions for a \$45 million region in the Southeast. Managed 14 division and district sales managers, 12 distribution centers, 6 retail outlet stores, and a total staff of 190 employees and independent operators.

Director of Business Planning

- Developed business analysis function for \$300 MM market that performed quantitative analysis for sales and marketing decision making including pricing, trade promotion, overhead and distribution.
- Managed real estate portfolio of 80 properties (owned and leased) including manufacturing plants, distribution centers, depots, retail stores, and sales offices. Negotiated leases, management of procurement and leasehold improvements projects, and site selection.

Financial Planning & Analysis Manager

Provided high-level analytical support to EVP and Controller, including risk and opportunities assessments, market analysis, P&L development and analyses, feasibility studies, cost-benefit analyses, full scope annual operational plans and forecasts.

Senior Financial Analyst

Developed comprehensive retail trade promotion analysis model used to retrospectively analyze every in-store discount program and to plan future spending.



Maria Perrin

Executive Oversight Team Advisor

• Developed product profitability models used to develop spending and investment strategies.

Nissan Motor Corporation

Financial Analyst, 1997 - 1998

Worked with Marketing and Sales to plan and manage \$200 million Retail Contest and Incentive budget, and \$10 million G&A budget.

University of Miami Department of Marketing

Adjunct Professor

Education

- MBA, Finance, University of Miami, Coral Gables, 1997
- BA, Economics, University of California, Los Angeles, 1991

Other

Chairman, Board of Directors IntegriGuard, LLC



Kimberly Glenn

Executive Oversight Team Advisor

Field Operations, Program/Project Management Leader & Strategist

Utilization Management / Program Integrity (Pre and Post Pay) / Medicaid and TPL Recovery /State Plan Amendment and Research/ Fraud & Abuse Referral and Investigation / Data Mining/Predictive Modelling and Provider Scorecarding / Eligibility Enrollment / Eligibility Integrity & Enrollment Broker / Pharmacy/DME Audit / Government Relations / Cost Containment Strategies / Claims Processing / Provider & Employer Relations / Business Solutions / Strategic Planning / Contract Compliance / HIPAA Compliance / Quality Assurance / Regulatory Expertise/Managed Care Audit and Recovery

Current Practice

HMS

Senior Vice President, Government Services State Government Services, 2006-Present

- ▶ Provides executive oversight and product development focus for State Government Services Market
- ▶ Directs RAC Program Implementation and Product Development for Early RAC States, including:
 - n SC Medicaid RAC contract
 - n NYS Office of Medicaid Inspector General Medicaid RAC Compliant Payment Integrity contract
 - n NJ Office of Medicaid Inspector General Medicaid RAC Compliant Payment Integrity contract
 - n State of Connecticut Medicaid RAC contract
 - **n** State of Maine Medicaid RAC contract
 - n State of Utah, Office of Medicaid Inspector General Medicaid RAC Contract
- Directs Clinical and Financial Audit Large Complex Implementations and Product Development for Key States (Pre and Post Pay):
 - n NJ Pharmacy Audit Contract
 - n NJ Utilization Review Contract.
 - n MassHealth Acute Hospital Utilization Management Program
 - n South Carolina Medicaid Pre Pay NCCI and Regulatory Edit Contract
- Works with Product Development Executive at HMS on MCO Audit RAC Program from Design to Implementation and Operation
- Directs and serves as Accountable Senior HMS Executive for third-party identification, revenue recovery and cost containment solutions for HMS national State Government Services market including: Medicaid, CHIP, Aids Drug Assistance, Charity Care, State Pharmacy Assistance, State Employee Health Benefit Plan and County work
- Directs client project implementations and ongoing operations in HMS State Government Services local offices.



Kimberly Glenn

Executive Oversight Team Advisor

- Directs project implementation, ongoing operations and transition back to agency for utilization management, cost containment, cost avoidance, and recovery projects including: provider based disallowances; nursing home resident lien programs; provider credit balance reviews for acute hospital, long term care providers, dialysis clinics and physician groups; Medicare and commercial balance bill reviews; program integrity claims edits and audits; and new initiative assessments. Assists state clients in drafting TPL action plans, State Plan Amendments, and public notices.
- Has prior experience directing Medicaid federal revenue maximization and provider rate setting projects in AK, AL, KY, MA, NC, NJ, NV and WV. Served as Project Director overseeing the following projects: Enhanced FFP for family planning (managed care and FFS), enhanced FFP for administrative services, Balance Bill Review of Dual Commercial/Medicaid and Dual Medicare and Medicaid Crossover Claims, Billing and Operations for State Operated Facilities, Rate Setting and Reimbursement Methodologies, J Code Enhanced Drug Rebate Claiming, and Medicare Buy in Program Operations.
- From 2006 through 2007 served as senior executive overseeing HMS's two federal CMS RAC Medicare Secondary Payor audit contracts in Florida and New York.
- n Assists state clients in drafting TPL action plans, State Plan Amendments, and public notices.
- Applies 21 years of experience directly managing national portfolio Third Party Liability and cost containment and revenue recovery projects for Medicaid Agencies, State Children's Health Insurance Programs, State Pharmacy Assistance Programs, Ryan White Foundations and Medicaid HMOs.

Career History

PCG

Manager and Shareholder, 1998 - 2006

> Directed southern US cost containment state government line of business.

Deloitte and Touche

Senior Manager, 1990–1998

Managed national Third Party Liability and revenue maximization practice for East Brunswick and Parsippany New Jersey Offices.

Keystone Group

Research Analyst, 1989–1990

Assisted in the qualitative and quantitative analysis of mutual fund performance for several industry types.

Education

B.A., Political Science and Economics, Colgate University, 1989



Stephen Vaccaro

Executive Oversight Team Advisor

Program Integrity, Utilization Review and Provider Audit Executive

Medicaid RAC / Data Mining / Provider Scorecarding / Quality Control / Carrier Operations and Relations / Provider Relations / Yield Management Project Management / Business & Contract Development / Revenue Maximization / Cost Containment / Systems Reengineering / Data Matching / Medicare Recovery / Cost Avoidance Payment Integrity / Provider Audit / Utilization Review / DRG Review / Pharmacy Audit / Correct Coding / Provider Relations / Appeals / Regulatory Expertise / Project Management Office / Large-Scale Project Implementation / Third Party Liability / Eligibility Services / Product Development

Current Practice

HMS

Program Integrity General Manager, 2008 - Present

- Serves as SVP and General Manager for all HMS Program Integrity functionality including: Medicaid RAC Division, and Data Mining Products Permedion Clinical Review Service Line Offering, Pharmacy Audits, Fraud/Waste/Abuse Product, Chief Medical Officer, Research and Development, and Financial Provider Audits.
- Manages Program Integrity Lines of Business collaboratively in response to PPACA Medicaid RAC Legislation for comprehensive service delivery.
- P&L responsibility for shared services organization serving all HMS strategic business units providing comprehensive Program Integrity Service offerings including: State Government Services, Federal Market, and Managed Care Organizations nationwide.
- Oversees all human resources, financial reporting, project management, strategic partners, project management, and research and development of program integrity initiatives.
- Meets weekly with Data Mining Team and Information Systems team to ensure timely and quality client deliverables.
- Collaborates with Client Services Executive Team on all key project implementations.
- Works closely with Marketing and Client Services Team on Program Integrity business development for existing and new HMS clients.
- Ensures adequate resources are committed to HMS client engagements for service delivery.

Career History

HMS

Senior Vice President, Coordination of Benefits, 2003 - 2008

- P&L responsibility for shared services organization serving all HMS third party billing and third party Cost Containment Client Markets including Medicaid, Managed Care Organizations, Child Support Agencies and Veterans Administrations. Oversaw all aspects of project management and financial reporting. Accountable for timing, volume and quality of all key client deliverables.
- Collaborated with Client Services team on all initiatives including new product development, yield management optimization on current products, and project enhancements.



Stephen Vaccaro

Executive Oversight Team Advisor

Coordinated with Corporate QA Team to ensure overall quality and HIPAA compliance of final client

deliverables related to third party recovery, overpayment recovery and cost avoidance projects.

Managed strategic operational support teams including: Legal, Project Management, Carrier Relations, Billing and Cost Avoidance Operations, Provider Relations, Contract Development, and Yield Management.

Accordis, Inc.

Senior Vice President, Operations, 1998 - 2003

- Directed team responsible for all claims processing, billing, and project enhancement activities for Accordis healthcare provider engagements and oversaw the timely coordination of complex billing cycles.
- Maintained overall responsibility for: staff management and resource allocation, operational management, client strategy development, profit and loss management and oversight.
- Established the first faculty practice outsourcing service offering, which generated \$5 million in recoveries for the State of Louisiana Physician Healthcare Network.

HMS

Director of Payor Operations, 1997 - 1998

- Strategic and profit and loss responsibility for the Third Party Liability (TPL) business unit. Managed department of 22 account managers, business analysts, and technical analysts responsible for application design, programming, and execution of client specification.
- Developed and implemented a Lotus Notes application for the management of client change requests. Resulting client satisfaction contributed toward 13 contract renewals (i.e., every expiring contract) during a 12-month period.
- Successfully implemented and grew the TPL client base to \$17 million, representing an increase of over 40% from the prior fiscal year and reduced operating costs by \$3 million through several process and operational improvements, resulting in a contribution margin increase of 70%.

Education

- ▶ M.B.A., George Washington University, Washington, D.C., Master's Certificate in Project Management Hofstra University, Hempstead, NY
- ▶ B.S., State University of New York at Stony Brook

Certifications/Accreditations

- America's Health Insurance Plans (AHIP)
- ► Health Insurance Associate (HIA)
- ► HIPAA Professional (HIPAAP)
- National Association of Subrogation Professionals
- Certified Subrogation Recovery Professional (CSRP)
- National Association of Subrogation Professionals



Alexandra Holt, CHC

Executive Oversight Team Advisor

Vice President, Chief Compliance Officer

Quality & Compliance / State and Federal Privacy, Security & Transaction Processing Requirements / Business & Contract Development / Technical Process Documentation / Data Management & Control / Standard Operating Procedures / Training / Operations / MMIS Systems/Conflict of Interest/Operational Audit

Current Practice

HMS

Vice President, Chief Compliance Officer, 2008 - Present

- Directs the HMS Holdings Corp. Corporate Compliance Program governing all operating entities, ensuring adherence to all state and federal regulations, ethical business practices, HIPAA privacy, security and transaction processing and contractual requirements
- > Oversees compliance training, policy and procedures, tracking and reporting
- > Supervises all compliance auditing, mitigation procedures and issue resolution
- Reports to the Compliance Committee of the Board of Directors on the status of all compliance-related issues
- Serves as HMS's Chief Privacy Officer, overseeing the Company's HIPAA privacy compliance activities
- ► Chairs the HMS Corporate Compliance Committee

Career History

HMS

Director of Quality Assurance and Training, 2003 - 2008

- Developed Quality Assurance (QA) department, policies and procedures. Implemented service and deliverable-specific QA algorithms, checklists, reports, analytic methods, resolution processes and process improvement specifications.
- Directed both Quality and Training functions, ensuring HMS staff possess the skills and knowledge to execute job responsibilities optimally
- Oversaw Management, Inventory and Audit of Compliance requirements and practices
- Served as a member of the Corporate Compliance Committee
- Monitored Contract Statements of Requirements and contractual compliance reviews
- Developed and maintained Standard Operating Procedures and technical documentation for all project types.
- Developed and delivered Training Programs for all staff categories.
- Designed and implemented HMS's "corporate university—an electronic knowledge repository and training facility.

Executive and Operational Management roles, 1983 - 2004

• Acquired wide-ranging industry and discipline expertise, including:



Alexandra Holt, CHC

Executive Oversight Team Advisor

- **n** Federal and state regulations and requirements regarding (1) coordination of benefits, (2) processing Medicaid subrogation claims, and (3) revenue maximization opportunities.
- n Medicaid MMIS systems and HMS's proprietary processing systems.
- n Yield management and provider relations.
- n Financial reporting and controls.

Director of Contract Operations

- Acted as Director of Contract Operations in the above timeframe.
- ▶ Responsible for executive management of recovery service operations.
- Oversaw all commercial insurance billing, Medicare disallowance processing and cost avoidance processing.
- > Specified and implemented processing enhancements.
- Managed orderly transition of projects from the Business Systems Development group to core operations.
- ▶ Provided management reporting and analysis on all deliverables.

Medicaid Recovery Services Operations

- Managed core and special project execution.
- Managed development, delivery and documentation of Medicare/Medicaid excess pay projects.
- Resolved technical issues with clients.
- ► Coordinated quality review procedures with clients.
- Worked in partnership with clients to explore and implement additional revenue recovery opportunities.

Education

- M.A., Cornell University, Ithaca, NY, 1976
- B.A., Oberlin College, Oberlin, OH, 1973

Certifications/Accreditations

► Health Care Compliance Association, CHC



Stephanie G. Lilly

Implementation Manager

Experienced Healthcare Auditor

Medicare and Medicaid Policy and Reimbursement /Provider Audit & Recovery / Regulatory Compliance with Government and State Agencies / Client Relationships / Program Implementation / Audit Reporting / Cost Reports

Current Practice

HMS

Auditor/Senior Auditor, 2009 – Present

- Conduct research on relevant State specific billing/reimbursement regulations.
- Define and implement methodology for recovery audit implementations.
- Create audit test plans for audit assignments.
- Perform desk and field audits of hospitals, nursing homes, and pharmacies to ensure compliance with State Medicaid regulations.
- Ensure audit timelines were met in accordance with contractual requirements.
- > Prepare draft audit reports summarizing audit findings submitted to client.
- Coordinate review of audit findings with appropriate clinical staff.
- Coordinate review of/response to client, State and provider comments/questions/support for audit findings with project team.
- Perform QA assessments on work performed by audit staff. Serve as a mentor and trainer to clinical and financial audit staff.

HCA Healthcare Inc.

Medicare/Medicaid Reimbursement Consultant, 1995 - 2004

- Performed tasks related to preparation of Medicare/Medicaid Cost Reports to ensure proper reimbursement of costs incurred by several hospitals.
- > Performed Bad Debt reviews to determine potential amount of risk exposure.
- > Performed analysis of fixed asset accounting for reimbursement purposes.
- Reviewed hospitals' monthly contractual adjustment computations for accuracy and compliance with policies.
- Interfaced with fiscal intermediary auditors with data and support used to prepare cost reports and answered any questions regarding the cost reports.

Mutual of Omaha

Medicare Reimbursement Auditor, 1988 - 1995

 Audited hospitals in Texas, Oklahoma, Louisiana, and Arkansas for compliance with Medicare regulations



Stephanie G. Lilly

Implementation Manager

- > Performed field audits of health providers' cost reports submitted for Medicare reimbursement
- Implemented an audit program in examination of accounting records to assure compliance with Medicare regulations established by CMS
- Evaluated internal control of the health providers
- ▶ Researched issues using appropriate reimbursement manuals and Federal regulations
- Prepared and presented formal audit findings

Texas Comptroller of Public Accounts

Sales/Franchise Tax Auditor, 1985 - 1988

Audited all forms of businesses (corporations, partnerships, sole proprietorships, retail, manufacturing, wholesale, etc.) for compliance with the State of Texas' sales and franchise tax regulations.

Education

- Project Management Certificate, North Lake College, Irving, TX, April 2012
- BBA (Accounting), Texas A&M University, College Station, TX, August 1985



Security/HIPAA Compliance Director

Field Operations, Program/Project Management Leader & Strategist

IT Security / Business Continuity Planning / Systems Analysis & Management / Data Migration / Network Administration / Hardware / Software / Computer Operations / Enterprise Architecture / Applications Development / Risk Assessment / Forensic Investigation

Current Practice

HMS

Chief Security Officer, 2009 - Present

- > Oversee HMS's technical and physical security policies and procedures, controls, and audits.
- ► Coordinate with business units to implement best practices.
- Develop educational programs.
- Lead refinement of corporate risk assessment, business continuity and disaster recovery planning.
- Chair the HMS Security Committee and serve as member of the internal Corporate Compliance Committee.
- Work closely with technical and operational groups to improve internal structures and service deliveries.

Career History

Baylor Health Care System

Corporate Director, Office of Information Security, 2004 - 2008

- Led team of information security professionals responsible for implementing information security architecture to match business goals and objectives of company.
- Developed information security policies, standards, baselines, and procedures in compliance with HIPAA.
- Established job positions, corresponding job descriptions, salary levels, and performance criteria to support career path for technical and non-technical personnel.
- Worked directly with police, compliance, and human resources departments to provide necessary information to determine responsibility of unauthorized action/crime.
- Developed structure and components of information security architecture based on capability maturity model.
- ▶ Implemented multi-site information security awareness program.
- > Developed and implemented incident management program for performing forensic investigations.

American Airlines

IT Security Manager, 2000 - 2003

Developed and implemented first set of official information security policies owned and dictated by company.



Security/HIPAA Compliance Director

- Coordinated activities of information security committee.
- > Provided direct information security training to all employees, contractors, alliances, and third parties.
- Monitored compliance with information security policies/procedures among employees, contractors, alliances, and third parties. Referred problems to appropriate department managers and administrators.
- Oversaw internal control systems to ensure maintenance of appropriate information access levels and security clearances. Performed information security risk assessments.
- Served as liaison with internal audit for information security processes.
- ▶ Initiated and facilitated activities to foster information security awareness within organization.
- Reviewed all system related information security plans throughout the organization network.
- > Acted as liaison to information systems department.
- Organized and established information security department of compliance, policies/procedures, security architecture and security engineering functions.
- ▶ Interviewed, hired, and managed 18 employees in department.
- Oversaw team closing more than 400 audit findings concerning information technology security.
- Designed and implemented state-of-the-art demilitarized zone in new web hosting facility.
- Developed and implemented e-business access control system utilizing first corporate directory to provision and grant employees access to employee portal automatically based on characteristics.
- Coordinated and managed physical/logical access as well as corresponding security for employees.
- ▶ Worked closely with company team and FBI in emergency response mode after 9/11.

Ernst & Young, LLP

Senior Manager, 1997 - 2000

- **b** Budgeted, staffed, and managed to budget all jobs.
- ▶ Held responsibility for realization and staff utilization numbers for security architecture group.
- Co-developed rapid profiling and risk assessment methodologies.
- Built strong client relationships and trust with several of the company's biggest IT security clients in the U.S.
- Developed southwest area penetration methodology.
- Sold, managed, and implemented two largest security architecture jobs in firm history.
- Developed strategic marketing plan to grow department by 50% in 18 months.
- Served in development of architecture of security department at nation's fifth largest bank.



Security/HIPAA Compliance Director

Tandy Corporation

Information Security Manager, 1995 - 1996

- **b** Designed, implemented, and monitored system security access and controls on multiple platforms.
- Worked closely with hardware evaluations and sizing. Managed six member team of security administrators with 24/7 coverage.
- Managed and coordinated user account administration for employees, including native access as well as access to utilities, applications, and file systems. Coordinated TCP/IP numbers and network user email accounts.
- Oversaw AS/400 and managed mainframe change control software and corresponding procedures.
- ▶ Directed Tandem and UNIX native change control facilities and procedures.
- Managed remote access security to LAN, including dial-up, frame relay, and Internet/Intranet access for employees, vendors, and customers.
- ▶ Researched and reported findings on leading firewalls to replace in-house developed firewall.
- Coordinated two business continuity tests to restore mainframe and UNIX midrange machine. Successfully restored communication between two sites.
- > Served in security structure design for new enterprise wide retail store POS systems.
- Designed system and application security structure/controls as well as automated user security access request system.

Information Systems Auditor, 1994 - 1995

- Held responsibility for planning, coordinating, and conducting internal audits/technical reviews of administrative, manufacturing, financial and retail application systems.
- Performed risk assessments of system security software, operating system environments, change control management software, business continuity plans and disaster testing.
- Reviewed applications, including accounts payable/receivable, general ledger, inventory, point of sale, distribution, banking, warranty, mail order and customer information systems.
- Performed risk assessment and audit of Internet/Intranet connections, including corresponding system/application security structure, controls and policies.
- Conducted hardware performance evaluations. Presented audit findings and recommendations to executives.
- Installed mini-fiber-optic LAN on subnet to support information needs of independent profit recovery department.
- Worked with loss prevention department to investigate suspected fraud on unauthorized electronic payroll alterations.



Security/HIPAA Compliance Director

Pricewaterhouse

Information Systems Auditor, 1992 - 1994

> Planned, coordinated, and conducted formal audits and technical reviews for clients in banking,

manufacturing, retail, financial services, utility, high tech and data processing industries.

- Performed assessments of system security packages, operation system environments, program change management, disaster continuity plans and software.
- Reviewed accounts payable/receivable, general ledger, inventory, point of sale, demand deposit, savings, certificates of deposit, installment, mortgage, and commercial loans, teller, ATM, as well as customer information systems.

Education

B.B.A., Accounting, MIS, Texas Tech University, Lubbock, 1991



Tracy Mathis

Recovery Audit Analyst

Recovery Audit Analyst

Data Mining / Data Analysis / Analytics Review and Development / Algorithm Review and Development / Clinical Audit Team Resource / Client Relations

Current Practice

HMS

Recovery Audit Analyst, 2011 - Present

- Researches and analyzes local billing and reimbursement policies to develop overpayment algorithms. Organizes, documents, and communicates results to clients.
- Applies knowledge of discovered provider billing practices to research of client policy and identifies overpayment recovery opportunities
- Participates in the review of health insurance claims data and member eligibility information to uncover claims overpayment trends associated with non-compliance or misapplication of contract terms and rates, payment policies, medical policies, billing guidelines, and applicable regulatory requirements
- > Develops specifications for IT programming related to overpayment algorithms and analysis.
- ▶ Reviews IT programming results for quality assurance and proof of concept validation.
- Documents results and supports preparation of internal and external documentation and presentations related to research and new overpayment issues.
- Works with internal operations and clinical teams to develop and implement review/audit/recovery protocols and internal review guidelines.
- Supports project teams as needed through the development, implementation, operations, and appeal process.
- Develops and validates workflow and communication tools to best enhance audit production, client satisfaction, and quality assurance.
- Develops business criteria to maximize the identification of contractual and billing compliance audit recovery opportunities.

Career History

PRGX

Medicare Audit Strategy Specialist, 2007 - 2011

- > Assists Audit Strategy team in research and development of potential audits.
- Develops/assists with writing policies, procedures and project folders for all audits.
- Analyzes and researches statistical data to identify improper payments and aberrancies viewing simple, comparison, variance, ranking, and trending reports.
- Performs as a Medicare subject matter expert (SME); proficient in 25 different Medicare facilities/payment methodologies.



Tracy Mathis

Recovery Audit Analyst

- Assists with special reviews, projects and reports to CMS.
- ▶ Testifies as a non-party in Administrative Law Judge hearings.
- Facilitates Discussion Reviews between Medicare Providers and the Recovery Audit Contractor (RAC).
- Serves as a Provider Liaison assisting Providers and PRGX with escalated issues.
- ▶ Tracks and analyzes all levels of appeals.
- > Develops and authors customer service scripts.
- ▶ Proficient in the Part A Medicare Claims Processing Systems (FISS, CWF, DDE, HIQA).
- Coauthors, designs and compiles sections of Request for Proposals (RFPs).
- Assist Law enforcement agencies with training and clarification of Medicare Regulations.

Blue Cross and Blue Shield, Medicare Part A

Provider Representative, 1997 - 2006

- Developed and delivered educational seminars/workshops/ teleconferences Nationally for a CMS Affiliated Contractor and CMS.
- ▶ Researched, developed and designed Provider educational training collaterals.
- Analyzed and researched statistical data to identify inappropriate billing patterns and behaviors.
- ▶ Possesses proficiencies in 21 different Medicare facilities/payment methodologies.
- Thorough understanding of the Part A Medicare Claims Processing Systems and Test Environments (FISS, CWF, DDE, HIQA).

Account Consultant, 1995 - 1997

- ▶ Researched, developed and designed enrollment collaterals.
- Developed and delivered member enrollment sessions.
- Proficient in all health insurance plans available to large and small groups (HMO, PPO and standard plans).
- ▶ Provided utilization analysis to enrolled accounts; assisted accounts with yearly renewals.
- Developed, designed and compiled Request for Proposals (RFPs).

Health Promotion and Benefit Consultant, 1990 - 1995

- Conducted subscriber education sessions.
- ▶ Researched, developed and administered Wellness/Preventive Care programs to clients.
- Coordinated health fairs.
- ▶ Recommended and implemented cost containment initiatives.

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Tracy Mathis

Recovery Audit Analyst

Education

B.S., Business Administration Accounting, Columbus College, 1983



Henry Lefcourt, Director of Improper Payment Recovery Services

Manager, Financial/Billing Analytics

Date of Death Overpayment Specialist

Operations Management / Cost Avoidance / Data Matching / Date of Death Overpayment

Current Practice

HMS

Director of Overpayment Recovery Services, 2004 - Present

- Leads HMS's Date of Death Overpayment services, which has identified and recovered millions of dollars on behalf of our clients over the past 10 years.
- Developed and implemented Date of Death Master File process including automation of client enrollment file updates for 50 HMS clients.
- > Developed "Tier-two" case identification and investigation paradigm.
- Leads a team of business analysts who review Medicaid payments to identify and recover overpayments.
- Engages in retrospective claims payment reviews to identify payments made in excess of Medicaid liability.
- Conceived, designed, and developed TACTiCTM and other computer applications to perform retrospective claims reviews, processing large volumes of data with precision (findings represent well under 1% of processed transactions).
- ▶ Works with clients and managers to identify potential payment errors for investigation.
- Mines available client claims data to find and test new erroneous payment hypotheses.
- Uses Medicaid payment rules, regulations, and practices for clients, along with specific client feedback, to refine identified populations in order to remove false positives in data.
- Prepares populations of overpayments for dissemination to providers and generates deliverables; disseminates disallowance listings to provider communities.
- Instructs Provider Relations staff on project concepts to aid their ability to respond to questions and disputes.
- ▶ As needed, participates in various management teams, marketing efforts, and technical task forces.

Career History

HMS, Inc.

Director of Managed Care, 2003 - 2004

- Led HMS's advance into the Medicaid Managed Care arena by modifying processes designed for government clients to accommodate concepts and practices of managed care clients.
- Implemented and executed third party billing/disallowance services for six Medicaid Managed Care Organizations.



Henry Lefcourt, Director of Improper Payment Recovery Services

Manager, Financial/Billing Analytics

Director of Contract Operations, 2001 - 2003

- Oversaw revenue recovery processing operations and improvement activities for Third Party billing/disallowance services for government contracts. Interfaced with revenue recovery account managers, prioritized programming staff activities, and reported to senior management. Enhanced internal Quality Control Program.
- Directed project management staff as they executed commercial insurance (including TRICARE/CHAMPUS and BC/BS) and Medicare billings and disallowances.
- Conceived, designed, developed, coded, managed, and executed a wide variety of internal processes and development projects, including HMS's standard Cost Avoidance software OPERATM, the Medicare Common Working File interface, Ohio skilled nursing facility disallowance projects (which identified over \$30 million in overpayments), and Medicaid duplicates projects for many clients.
- Worked with HMS's data processing and programming departments to develop, improve, and document integrated applications for various core and non-core business projects and core business support utilities, as well as monitored for processing speed and efficacy.
- Designed, coded in part, and implemented HMS's cycle review application to facilitate Quality Assurance reviews of Commercial Insurance billing service deliverable populations.
- Led the development of HMS's standard Carrier Crosswalk application to facilitate quality Resource billing and maintain data integrity on critical internal files.
- Coordinated with internal and external resources to validate quality of findings, integrate disallowances, and establish parameters for responding to provider inquiries.
- Assured timely and accurate scheduling of commercial insurance, TRICARE/CHAMPUS, BC/BS, Medicare A, and Medicare B billings and disallowances for all HMS TPL clients.
- Supported "back end" deliverables functions—cost avoidance, recoupment tapes, A/R reconciliation with analysis and deliverable creation.
- Conducted bi-weekly meetings with client services staff to review and resolve issues relating to noncore project execution.
- Interfaced with clients to define business and electronic data requirements, resolve outstanding issues, clarify project proposals, and ensure that results meet client needs.

Senior Business Development Analyst, 1995 - 2001

Performed specialized overpayment recovery projects on behalf of state Medicaid agencies, including Date of Death, Duplicate Payments, DRG Readmissions and Transfers, etc.

Education

- M.A., St. Mary's University of San Antonio
- **B.F.A.**, NY State College of Ceramics at Alfred University



Henry Lefcourt, Director of Improper Payment Recovery Services

Manager, Financial/Billing Analytics

Certifications/Accreditations

Professional training, Miller/Heiman Large Account Management



Deborah Smith

Provider Relations Director

Current Practice

HMS

Provider Relations and Program Integrity Provider Service Manager, 2010 - Present

- Manage Provider Relations and Program Integrity Provider Services units; direct responsibility for performance management, staff training, recruiting and hiring, career development, and employee relations.
- Accountable for the overall success of the department to ensure key performance indicators and metrics are achieved.
- Forecasts and assigns daily/weekly work events and implements continuous process improvements to the provider disallowance process.
- ▶ Has experience working with providers on disallowance projects for all clients.
- Manages Program Integrity Provider Services unit, who are responsible for providing customer service to all RAC and RAC like contracts HMS has initiated since 2009.
- Earned certification as a Medicaid Professional under the Medicaid Learning Center's certification program and working toward AHIP certification as a Healthcare Customer Service Associate.

Career History

HMS

Provider Relations Supervisor, 2008 - 2010

- Supervise Provider Relations unit; responsible for training and supervising all members of the Provider Relations team including performance management, training, career development and employee relations.
- Forecast and coordinate staff activity in order to meet or exceed project deadlines, determining work procedures, schedules, and workflow and recommends process improvements for the disallowance cycle process.
- Ensure all staff members provide prompt and courteous service to the provider community in each HMS client state, through continuous call feedback and coaching.
- Monitor all staff members for correct updates to the HMS internal systems with accurate information, and keep organized files with records of all disallowance cycle activity.
- ▶ Resolve provider questions, errors, and complaints.
- Work with providers on Medicare A, Medicare B, and Commercial Insurance disallowances for over 40 state and Managed Care Organization clients. Act as point of contact when Team Lead cannot resolve a provider issue, perform quality assurance checks on agents work, and monitor calls to ensure excellent service is given to every provider.



Deborah Smith

Provider Relations Director

Triad Financial Corporation

Call Center Supervisor - Collections, 2006 - 2008

- Supervised collection agents and Team Lead including: candidate selection and retention; employee coaching and counseling; appraising performance to identify training, development needs; rewarding and recognizing employees; and adopting practices to ensure a positive and safe work environment.
- Thorough knowledge of dialer technology, scheduling and reporting functions, and high-level delinquency reports.
- Ensured maximum productivity of assigned team in order to prevent/recover losses, monitored and enforced compliance with current State and Federal laws in regards to calling activities.
- Resolved issues and assisted with difficult accounts via telephone and letter(s).
- Monitored, approved and routed accounts for all repossession, bankruptcy, legal and insurance claims and activities. Investigated, counseled and documented external agency, legal, or regulatory inquires or complaints.
- Provided reports to department management. Monitored work schedules to ensure proper floor coverage.

Capital One

Call Center Manager - Collections, 1998 - 2003

- Directed management of 20 45 inbound/outbound call center collection employees and Floor Supervisor, including meeting productivity goals, quality call coaching, training and career development, team morale, and disciplinary actions; indirect management responsibility for call center floor (200+ employees), including morale and disciplinary action.
- Promoted 50+ directed reports; 7 to supervisory positions. Calibrated managers on call center-scoring system as Department Quality Manager focused on customer satisfaction and FDCPA adherence.
- Created ways to improve quality and implement call monitoring changes while on cross-site Call Quality Review Team.
- Ensured proper management coverage for call center floor, including identifying and implementing management schedule alignments with team.

Education

- B.A., Business Admin, Human Resources / Organizational Behavior, University of North Texas 1999
- B.A., Business Admin, Marketing / Retail Management, University of North Texas 1999

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