Table of Contents – Tab 4.A: Relevant Experience

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Tab 4: Subject Matter Category

Tab 4.A Relevant Experience

For each Subject Matter Category for which the responder seeks to be considered, provide the following:

A. A description of relevant experience specific to this subject matter category;

Today, more than ever, states are facing financial pressure to close unprecedented budget gaps, and they are reviewing every possible opportunity to reduce costs and increase efficiencies. Minnesota's estimated budget shortfall for 2011–2012 is $5 billion. In response, Minnesota is taking the proactive step of leveraging enterprise data analytics initiatives to identify areas for improvement across multiple cost centers, including Medicaid and Medicaid fraud, waste, and abuse (FWA).

HMS is proposing to provide service to DHS under Subject Matter Category 4: Human Services, Medicaid Payments, Fraud, Prevention, Detection and Program Integrity. As described in **Tab 2. Introduction**, HMS offers DHS a comprehensive suite of services to prevent overpayments before they occur and to recover overpayments after they have been paid.

Unlike many vendors who focus primarily on preventing erroneous payments and have minimal recovery activities after a claim has been incorrectly paid, HMS maintains a robust, comprehensive recoveries function, ensuring that any overpayments made by DHS are recovered quickly, efficiently, and, most importantly, with minimal disruption of the provider's daily activities. In fact, as a trusted partner of state Medicaid agencies for more than 25 years, HMS leads the nation in designing and deploying improper Medicaid overpayment identification and recovery, cost containment, and coordination of benefits (COB) initiatives for government and public health programs.

HMS has recovered more than $15 million for DHS in the first year of a contract to provide limited-scope commercial insurance billing services, more than 30 times what was recovered during the preceding 18 months.

HMS offers DHS a solid record of accomplishment in the scope of work and an attractive Return on Investment. Every year, we recover more than $1 billion for our clients, using innovative approaches to identify and recover healthcare overpayments, and to identify and prevent potential FWA. Our success is rooted in our extensive experience in the Medicaid overpayment industry and our capacity to customize applications and procedures to meet each of our clients' unique needs, including DHS's. **Exhibit 4.A-1** summarizes our approach to designing and deploying a comprehensive solution.

Exhibit 4.A-1 ▶ *DHS Will Maximize Its Medicaid Overpayment Identifications and Recoveries by Relying on HMS's Robust Technologies and Customized Solutions*.

The HMS Solution	
	HMS will perform a complete of review of DHS's scope of work and program components to ensure that we correctly interpret policies, 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); the OIG Exclusion Database; and plans. In addition, we will meet with the various internal and external stakeholders to ensure that we meet DHS's program goals, provide DHS-specific education on program requirements/processes, and coordinate with other audit efforts.
Identification of Improper Payments	HMS will accurately and securely perform intake of DHS program's claims data, program eligibility, provider, reference, and other data as needed. HMS currently has a well-established, secured method of transmission of DHS data as well as data receipt protocols and reformatting already in place for these data files, including a database of DHS paid claims. Upon approval, we will utilize these mechanisms for any work related to this contract. While we bring to DHS a standard set of data mining algorithms, we go far beyond the implementation of "standard" algorithms. Using our library of improper payment algorithms, HMS will develop and configure data routines specifically for this engagement. HMS's Regulatory Research/Compliance and Data Analysis staff review 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 DHS's approval for the data routines that we will implement for this engagement, and we will continue to evaluate and incorporate, as appropriate, new payment identification algorithms.
Automated or Complex Review – Validation of Improper Payments	HMS has the technology, tools, and personnel necessary to determine with certainty if an overpayment occurred. Our experienced staff, which includes certified coding professionals, registered nurses, physician reviewers, financial/billing auditors, and other professionals, have years of in-the-field training in their specific responsibilities. Relying on this experience, team members not only can review documentation and assess if the improper payment occurred but also can identify additional target referrals for the detection of other improper payments. HMS incorporates strict protocols to ensure that we meet review deadlines as set forth by our clients. We validate improper payments by conducting automated (no review of documentation) or complex review (review of medical records or other documentation). Automated reviews occur 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 DHS-specific criteria and guidelines and perform desk/onsite audits to identify improper payments. Our staff, who are trained to identify suspected fraud and abuse, will report any suspected fraud directly to DHS.

The HMS Solution	
Leverage Technology to Identify Overpayments	HMS leverages custom-designed technology and numerous analytical tools to identify overpayments. Our technology includes sophisticated algorithms that review each paid claim and identify those with overpayment characteristics. Because different provider and claim types have different overpayment causes, HMS designed a specific approach and library of algorithms for each claim type, including inpatient/outpatient, dialysis, long term care (LTC), radiology, pharmacy, and mental health. This approach identifies significantly more overpayments than traditional overpayment identification processes that use only global criteria across all claim types.
Recovery of Medicaid Improper Payments	HMS will work with providers to maximize DHS's collection of improper payments. HMS's effective approach minimizes the administrative burden on providers, and our experienced Provider Relations team is available to communicate with providers throughout the recovery process, address their concerns, resolve issues, and ensure prompt payment. Our collaborative approach to working with the provider community is a key component of our ability to consistently achieve a high level of recovery for our clients. **Our 24/7, real-time, web-based Provider Portal is a secure tool that facilitates effective and accurate communication between stakeholders**. In addition, DHS can rely on HMS's outstanding record of recovering actual dollars and cash management experience.

The Strength of Our Identification Process: One Recent Example

HMS has designed our systems, interfaces, and processes based on feedback from our many state Medicaid agency clients and our in-depth knowledge of the healthcare industry. We have invested heavily in our people and processes, which yields significant results across the nation. **For a recent procurement in Utah, HMS participated in a competitive overpayment identification "bake-off" in which our results far outstripped those of our competitors.** **Exhibit 4.A-2** illustrates the strength of HMS's systems and our improper payment identification and validation capabilities.

Exhibit 4.A-2 ▶ *HMS Outscores the Competition*

Utah Proof of Concept

HMS Outscores the Competition

In 2010, the Utah Division of Medicaid and Health Financing released its RFP for Medicaid Overpayment Recovery Audit Services. The proposal process included a scored proof-of-concept exercise to demonstrate each bidder's proposed audit solution in action. After executing a Business Associate Agreement, each vendor was provided with a file of adjudicated claims in order to identify inappropriate payments and submit them with the proposal.

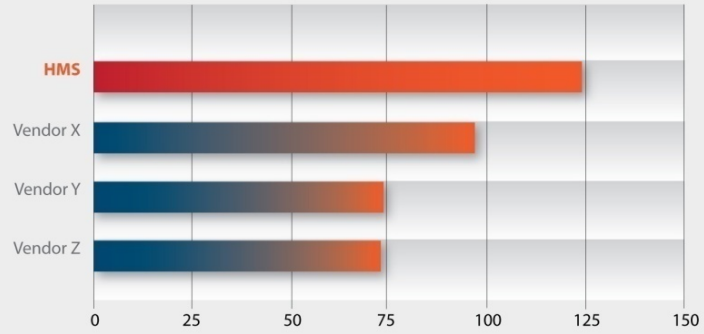
The Test

Of the claims that were overpaid, bidders were instructed to return exactly 150—along with the corresponding reason for overpayment. In turn, the State evaluated each vendor's findings to assess the validity of the overpayment based on State policy and appropriateness, including the Utah reimbursement methodology that was in effect at the date of service. Based on its analysis, the State then calculated scores based in part on the number of accepted claims, the amount of the overpayments identified, the variety of overpayment scenarios, and the likelihood of successful recovery.

How HMS Stacked Up Against Our Competitors

HMS's results far exceeded those of the other three vendors submitting proposals—including several current Medicare Recovery Audit Contractors.

Of the 150 points possible for this portion of the proposal, HMS earned over 124 points; the next nearest vendor was awarded only 96.



As this impartial evaluation proves, HMS's ability to audit claims and identify valid overpayments within the Medicaid environment is unsurpassed. Based on these results—as well as our qualified staff, corporate audit experience, documented approach, and thorough work plan—Utah awarded this contract to HMS.

RAC.0011.012711

Our Services Generate Financial Results

Founded in 1974 with the objective to serve the healthcare industry exclusively, HMS has provided overpayment identification and recovery services to Medicaid agencies continuously since 1985. Currently, 45 state Medicaid agencies, **including Minnesota**, rely on our capabilities to assist them in achieving their specific goals and in protecting the integrity of their programs. **Exhibit 4.A-3** summarizes

our successful Medicaid improper payment identification, audit, and recovery experience and high-level approach to the major audit categories.

Exhibit 4.A-3 ▶ *HMS: Successful Medicaid Overpayment Identification, Audit, and Recovery Activities*

Category	Type of Analysis/Review	Fiscal Year 2010 Recoveries
Automated identification of Improper Payments and Recoveries (All Provider Types)	▶ Data analysis targets clearly improper payments resulting from duplicate billing, readmissions and transfers, coding errors, DRG/APC/RUG upcoding, COB reporting errors, excess days paid, date of death vs. service date issues, 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. ▶ Improper payments are recovered by DHS, refutations are reconsidered, and a final determination is made. ▶ Providers have an opportunity to appeal.	$21 million
Clinical Review Scenarios (All Provider Types)	▶ Reviews target coding, inappropriate setting, and medical necessity/utilization errors, and medical record requests are made. ▶ Clinical staff review medical records against clinical criteria (i.e., InterQual) and other guidelines. ▶ Providers are notified of the determination and have an opportunity to discuss the findings with HMS. ▶ Reviews support a full reconsideration/appeal process. ▶ Improper payments are recovered by DHS.	$55 million
Billing/Financial Record Review Overpayment Scenarios (All Provider Types)	▶ Data analysis targets errors resulting from inappropriate billing, misreporting of third party payments, misreporting of patient cost of care, and other provider billing errors requiring review of documentation, and record requests are made. ▶ Verification of overpayment is accomplished through onsite or desk review. ▶ Overpayments are recovered by DHS, refutations are reconsidered, and a final determination is made. ▶ Providers have an opportunity to appeal.	$85 million
Focused Behavioral Health–, Home-, and Community-Based Service Audit Scenarios	▶ Data analysis targets/prioritizes providers. ▶ Audit team performs desk and onsite documentation review to validate services rendered and appropriate staff qualifications. ▶ Audit team issues audit report. ▶ Providers receive approved audit report and have an opportunity to discuss the findings. ▶ Reviews support a full reconsideration/appeal process. ▶ Improper payments are recovered by DHS.	$12 million

Special Techniques, Skills, and Abilities

HMS offers DHS a special set of techniques, skills, and abilities and applies best practices in similar cost containment engagements with clients across the nation, including the following:

- Independence. **Unlike some of our competitors, HMS is not owned by an insurance company that could also be a third party liable for reimbursing DHS**. Thus, HMS avoids potential conflict of interest issues, particularly when pursuing recoveries. 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 so runs the risk of not maintaining objectivity when dealing with Minnesota providers.
- An ability to implement improper payment projects rapidly due to **our knowledge of DHS's Medicaid programs, data structures, billing and payment requirements, and reimbursement logic**.
- Proven ability to implement **successful provider outreach and education programs** to facilitate smooth implementation of the project.
- 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.
- Proven methodology that reviews patterns across provider types, service areas, and providers or groups as well as the entire potential universe of claims, **delivering an impartial review of all providers and provider types.** HMS's process provides a more comprehensive range of payment review of claims services because we combine a joint review of claims payment data and supporting provider documentation.
- **Incorporation of state reimbursement methodologies** into our processes to reprice improperly paid claims accurately.
- **A highly skilled clinical review team comprising nurses, certified coders, and a panel of nearly 700 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 are 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 timeframes.**

- Experienced data analysts, auditors, and clinicians with expertise across **all Medicaid service types**, including hospital, LTC, pharmacy/DME, behavioral health, and waiver program services.
- A **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.
- The ability to create detailed yet easy-to-understand improper payment notifications regarding the reason for the improper payment. **This documentation minimizes provider questions and appeals and helps educate providers**.
- Many years of experience supporting our determinations through the provider reconsideration and appeal process, **with an outstanding track record in defending our findings**. (Marketing to assure that we reference our success somewhere in 4.B).
- An established **Provider Relations department** to resolve questions relating to the identified improper payment and recovery process, maintain effective provider relationships, and educate providers on improper payment issues.
- **Data processing capacity to perform effective recovery services in Minnesota**. Our technology infrastructure is dedicated to supporting data mining, improper payment or potential FWA identification and recovery, and cost savings projects for many complex engagements simultaneously. The results we attain for our government-sponsored clients speak for themselves.
- **State-of-the-art technology**. Our web-based solutions—including our proprietary TRAC case management system and Provider Portal—provide direct access to robust case management for any cost containment services needed by DHS, including fraud and abuse, compliance, and improper payments on a per case, per provider, or per event basis. **This means that DHS's staff can be assured that they will have the information they need when they need it**. Online access will give both HMS and DHS the ability to research and resolve any issues quickly—**HMS's data center consistently meets its availability goal of 99.9%, supporting maximum service and productivity on behalf of clients**.

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

Our Extensive Knowledge of State Medicaid Programs

HMS brings 26 years of hands-on experience and an in-depth national and state-specific understanding of Medicaid programs. We know the dramatic variances in state Medicaid programs, including those regarding audit/review regulations, provider sensitivity, state agency organizational structures, and program integrity practices, and we are experts in interpreting Medicaid policies.

HMS does more than just identify potential improper payments or FWA: **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 the unique environment of each state.

HMS has built databases of state program regulations, providers, claiming and policy practices and requirements, and reimbursement methodologies. Through our current work for DHS, we understand the unique characteristics of Minnesota Medicaid. This combination of national best practices and state-specific knowledge allows HMS to provide unparallel recoveries for Minnesota.

As a full-service cost containment and program integrity organization, HMS has the operational expertise, regulatory background, human resources talent, overpayment identification logic, and technological resources to provide a comprehensive cost containment program. We have a solid foundation of Medicaid experience in processing claims and eligibility information efficiently, establishing provider and other stakeholder relationships, and deploying local and national subject matter experts to generate measurable results quickly.

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

Exhibit 4.A-4 ▶ *HMS Has Extensive Relevant Overpayment and FWA Identification and Recovery Experience*

HMS Client	Overpayment Recovery	Clinical/Medical Review	TPL/COB Recovery	Fraud, Waste, and Abuse
Medicaid Agencies				
Alabama Medicaid Agency	✓		✓	
Alaska Dept. of Health and Social Services	✓		✓	
Arizona Health Care Cost Containment System	✓		✓	
Arkansas Dept. of Human Services	✓		✓	
California Dept. of Health Services	✓	✓	✓	
Colorado Department of Healthcare Policy and Financing	✓	✓	✓	✓
Connecticut Dept. of Social Services	✓		✓	
D.C., Washington Department of Health Care Finance			✓	

Minnesota Department of Health and Social Services			✓	
Florida Agency for Healthcare Administration	✓		✓	
Georgia Dept. of Community Health	✓		✓	
Hawaii Department of Human Services	✓			
Idaho Dept. of Health and Welfare	✓	✓	✓	
Illinois Department of Healthcare and Family Services		✓		
Indiana Family and Social Services Administration	✓		✓	
Iowa Dept. of Human Services	✓		✓	
Kansas Health Policy Authority	✓		✓	
Kentucky Cabinet for Health and Family Services	✓		✓	
Louisiana Dept. of Health and Hospitals	✓		✓	
Maine Dept. of Health and Human Services	✓		✓	
Maryland Dept. of Health and Mental Hygiene	✓		✓	
Massachusetts – University of Massachusetts Medical School		✓	✓	✓
Michigan Dept. of Community Health	✓		✓	
Minnesota Department of Human Services			✓	
Mississippi Division of Medicaid			✓	
Missouri Division of Medical Services	✓		✓	
Nevada Dept. of Human Resources	✓	✓	✓	
New Jersey Department of Human Services	✓	✓	✓	✓
New York Office of the Medicaid Inspector General	✓		✓	✓
North Carolina Dept. of Health and Human Services	✓	✓	✓	
Ohio Department of Job and Family Services	✓	✓	✓	✓
Oklahoma Health Care Authority	✓		✓	
Pennsylvania Dept. of Public Welfare	✓		✓	
South Carolina Department of Health and Human Services	✓	✓		✓
South Dakota Department of Social Services			✓	
Tennessee TennCare	✓		✓	
Texas Health and Human Services Commission			✓	
Virginia Department of Medical Assistance Services—Coding Review	✓	✓	✓	✓
Virginia Department of Medical Assistance Services—Behavioral Health		✓		✓
West Virginia Dept. of Health and Human Resources	✓		✓	

Managed Care Organizations				
WellCare		✓		✓
AmeriHealth Mercy Family of Companies		✓		✓
CareSource Management Group		✓		✓
Corrections				
Ohio Department of Rehabilitation and Correction		✓	✓	✓
State Agencies (Insurance and Labor Industries)				
Arizona Department of Insurance		✓		
Colorado Division of Insurance		✓		
Connecticut Insurance Department		✓		
Georgia Department of Community Health		✓		
Indiana Department of Insurance		✓		
Maryland Department of Health and Mental Hygiene		✓		
Michigan Department of Energy, Labor & Economic Growth, Office of Financial and Insurance Services		✓		
New Jersey Department of Banking & Insurance		✓		
Ohio Department of Insurance		✓		
Oregon Insurance Division		✓		
Pennsylvania Department of Health		✓		
Washington Department of Health		✓		
Washington Department of Labor & Industries		✓		
Wisconsin Office of the Commissioner of Insurance		✓		

HMS Is a Medicaid RAC Leader

In addition to delivering financial results, we provide expert consultation on legislative, regulatory, and operational issues to our Medicaid clients. As CMS releases the final regulations regarding Medicaid Recovery Audit Contractors (RACs), many states are forging ahead, selecting HMS to assist in complying with the RAC requirements. HMS has recently been awarded RAC contracts through competitive procurements in Utah, Tennessee, Pennsylvania, and Indiana. We are the prime vendor in Utah and Tennessee and a subcontractor in Pennsylvania and Indiana. Since HMS has been providing automated and complex reviews in South Carolina and New York (prior to ACA), those states have received approval for a State Plan amendment, naming HMS as the RAC provider. New Mexico has issued a Letter of Intent to Award HMS its RAC contract. In addition, HMS performs RAC-like services in New Jersey.

A Word about Our Experience in Medicaid Fraud and Abuse

The identification and prevention of FWA is an integral component of all of the services that we provide, and our results are reflected as part of **Exhibit 4.A-3**. Because the identification and prevention of FWA cuts across all four of the Desired Services under Subject Matter Category 4 of this RFP, it is appropriate to describe our expertise in this area.

HMS understands the coverage, utilization, billing, reimbursement, and abuse issues that are common to government-sponsored healthcare programs. 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 analytics, and we know how to leverage the interrelatedness of the cost containment services that we offer to identify overpayments and underpayments across the entire paid claims population. Our extensive technological and analytic capabilities enable us to transform data into information, solutions, and savings. We provide a comprehensive suite of fraud services, summarized as follows:

- **Analyze paid claims data to determine overpaid or inappropriately paid services** in accordance with applicable federal and state laws and regulations. HMS incorporates all applicable federal and state regulations as well as state agency policies into our systems and processes.
- **Support preliminary and extensive investigations** to further overall fraud and abuse programs and objectives and to meet state reporting requirements. While conducting retrospective investigations, we have uncovered substantial fraudulent activity.
- **Detect new, emerging, or otherwise unknown fraud schemes within the Medicaid program**. One of the newer schemes that our investigators have identified is lab panel unbundling. This scheme is now becoming one of the most common forms of lab panel fraud and entails a provider unbundling a lab panel and charging for each test individually, so that the lab or hospital receives a 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 for 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 our competitors' standard editing systems to detect. Our system does.

HMS continually develops and refines analyses 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

Additionally, with the implementation of the National Correct Coding Initiative (NCCI), HMS is assisting state Medicaid agencies in incorporating "compatible methodologies" of the NCCI edits to receive the increased matching funds available for MMIS systems. As part of our FWA services, our Regulatory Compliance and Research department codes and maintains Medicare, Medicaid, CHIP, and NCCI rules in our system—and we have done so since 2005. Our strong focus on researching and coding enables us to create edits for most provider types—not just physicians and hospitals. Our program can apply NCCI edits for the following claim types:

- Ambulatory surgical centers
- DME
- Hospice
- Outpatient hospital
- Prescriptions
- Ancillary providers
- Dental
- Inpatient hospital
- Outpatient physical therapy
- Rural health clinics
- Behavioral health providers
- Home health agencies
- Laboratory
- Physicians
- Vision

Investigations of Medical and Pharmacy FWA

HMS is nationally recognized for its FWA identification programs that deliver statistical evidence backed by clinical expertise on behalf of our state Medicaid clients for use in the prosecution of FWA cases. In addition, we provide supporting documentation and research to support in-house clinical audit staff. HMS's FWA programs have recouped millions of dollars in critical healthcare funds on behalf of state Medicaid programs, Medicaid MCOs, and CMS. Our efforts lead to the effective discontinuation of fraudulent billing practices and hinder the development of additional unethical billing practices.

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 a few general examples from various HMS clients:

- HMS Holdings Corp. received an anonymous tip through our fraud hotline 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 the DEA's jurisdiction.
- HMS's New Jersey PI 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 New Jersey

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

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

- HMS was asked to perform an analysis on behalf of an MCO to review physician records to identify the physicians billing a disproportionately greater volume of claims with higher reimbursement codes compared with other practitioners. Evaluation and Management CPT codes were reviewed for services provided from 2006 through 2009 against a randomized physician selection process that ultimately identified a physician upcoding Evaluation and Management CPT codes in more than 88% of the submitted claims. This case is currently pending litigation.
- HMS reviewed a Virginia behavioral health provider for Intensive In-Home (IIH) services. The provider had unusually high payment compared with peers, for example:
  - Medicaid growth of 369% from 2007 to 2008. Received more than $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 were 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's files, employee records, and medical records was referred to DHS of Medical Assistance Services for possible fraud. The case was accepted by the Attorney General's office and is currently under review.

DHS Will Benefit from HMS's National Leadership

HMS is a vigorous participant in all major associations and organizations that focus on Medicare/ Medicaid cost containment and fraud, and we regularly conduct presentations and seminars, participate in roundtable and panel discussions, and provide sponsorship for select events. Our membership keeps us on the cutting edge of discussion surrounding this complex area. It gives us, as a national leader in this arena, an invaluable opportunity to learn from and share with those who face the challenge of identifying, anticipating, and, finally, mitigating improper payments as well as fraud and abuse.

HMS is a member of or participant in the following relevant organizations and work groups:

- Partner, Medicaid Managed Care Health Plans of America
- Partner, Association of the Community Affiliated Health Plans
- Pharmacy Benefit Management Institute
- A sponsor of The Blue Cross and Blue Shield Association (BCBSA) National Internal Audit and Anti-Fraud Conference
- Association of Certified Fraud Examiners
- Eastern Medicaid Pharmacy Administrators Association (EMPAA)
- Participant, National Council for Prescription Drug Programs (NCPDP), committees for Government Programs, and task groups related to Medicaid Subrogation
- Participant, Western Claim Association
- Participant, Department of Health and Human Services Office of the National Coordinator for

(ACFE) Fraud Conference & Exhibition
- National Association of Medicaid Program Integrity (NAMPI)
- National Health Care Anti-Fraud Association (NHCAA) Anti-Fraud Expo
- National Council Prescription Drug Programs (NCPDP)
- Association for Community Affiliated Plans (ACAP) CEO Summit
- Managed Care Risk Association (MCRA)
- America's Health Insurance Plans - AHIP Institute
- Health Information Technology Enrollment Workgroup
- Participant, Department of Labor/CMS CHIP Working Group
- Western Medicaid Pharmacy Administrators Association (WMPAA)
- Health Care Administrators Association (HCAA) Executive Forum
- Self Insurance Institute of America (SIIA)
- American Association of Preferred Provider Organizations (AAPPO)

Additionally, HMS maintains close working relationships with multiple divisions of CMS that are focused on healthcare reform, and program integrity. The knowledge gained from these discussions informs our approach to all aspects of cost containment for our Medicaid agency and healthcare plan clients.

We are also active in numerous organizations that develop and implement state Medicaid policies, including eligibility, coverage and cost containment services. These organizations include:

- National Association of Medicaid Directors, of which HMS is a sponsor
- National Governor's Association, of which HMS is a corporate fellow
- National Association for Medicaid Program Integrity, where HMS is an invited speaker sponsor
- National Council of State Legislators

HMS: The Choice for Minnesota

HMS's approach is comprehensive, technically sound, and second-to-none in terms of accuracy and effectiveness. **Our understanding of Medicaid policy across the nation, the Minnesota program in particular, national best practices, and the federal legislative and regulatory environment qualifies us to continue to serve as a valued resource for DHS. Our solution is risk free to DHS; we have provided services on a contingency-fee basis for DHS, and can continue to do so**.

Table of Contents – Tab 4.B: Data Analytics Services

All pages marked within this section contain trade secret information as defined by the State of Minnesota statute. This information provides detailed descriptions of our proprietary data analytics services, including specific methods and processes. Disclosure of this information would cause substantial injury to the competitive position of HMS.

Tab 4.B.1 Improved Pre-Payment Identification and Rejection of Improper Medicaid Payments &Tab 4.B.2 Predictive Modeling Techniques

Compliance Table

Our system deeply integrates predictive modeling as part of our standard claims analysis approach and routine. This explains our combined response in this section. Likewise, our system can be applied either pre-payment or post-payment, as needed by DHS.

Service	Location of Responsive Text
4.1.1 and 4.2.1 Reporting/Data Extraction	Pages 18 – 38
4.1.2 and 4.2.2 Data Analysis*	Pages 6 – 42
4.1.3 and 4.2.3 Advanced Analytics*	Pages 6 – 42
4.1.4 and 4.2.4 Investigation and Substantiation	Pages 42 – 47
4.1.5 and 4.2.5 Collection of Overpayments	Pages 50 – 53 (applicable only under 4.2)

*** NOTE**: The HMS processes and methodologies represented by these two service lines are so deeply intertwined and integrated that separating them without a specific Work Order is not possible; therefore, the pages indicated in the compliance table above cover both of these Service Levels.

Addressing Today's Healthcare Challenges

HMS has been effectively addressing healthcare challenges for more than 25 years. We have worked hand in hand with our clients during major overhauls of regulations, development of new technologies, and the creation of experimental processes that are now industry standards. The knowledge that we have gained has enabled us to create a solution to analyze healthcare claims that is uniquely configured to each client's specific requirements, whatever the challenge and whatever the system.

HMS's claims editing system—Automated Claims Evaluator (ACE) —meets the objectives of DHS as described in the RFP and addenda, including the ability to provide advanced reporting and information extraction and data analysis, to apply advanced analytics, and to identify inaccurate coding and payments. The system can be used in conjunction with our Special Investigation Unit (SIU) to conduct additional claim analysis and investigations.

The ACE system conducts **automated pre-payment or post-payment analysis** identifying inaccurate claim transactions and behavioral patterns as well as other areas of concern identifiable through claims analysis, such as overpayments; noncompliance; over/underutilization; and potential fraud, waste, and abuse (FWA). Analytics are configured for transaction-level application and work concurrently with

cross-claim and other layered analytics. The resulting analysis of claim data is at once detailed and comprehensive, offering macro perspectives on claim trends and micro details for each claim transaction.

The analysis capabilities of the system are formidable and effective, providing the means to identify cases that have resulted in multimillion dollar settlements and preventing inaccurate payments, resulting in significant financial savings, as the following examples demonstrate

Our Pre-Payment Claims Editing Solution Uncovers Massive Medicaid Fraud

As a result of our ACE pre-payment editing solution, we identified one of the largest cases of Medicaid fraud in the history of the State of Texas. Through our data analysis, HMS's analysts and investigators discovered that one provider was issuing, on average, six prescriptions per patient seen in his office, even if the member were actually seen by another provider. Of these prescriptions, 99% were issued by the pharmacy in his office. The resulting investigation resulted in a multimillion dollar settlement.

Our Pre-Payment Claims Editing Flags Invalid Modifiers, Saves Client Thousands

When the ACE system is utilized as a pre-payment solution, the biggest savings occur in preventive payments. In one year, the system flagged 1500 transactions with a M01 edit, an edit identifying invalid modifiers, for one provider. Had the transactions not been flagged, the client could have paid more than $59,000 i overpayments.

A snapshot of recent results also illustrates our impressive outcomes for clients:

Membership	Services	Identified Savings (Denials and Adjustments)	All Savings Identified
626,500	Claim Editing	$490,899,401	$4,920,047,530
130,000	Correct Coding/FWA	$214,194,884	$1,090,799,310
53,000	Correct Coding/FWA	$19,928,881	$129,453,857
45,000	Correct Coding/FWA	$15,966,190	$98,944,525
48,000	Correct Coding/FWA	$35,036,013	$292,735,232
110,000	Correct Coding/FWA	$47,420,327	$171,983,252
179,000	Correct Coding/FWA	$2,004,915	$31,917,150
330,000	Correct Coding/FWA	$31,007,806	$271,947,267
20,000	Correct Coding/FWA	$11,324,547	$67,981,182

An Effective Solution

Our system’s effective claims analysis and cost savings is rooted in its foundation of 26 years of system and process refinement, distilling our efforts to create one comprehensive system that offers DHS the following features:

- Extensive and integrated technological and analytic capability, enabling us to transform data into information, solutions, and savings.
- Cutting-edge, multiaxis analytics on the forefront of preventive payment strategies—moving beyond predictive modeling to the next generation of analytical strategies to identify and prevent future instance of FWA.
- Identification of overpayments and issues related to FWA. Our ACE system will analyze 100% of DHS's paid claims data to identify inappropriately paid claims and FWA.
- Ongoing analysis, development, and implementation of new rules, analytics, and processes to ensure complete support for DHS in the ongoing identification of overpayments, FWA, and noncompliance as the healthcare environment evolves.

On behalf of DHS, HMS proposes to implement the following processes:

- Perform pre-payment analysis of adjudicated claims data to identify overpayments, noncompliance, and claim patterns that indicate potential FWA. Provide timely electronic transactions to DHS's processing systems that prevent overpayments and any payment for claims related to FWA.
- Provide analytical, investigative, and clinical resources to support the identification, investigation, and resolution of FWA and other areas of claims analysis.
- Perform the recovery of all overpayments.

Our long history of experience enables us to support DHS through our:

- Extensive clinical and investigative (SIU) capabilities to support the review of issues, claims, and providers or members targeted through data analysis
- Infrastructure, resources, and experience, which is necessary to recover overpayments while minimizing provider abrasion
- Being engaged nationally in the identification, resolution, and prevention of overpayments and FWA, with the resources necessary to identify and transfer best practices and to support DHS in ensuring a reduction in future FWA and compliance with fiduciary and regulatory requirements.

Our Experience

HMS has identified and recovered FWA and related improper payments for more than 25 years on behalf of state Medicaid agencies, managed care health plans, and Medicare, and we recover more than $100 million in overpayments annually. Our data analysis processes analyze more than 100 million new claims each month, and our nurses and certified coders review more than 50,000 medical records annually.

Provider Relations Team Facilitates Recovery Process

HMS maintains a dedicated Provider Relations team focused on facilitating communications and operational transactions between the Minnesota provider community and HMS. The goal of HMS's Provider Relations team is to establish and maintain effective communication with providers while monitoring the review and recovery process. Our Provider Relations team utilizes a customer-service approach to their role, in both attitude and operations. They understand the importance of maintaining a positive relationship with providers throughout the process.

Provider Relations Representatives

HMS's qualified and experienced Provider Relations representatives will be knowledgeable of HMS's efforts on behalf of DHS, including 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 DHS 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.

Effective communication is an important part of a successful PI program. Through the HMS provider communication process, we inform providers of 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 DHS upon approval:

- Provider communication:
  - Utilize overpayment notification letters that contain specific information regarding errors as an effective tool to inform providers regarding 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 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 DHS and the providers, subject to DHS's approval
  - Our ability to provide information about DHS'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. TRAC 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.

- Direct interaction with providers can provide overall understanding and cooperation for achieving DHS enterprise data analytics program goals. With communication and information, providers will support Medicaid policies, communicate regularly with our team, and promote evidence-based interventions.

At predefined intervals—customizable to meet the needs of DHS—HMS Provider Relations specialists contact those 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.

Provider Education Increases Understanding and Influences Behavior

HMS understands that direct interaction with providers can enhance overall understanding and cooperation for achieving DHS's program goals.

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. Once effective working relationships are established, a multifaceted program can educate and update providers on the progress of each audit effort.

Prior to conducting the services we propose, HMS will implement a state-approved provider orientation initiative that will reach out to Minnesota provider associations as well as individual providers (through association meetings and webinars) and will ensure that providers have a clear understanding of the project's objectives and process. With DHS's approval, HMS's orientation process will be ongoing throughout the project and will provide a forum for dialogue between providers and HMS staff related to the project.

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 increased quality of care. This also equates to a greater understanding by the provider community of DHS's rules and regulations surrounding admissions to acute hospitals and ongoing care in provider facilities, which helps to ensure that DHS spends its dollars appropriately and wisely.

Through our experience in Minnesota and across Medicaid programs, HMS understands that positive provider relations are critical in the successful implementation of a large-scale provider audit program. Through our years of working with DHS, we have a history of successfully working with providers in DHS's and surrounding regions.

The table below provides 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 toward provider outreach.

Item	Outreach Activity	Information
1.	Meetings of Introduction	HMS will schedule meetings to introduce our company and discuss the purpose of the program and the process.
2.	Provider Webinars	HMS will reach out to providers and other stakeholders and offer webinars prior to any audit activity.
3.	Newsletter	HMS will produce a stakeholder newsletter that will provide continuous information about the project and its processes and answer questions related to HMS or our process.
4.	Website	HMS will maintain a public website for all stakeholders that will house educational materials and FAQs, with a link to the DHS website for additional information.
5.	Email	HMS will provide a specific email address for providers/stakeholders to use to submit questions or comments and for an avenue to present additional information to individuals. Email will be continuously monitored and answered by HMS Provider Relations staff.
6.	Toll-Free Telephone Number	HMS will provide a specific toll-free telephone number directly to our Provider Relations staff to assist all providers and answer any appropriate questions; all policy-specific questions will be referred to DHS.
7.	Special Sessions	HMS will hold special meetings or educational forums as needed and will invite all providers/stakeholders; these sessions can be scheduled regionally.

HMS's Approach to Provider Education

HMS will deploy the following informational and communication tools and materials upon approval from DHS.

Website

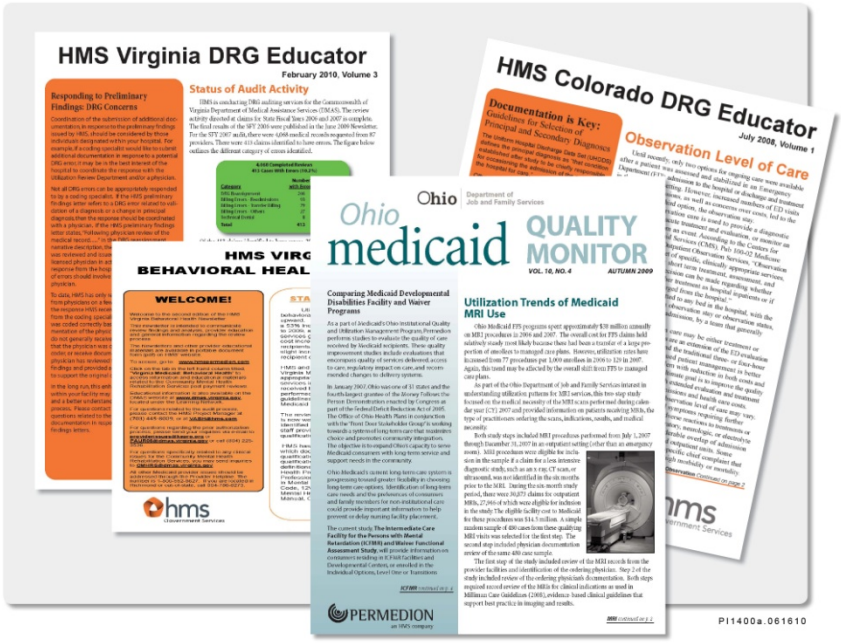
HMS will offer providers our secure, web-based Provider Portal as a primary point of contact throughout the overpayment identification and recovery process. Once providers register and supply proper credentials to validate their identity, HMS's web portal will allow them a broad scope of self-service options. Providers may update contact information for Medicaid billing inquiries and requests, download overpaid claim listings and detailed cover letters, respond to HMS's recovery requests electronically, and submit questions to HMS's Provider Relations team.

The 24/7 web portal will also allow providers to elect to go "paperless." By selecting this option, providers will receive an email at their registered email address any time a new claim listing/letter has been posted on the portal. Once logged in, a provider will be able to download the reports immediately, rather than waiting for delivery via postal mail. As an added benefit, HMS will also be able to automatically log which members of a provider's staff accessed a given claim listing and when it was downloaded. This information has proven extremely valuable for current HMS clients when providers

submit an appeal stating that the recovery request was never received. Please see our response to **Tab 4.C Tools, Hardware and Software** for details about this innovative application and its reporting functionalities for providers and state staff alike.

Newsletters

HMS publishes trends and issues encountered in our provider newsletter.



Webinars

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

Notification Letters

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

Trend Reports

HMS's trend reports, which providers can download, outline the provider's experience compared with various benchmarks and highlight specific areas of potential concern (similar to the CMS PEPPER reports).

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 and has 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.

Tab 4.B.3 Recovery Audit Contractor (RAC)

Compliance Table

Service	Location of Responsive Text
4.3.1 Reporting/Data Extraction	Pages 101 – 110
4.3.2 Data Analysis*	Pages 63 – 81
4.3.3 Advanced Analytics*	Pages 63 – 81
4.3.4 Investigation and Substantiation	Pages 84 – 95
4.3.5 Collection of Overpayments	Pages 95 – 99

*** NOTE**: The HMS processes and methodologies represented by these two service lines are so deeply intertwined and integrated that separating them without a specific Work Order is not possible; therefore, the pages indicated in the compliance table above cover both of these Service Levels.

HMS: A Strategic Partner in Health Care Reform

Both payors and providers are determining the impact of the recently passed Health Care Reform legislation that impacts virtually every facet of healthcare operations and financing. The Patient Protection and Affordable Care Act (known as the ACA) expanded Recovery Audit Contractors (RACs) to Medicaid and Medicare C and D. As the Minnesota Medicaid agency and a fiduciary for residents in Minnesota, DHS is challenged to identify overpayments quickly and efficiently. However, as a payor in Minnesota, the overpayment recovery process deployed by DHS can have a significant impact on the provider community.

HMS has worked hand-in-hand with clients; providers; insurance carriers; Pharmacy Benefit Managers (PBMs); Third Party Administrators; ERISA plans; Medicare; and a host of state, regional, and national organizations to develop the tools and resources necessary to promptly identify and effectively recover Medicaid overpayments. As a result, HMS is well positioned to serve as DHS's strategic partner in Health Care Reform and can assist DHS by initiating the retrospective claim review activities required for the RAC expansion.

HMS implements best practices in the performance of Medicaid RAC activities. **We bring to Minnesota a proven RAC approach, which includes a complete review of DHS's scope of work, policies, and program components to ensure that we correctly interpret policies and understand the systems, state requirements, program data, regulations, and plans.** Our proposed solution comes equipped with the functionality necessary to help DHS comply with ACA provisions, effectively initiate recovery efforts, minimize provider abrasion, and achieve immediate project results.

As part of the Minnesota Medicaid RAC program, we will deploy proven identification/data analysis, audit/review, and recovery services to yield positive results for DHS. Our approach (**Exhibit 4.B-25**) includes the following:

state Medicaid data. HMS analysts have extensive experience in working with Medicaid data. We currently have more than 10 billion Medicaid claims records in our data warehouse, against which we perform data analysis to identify overpayment recovery opportunities for state clients. Every month, HMS receives, copies, reformats, nets, stores, and analyzes more than 100 million new claim records.

HMS Knows DHS Medicaid Data

Through our relationship with DHS, HMS has extensive experience with its data and a solid working knowledge of its data fields, definitions, and values. HMS currently receives data files from DHS bimonthly via FTP transmission, including MMIS paid claims, Medicaid eligibility, and provider files. Our detailed understanding of the DHS files, combined with our national best-practice perspective, allows us maximize recoveries on behalf of DHS.

External Data

In addition to claims data, we are experts in using beneficiary eligibility and provider data as well as various other MMIS reference files.

HMS's Established Data Protocols

HMS has developed and implemented multilayered systemic and operational protocols and processes around the request, receipt, copying, validation, processing, organization, QA, and control of our client's data. We have invested tens of millions of dollars developing and enhancing HIPAA-compliant, SAS 70–audited technology and infrastructure that enables us as an organization to secure, store, back up, and access this data effectively.

HMS devotes significant resources to the loading and validation of DHS data to ensure ongoing data quality. Before we load new data 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 immediately initiates a review of the data. We run data analysis/validity check routines monthly against DHS's historical claims data, both on initial load and ongoing. For example, we check all files for duplicate claims. If this duplicate measurement exceeds an established threshold level, we stop all processes—most Medicaid programs have some duplicates. A high duplicate level may signal a problem with claim void/adjustment netting. HMS also runs distributions on a wide range of data elements to find anomalies, such as a high volume of invalid diagnosis codes. Results outside a threshold range could indicate a potential problem with the data. HMS receives information from more than 40 Medicaid clients regarding potential targets in our ongoing reviews.

Inaccurate data causes:

- False positives
- Missed recoveries
- Unnecessary cost
- Provider abrasion
- Decreased credibility

The application of HMS's innovative solutions in Minnesota will support the state as it explores every opportunity to maximize the value of the funds that it receives from taxpayers. HMS is ideally suited to implement new ways in which costs can be contained over both the short and long terms.

The specific services and programs most applicable to the state of Minnesota and described in detail in this section, include the following:

- Pharmacy services:
  - **COB***Manager*
  - **COB***Now*
  - Pharmacy audits
  - Drug Rebate Assistance
- Specialized credit balance audits
- Asset verification
- Trust recovery
- Clinical review services:
  - Prior Authorization (PA)
  - Verification of PA Information
  - Retrospective Review
- Medicare Buy-in services

HMS understands that DHS requires the experience and qualifications of a full-service contractor who is able to apply proven processes to increase the overall value to Medicaid in addition to those provided via the delivery of the services requested in the RFP. All proposed solutions align with TPL and RAC project goals and the RFP-defined scope of work with no overlap.

Before implementing the projects described in this section, HMS will conduct a needs assessment and planning session with DHS to ensure agreement on project deliverables, HMS's approach, and integration of efforts into our core scope of work. As part of the assessment process, HMS will provide detailed information regarding deliverables and project management timelines for each project pursued.

Pharmacy Services

As Medicaid enrollment continues to expand both nationally and in Minnesota, program costs associated with the delivery of pharmacy services challenge the limited funds of the state's Medicaid agency. Consequently, more vigilance is required to ensure that Medicaid avoids paying for all claims for which a third party is liable, especially in high-cost/high-volume areas such as pharmacy services. In the pharmacy

HMS is the leader in providing pharmacy cost avoidance services for Medicaid agencies.

Table of Contents – Tab 4.C: Tools, Hardware, or Software

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Tab 4: Subject Matter Category

Tab 4.C Tools, Hardware, or Software

C. A description of any tools, hardware, and software that would be needed to support the services you are offering for the subject matter;

The tools, hardware, and software used to support the services offered by HMS are fully integrated into our service offering. **DHS will not be required to purchase, license, or maintain any tools, hardware, or software needed to support the services that HMS proposes to provide. HMS will bear all such costs**.

HMS uses a host of proprietary systems to address all of the services that we propose to provide to DHS. These systems are fully integrated into our service offerings, and descriptions of the tools used by HMS can be found throughout our narrative under **Tab 4.B Data Analytics Services**.

In addition, we have a fully integrated, comprehensive reporting platform for all services that will be available to the state at no additional cost. A description of this reporting platform can be found in **Tab 4.M Reporting Platform**.

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Key HMS Enterprise Data Analytics Program Staff for the State of Minnesota

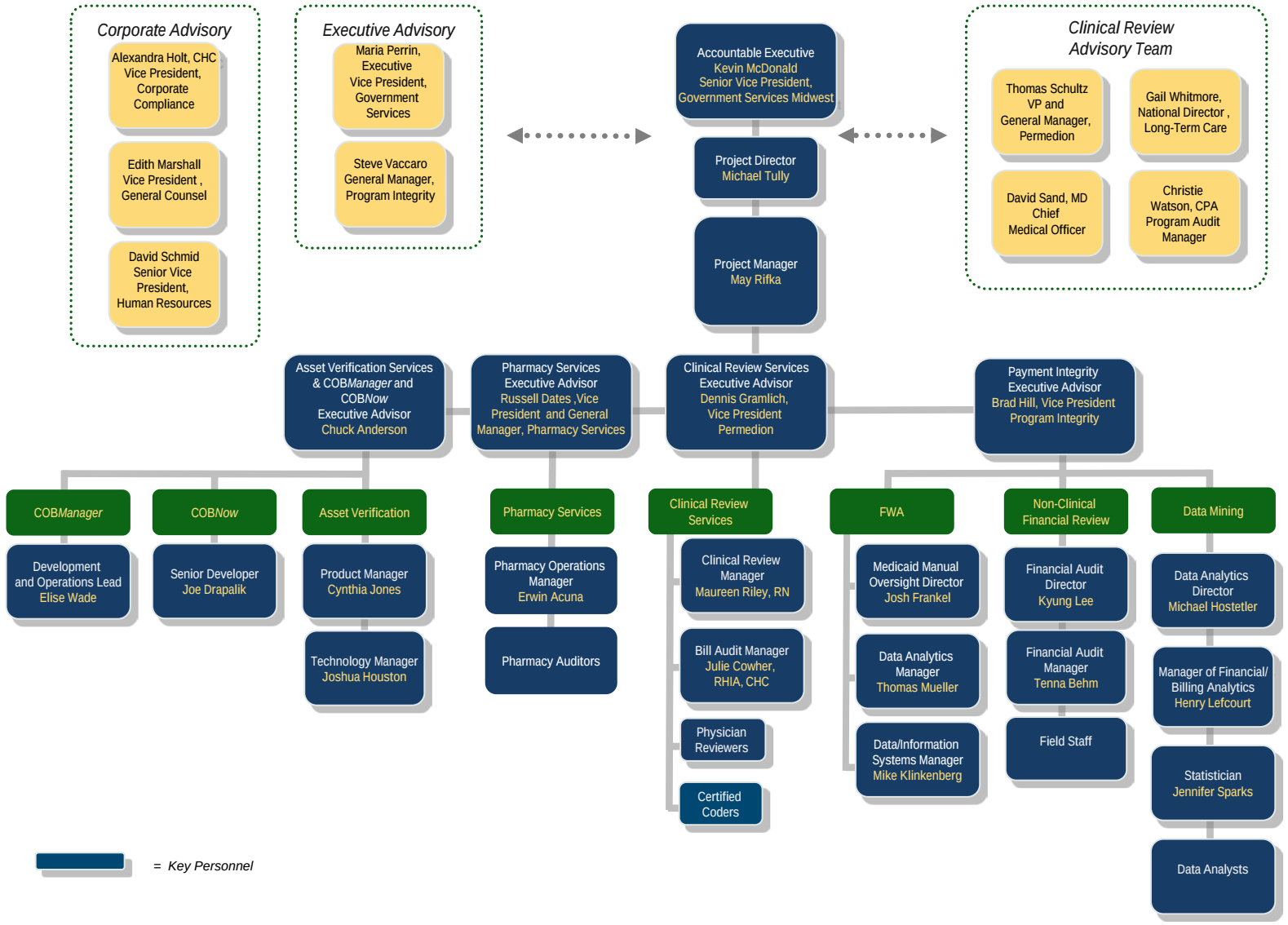

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Table of Contents – Tab 4.D: State Involvement

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Tab 4: Subject Matter Category

Tab 4.D State Involvement

For each Subject Matter Category for which the responder seeks to be considered, provide the following:

D. To the extent you are able, indicate the level of State involvement necessary for the successful implementation of the services you are offering. Include estimates of resource levels and time.

The services that we offer to DHS require minimal state involvement for successful implementation. Without a scope of work, it is difficult to estimate the specific resource levels and time required of state personnel; however, most of our services will be based on our analysis of Medicaid paid claims data.

Because HMS is the current DHS TPL vendor, we have the experienced staff, interfaces, systems, and processes in place to minimize state involvement for implementation of additional services. Consequently, for most projects, we anticipate that DHS will need to designate a point person to respond to questions and a point person to address data and file transfer issues.

Our ability to share data, insights, and results across all of our cost containment and recovery audit functions is a cornerstone of our integrated approach. We understand how eligibility, coverage, utilization, clinical, and financial information can be used together to profile errors and identify potential improper payments, and we leverage the interrelatedness of the identification and recovery services that we already provide with the services that we propose to deliver to identify and recover improper payments.

Our proposed services share a common set of operational activities that include program analysis, data intake and netting, data analysis, reimbursement analysis, and development of recovery processes that encompass provider notification; provider relations; appeals support; and overpayment tracking, recovery, and reporting. **HMS will share the implementation and maintenance of these common processes, resulting in significant cost and time efficiencies.**

For each project or scope of work that HMS is selected to fulfill, we will provide a detailed implementation timeline. Each timeline will identify the scope of work; detailed step and timeframes for all of the work to be performed; and an assessment of the relative difficulty of each task, DHS's involvement, and all other facets of the project.

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Table of Contents – Tab 4.E: Personnel

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Tab 4: Subject Matter Category

Tab 4.E Personnel

D. A list of personnel anticipated to provide professional services under this master contract program; provide a narrative of their individual qualifications or provide a resume or curriculum vitae specific to each proposed subject matter category;

The team assembled for this contract consists of professionals whose combined experience offers DHS expertise in all operational areas needed to implement the full scope of services we propose to provide. The proposed HMS project team includes healthcare professionals with specific expertise and practical experience within the contexts of pre-pay Medicaid program best practices, the National Correct Coding Initiative (NCCI), regulatory research and compliance, Minnesota Medicaid, clinical reviews, appeals, provider relations, and training.

Qualified and Experienced Project Team

While HMS has made considerable investments in technology and processes throughout our history, we recognize that the most valuable resources we offer are the qualified personnel we assign to fulfill each engagement. Our employee base of more than 1,600 healthcare service specialists includes nationally recognized experts in the fields of healthcare and public policy administration, health insurance, data processing, systems analysis and development, information management, claims processing, overpayment analysis, and supporting operations.

HMS's project team members have experience designing, implementing, and managing a full scope of pre-payment/correct coding editing services and overpayment recoveries.

We understand the unique challenges facing government-sponsored and public healthcare programs as they struggle to provide quality services amid budget constraints and ongoing economic challenges. Our flexible, scalable service delivery model ensures that the right resources are available at the right time to support the program-specific requirements of our clients, and to maximize their results.

Our team members have expert knowledge that DHS requires in associated business processes and rules, best practices, and federal and state regulations as well as in Minnesota Medicaid. In particular, our team knows how to operate successfully within the Medicaid environment, and understands the Medicaid-specific rules that define DHS's programs.

HMS project team members will work closely to oversee day-to-day operations, and we will provide appropriate staffing levels to maximize project results while adhering to all contract requirements.

HMS has assigned healthcare professionals to DHS's engagement that have relevant education, experience, and a documented history of effectively performing, overseeing, and/or managing the service activities contained within the scope of DHS's RFP. Our Project Director, Michael Tully, will manage the project team, and will provide a single point of contact for our services. To ensure a smooth implementation and continuing operation of any service, the project team will receive the full support of the advisory teams described below.

HMS Advisory Teams

HMS is an industry leader in developing customized Medicaid cost containment and program integrity solutions. Our advisory teams include members from our executive leadership group, who not only understand Medicaid but also possess years of practical experience in the specific analytics and services that we propose to provide. Members of our team have worked side-by-side with CMS, Medicaid agencies, CHIP programs, ADAP programs, High-Risk Populations, State Pharmacy Assistance Programs, Charity Care Programs, commercial payors, and elected officials to form policy, design solutions, and contribute consultation in areas affecting Medicaid payment.

This expertise in both policy development and data proficiency differentiates HMS from its competitors. As the evaluation committee is aware, Medicaid and Medicare programs and systems are vastly different, and HMS can best serve DHS due to its expansive national Medicaid experience and specific DHS knowledge.

Executive Advisory Team

Lending their Medicaid, cost containment, and FWA expertise and understanding will be **Maria Perrin, Executive Vice President, Government Services,** and **Stephen Vaccaro, General Manager, Program Integrity.** Ms. Perrin and Mr. Vaccaro possess significant knowledge regarding payment integrity program best practices as well as broad ACA expertise.

Corporate and Clinical/Pharmacy Advisory Teams

HMS's Corporate and Clinical/Pharmacy Advisory teams include multiple professionals with experience in virtually all of the operational areas needed to implement all proposed review services. Members of this team will serve as resources as needed throughout the life of this contract, and will engage HMS's technical, administrative, and management resources as requested to ensure that we exceed DHS's requirements.

Corporate Advisory Team

Consisting of **Vice President, Corporate Compliance Alexandra Holt; Vice President, General Counsel Edith Marshall;** and **Senior Vice President, Human Resources, David Schmid,** the Corporate Advisory team will ensure that all necessary business units within HMS, including government services, program integrity, human resources, and corporate compliance, cooperate to support this engagement. Our corporate advisors will provide high-level oversight and advisory functions relating to the services that we provide under this contract in addition to the innovative concepts we present as part of this response.

Clinical Review/Pharmacy Advisory Team

Our clinical advisors consist of **Permedion VP and General Manager Thomas Schultz and HMS Chief Medical Officer David Sand, M.D.** These team members will ensure that all clinical staff members are properly credentialed and trained. **Program Audit Manager Christie Watson** will lend her expertise in behavioral health to ensure that our customized edits and related review services for DHS are comprehensive.

HMS Resources: Functional Areas of Expertise

The HMS project team is supported by staff members with a broad range of advanced knowledge and experience in providing a full spectrum of cost containment services. The ability to determine that a payment is improper requires the unique experience of data analytic experts, certified coding professionals, and physician reviewers.

HMS's high standards guarantee that only appropriately trained, qualified professionals provide services to our clients. All of our staff possess multiple years of Medicaid experience and/or correct coding claims processing experience and are credentialed and licensed where appropriate. Certified coders, who possess a minimum of three years experience in coding review, review all issues of medical necessity coding and have access to our panel of nearly 700 physicians.

HMS will provide sufficient staff resources to fulfill all project requirements, and we will maintain adequate staffing levels throughout the contract term. HMS has more than 1,600 qualified specialists dedicated to HMS's core business, providing us with the unique advantage of experienced and talented staff to draw from to support DHS's business objectives. **Exhibit 4.E-1** describes the areas of expertise of our national team of healthcare professionals supporting this project.

Exhibit 4.E-1 ▶ *HMS Project Team Members Have the Requisite Skills and Experience to Ensure the Success of DHS's Medicaid NCCI and Other Pre-Payment Edit Program*

Function/Area	HMS Staff Expertise
Data Algorithms, Pre-Payment Edits, and SC Rules	▶ HMS's team of data analysts uses proprietary analytical processes, algorithms, and rules-based analysis routines and systems developed and fine-tuned through many years of pre-payment editing experience. ▶ Algorithm and analysis process will be customized for DHS to identify potential improper payments. ▶ HMS will develop and implement approved, unique modules that fit DHS's Medicaid program's data, policy, and regulations as well as State-directed and -defined exclusions. ▶ HMS's Regulatory Research and Compliance department reviews all relevant regulations and policies to ensure the applicability of each algorithm to the program and to set the appropriate parameters for each algorithm. ▶ HMS's team possesses expertise in customizing analytics for federal, state, program-specific (CHIP, Medicare Advantage, Healthy Families, etc.), and client-specific contractual policies.

Function/Area	HMS Staff Expertise
Working with Providers and Other Stakeholders	► Established relationships and processes with providers and other state departments/offices in Minnesota ensuring a minimal impact on key stakeholders ► In-depth knowledge of health insurance plans and benefit packages ► Knowledge of claim coding (CPT, HCPCS, ICD-9/ICD-10) ► Experience processing large volumes of data, meeting all requirements for accuracy, timeliness, and reporting
Privacy and Security Compliance, Including HIPAA	► Adherence to standards enforced by the Security Review Committee, an HMS team that reviews and audits compliance with security and HIPAA policies and procedures ► Extensive Corporate Compliance program that fosters broad awareness of HMS's high standards regarding control and security among employees and helps to prevent fraud, waste, and abuse in the healthcare system ► Accessing data from clients, insurers, and other project stakeholders only for processing activities under the client's contract and only through an access-controlled data interface
Interfacing with MMIS and Other Healthcare Information Systems	► Extensive experience with MMIS systems from across the country and various vendors, including self-managed systems ► Understanding data file structures on a detailed operational and development level ► Knowledge of HIPAA requirements to ensure that HMS performs services in compliance with HIPAA
Providing Support to Other Public Assistance Programs	► Child Support (Title IV-D) Programs ► State Title XXI Child Health Insurance Programs (CHIP) ► Pharmacy subsidy programs ► Medicaid Managed Care Organizations ► Other public assistance programs ► AIDS Drug Assistance Programs (ADAP) ► State Employee Health Benefits Plans (SEHBP)

HMS has demonstrated our ability to assemble a diverse and uniquely talented team representing these operational units. We will coordinate the team's activities to achieve DHS's goals and achieve maximum results.

Organization

The project team organization chart on the next page shows the name and position of each proposed team member.

Accountable Executive

The Accountable Executive for this project will be **Kevin McDonald, Vice President, Government Services Midwest**. Mr. McDonald is fully authorized to commit resources to ensure both an effective project implementation and ongoing project success. Mr. McDonald will oversee the project implementation, management, and all technical aspects of any engagements resulting from this procurement. He will work closely with all advisory teams and the project director to ensure that HMS's services fulfill objectives, and will provide executive-level project oversight during all phases of contract operations.

Mr. McDonald's qualifications include more than 20 years of experience working with Medicaid agencies to deliver payment integrity solutions. He currently oversees HMS account management and field offices for HMS's Government Region Midwest, which includes Minnesota.

Project Director

Regional Vice President Michael Tully will serve as project director and the single point of contact for DHS. Mr. Tully serves in this capacity for our current work with DHS and has a detailed understanding of Minnesota policies. Mr. Tully knows how to apply HMS's expansive resources to meet contract goals; having served in similar project roles, Mr. Tully has experience in developing and implementing innovative solutions as well as applying best practices to ensure that all contract requirements have been met or exceeded. Mr. Tully has 10 years of experience serving Medicaid programs on both pre- and post-pay cost containment solutions.

For this engagement, Mr. Tully will work closely with HMS's project and advisory teams, DHS, and other stakeholders to provide project oversight and ensure that project goals are achieved, contractual objectives are met, and the services provided by HMS continue to bring high value to DHS.

Project Manager

May Rifka will serve as project manager, providing oversight and guidance to HMS's team and working closely with the project director on all implementation and technical aspects of the engagement. She will be available by email and telephone, as well as in person as requested, to meet with SCDHHS staff. Her deep expertise, which is a result of more than 30 years' experience with state Medicaid programs, will assure that DHS benefits from all of the features and capacities of our proposed services and their related advanced analytics.

HMS Project Team's Related Experience

HMS recognizes the critical importance of assigning healthcare program service specialists to this engagement who have the relevant education, experience, and a documented history of effectively performing, overseeing, and/or managing the service activities sought by DHS. As such, the individuals proposed to support the services and tasks associated with this procurement were selected because of their established history of success pertaining to the specific tasks and responsibilities to which they are

assigned. By matching the talents of each team member in this manner, we ensure the successful, timely, consistent, and predictable delivery of our services.

Exhibit 4.E-2 summarizes each team member's project role, and their years of health-related experience.

Exhibit 4.E-2 ▶ *HMS Offers DHS a Qualified and Experienced Project Team*

Team Member	HMS Title	Project Position/ Area of Responsibility	Years of Health Related Experience
Executive Advisory Team			
Maria Perrin	Executive Vice President, Government Services	Program Integrity Advisor	4
Stephen Vaccaro	Senior Vice President and General Manager, Program Integrity	Program Integrity Advisor	20
Corporate Advisory Team			
Alexandra Holt	Vice President, Corporate Compliance	Security Advisor	25
Edith Marshall, Esq.	Vice President, General Counsel	Legal Counsel	34
David Schmid	Senior Vice President, Human Resources	Human Resources Advisor	15
Clinical/Pharmacy Advisory Team			
Thomas Schultz	Permedion VP, General Manager Clinical Services	Program Integrity Advisor	26
David Sand, M.D.	Chief Medical Officer	Chief Medical Officer	28
Christie Watson	Program Audit Manager	Behavioral Health Advisor	15
Project Management Team			
Kevin McDonald	Senior Vice President, Government Services Midwest	Accountable Executive	20
Michael Tully	Regional VP	Project Director	10
May Rifka	Program Director	Project Manager	31
Brad Hill	Vice President, Program Integrity	Payment Integrity Executive Advisor	25
Dennis Gramlich	Vice President, Permedion	Clinical Review Service Advisor	39
Russell Dates	Vice President and General Manager, Pharmacy Services	Pharmacy Services Advisor	20
Chuck Anderson	Vice President, Development	Asset Verification and **COB***Manager* and **COB***Now* Executive Advisor	16
FWA Services			

Team Member	HMS Title	Project Position/ Area of Responsibility	Years of Health Related Experience
Josh Frankel	Compliance Manager	Medicaid Manual Oversight Director	7
Thomas Mueller	Database Administration Manager	Data Analytics Manager	7
Mike Klinkenberg	Senior Director – BI	Data/Information Systems Manager	27
Data Mining Services			
Michael Hostetler	Vice President of Program Integrity	Data Analytics Director	20
Henry Lefcourt	Director of Improper Payment Recovery Services	Manager of Financial/Billing Analytics	15
Jennifer Sparks	Health Research Analyst	Statistician	13
Data Analysts			
Non-Clinical Financial Reviews			
Kyung Lee	Director Program Integrity Implementation & Operations	Financial Audit Director	9
Tenna Behm	Manager, Financial Audits Operations	Financial Audit Manager	17
Field Staff			
Clinical Review Services			
Maureen Riley, RN	Director of Clinical Review Services	Clinical Review Service Manager	30
Julie Cowher, RHIA, CHC	Bill Audit Manager	Bill Audit Manager	14
Physician Reviewers			
Certified Coders			
Pharmacy Services			
Erwin Acuna	Director, Pharmacy Audit Services	Pharmacy Operations Manager	25
Pharmacy Auditors			
Joe Drapalik	Vice President, Applications Development	**COB***Now* Senior Developer	21
Elise Wade	Development/Analyst Manager	COBManager Development and Operations Lead	5
Asset Verification Services			
Cynthia Jones	Senior Director, Enrollment Services	Product Manager	16

Team Member	HMS Title	Project Position/ Area of Responsibility	Years of Health Related Experience
Joshua Houston	Technology Manager of Eligibility Services	Technology Manager	6
Total Years of Experience			**560**

Physicians and Certified Coding Professionals

Physician Reviewers

HMS's wholly owned subsidiary, Permedion, maintains a reviewer panel of nearly 700 physicians and other healthcare providers, and we continue to recruit additional reviewers on a constant and consistent basis. All of our physician reviewers are employed by HMS as independent contractors, with the exception of our fulltime Chief Medical Officer Dr. David Sand, and our part-time Assistant Medical Officer, Dr. Anthony Beisler.

Physician reviewers are all board certified by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA) and hold current, unrestricted licenses to practice healthcare, within the scope of their licensure, in the United States.

Reviewers who are not physicians hold current certification recognized by their profession's respective licensing or specialty board, if applicable. Physicians and other licensed clinical providers from the same discipline/specialty as the attending provider will complete the medical review.

With an extensive panel of physician reviewers representing all ABMS-recognized specialties and many subspecialties, we are able to provide true peer-matched physician reviews with reliable, authoritative, evidence-based determinations.

Exhibit 4.E-3 and **Exhibit 4.E-4** outline the specialties and subspecialties on our panel:

Exhibit 4.E-3 ▶ *Current National Physician Reviewer Panel*

Specialty	Subspecialty	Number of Specialists
Allergy and Immunology		6
Allergy and Immunology	Pediatrics	2
Anesthesiology		17
Anesthesiology	Pain Management	8
Colon and Rectal Surgery		1
Dermatology		5
Emergency Medicine		12
Emergency Medicine	Undersea Medicine	1
Family Practice		26

Specialty	Subspecialty	Number of Specialists
Family Practice	Geriatric Medicine	4
Family Practice	Hospice Care and Palliative Medicine	1
General Surgery		24
General Surgery	Surgical Critical Care	2
General Surgery	Surgical Oncology	1
General Surgery	Transplant Surgery	1
General Surgery	Vascular Surgery	5
Internal Medicine		42
Internal Medicine	Cardiovascular Disease	24
Internal Medicine	Clinical Cardiac Electrophysiology	3
Internal Medicine	Critical Care Medicine	6
Internal Medicine	Endocrinology	5
Internal Medicine	Endocrinology, Diabetes, & Metabolism	3
Internal Medicine	Gastroenterology	13
Internal Medicine	Geriatric Medicine	4
Internal Medicine	Hematology	9
Internal Medicine	Infectious Disease	7
Internal Medicine	Interventional Cardiology	2
Internal Medicine	Medical Oncology	17
Internal Medicine	Nephrology	8
Internal Medicine	Pulmonary Disease	4
Internal Medicine	Rheumatology	7
Internal Medicine	Sleep Medicine	2
Internal Medicine	Transplant Hepatology	1
Medical Genetics	Clinical Genetics	1
Neurological Surgery		9
Nuclear Medicine		2
Obstetrics/Gynecology		27
Obstetrics/Gynecology	Gynecological Oncology	5
Obstetrics/Gynecology	Maternal & Fetal Medicine	2
Obstetrics/Gynecology	Reproductive Endocrinology	2
Ophthalmology		14
Oral Maxillofacial Surgery		8
Orthopedic Surgery		22
Orthopedic Surgery	Hand Surgery	3

Specialty	Subspecialty	Number of Specialists
Otolaryngology		16
Otolaryngology	Pediatric Otolaryngology	1
Pathology		1
Pediatrics		21
Pediatrics	Pediatric Behavioral Developmental	4
Pediatrics	Pediatric Critical Care	2
Pediatrics	Pediatric Emergency Medicine	1
Pediatrics	Pediatric Endocrinology	5
Pediatrics	Pediatric Gastroenterology	1
Pediatrics	Pediatric Hematology-Oncology	5
Pediatrics	Pediatric Infectious Diseases	1
Pediatrics	Medical Toxicology	1
Pediatrics	Neonatal-Perinatal Medicine	4
Pediatrics	Pediatric Cardiothoracic Surgery	1
Pediatrics	Pediatric Surgery	1
Physical Medicine & Rehabilitation		16
Plastic Surgery		19
Preventive Medicine		2
Preventive Medicine	Medical Toxicology	1
Preventive Medicine	Occupational Medicine	6
Psychiatry & Neurology	Addiction Psychiatry	2
Psychiatry & Neurology	Child & Adolescent Psychiatry	8
Psychiatry & Neurology	Child & Adult Neurology	2
Psychiatry & Neurology	Forensic Psychiatry	2
Psychiatry & Neurology	Child Neurology	3
Psychiatry & Neurology	Neurology	14
Psychiatry & Neurology	Psychiatry	17
Psychiatry & Neurology	Sleep Medicine	1
Radiology	Diagnostic Radiology	7
Radiology	Neuroradiology	3
Radiology	Nuclear Radiology	4
Radiology	Radiation Oncology	4
Radiology	Vascular & Interventional Radiology	4
Thoracic Surgery		6
Thoracic Surgery	Cardiothoracic/Vascular Surgery	3
Urology		15

Specialty	Subspecialty	Number of Specialists
TOTAL (may include reviewers with more than one specialty)		**572**

Exhibit 4.E-4 ▶ *Other National Clinical Specialist Areas*

Specialty	Number of Specialists
Acupuncture	4
Chiropractic Care	24
Chiropractic Care/Board of Radiology Diplomat	1
Dentistry	4
Naturopathy	1
Pharmacy	1
Physical Therapy	5
Physician's Assistant	1
Podiatry	6
Prosthetics	5
Psychology	4
Psychology (Forensic/Child/Adolescent)	1
Speech Therapy	1
TOTAL	**58**

Credentialing for Physician Reviewer Candidates

Our credentialing process guarantees that reviewers conducting external reviews have the appropriate professional qualifications and are appropriately licensed, registered, or certified. Reviewers conducting external reviews are required to meet the following criteria:

- Current Board Certification in specialty
- Current, unencumbered U.S. Medical License (full, unrestricted licensed; not on probation, supervision, or regularly reported to the state board)
- Actively practicing physician with a minimum of five years experience in stated specialty
- Submission of all appropriate documentation
- Completion of an orientation to become a reviewer

As part of the signed agreement with the reviewer, any history of disciplinary actions or sanctions must be disclosed, including, but not limited to, the loss of staff privileges or any participation restriction taken or pending by any hospital, state, or federal government regulatory agency for wrongdoing by the healthcare professional. We do not credential or maintain credentials for any reviewer who has a history of sanctions and/or disciplinary actions. Verification of professional credentials includes:

- Current licensure
- Current board certification, if applicable
- History of sanctions and/or disciplinary actions
- Professional experience
- Actively practicing
- Potential conflict of interest
- Signed confidentiality agreement
- Report from National Practitioner Data Bank (NPDB) query:
  Liability insurance and claims history for past five years
  License sanctions
  Medicare/Medicaid sanctions

We perform our own primary credential verification as part of the formal credentialing process. This includes verification of licensure, board certification, and active-practice status in addition to a query of the NPDB, which a resource to assist eligible entities in investigating the qualifications and credentials of healthcare practitioners, providers, and suppliers. We feel that physicians with significant entries in the NPDB are not appropriate reviewers for quality of care issues, and they do not receive credentials.

Every reviewer is re-credentialed every two years and must submit a Personal Disclosure statement and Attestation regarding conflict of interest. Finally, our Reviewer Contract specifies required compliance with the Health Insurance Portability and Accountability Act of 1996. Additionally, with every review assignment, our physician reviewers are required to attest that they have no conflict of interest. Finally, we perform ongoing quality assurance (QA) on our physician reviewers; those not meeting acceptable standards for their review work are offered additional direction and education, and if no improvement is seen, they are ultimately dropped from our panel.

This constant recruitment-credentialing-QA cycle ensures that only the most qualified physicians perform reviews and that those reviews yield determinations that are accurate, dependable, and defensible. These attributes, as well as the care with which we render our determinations, result in lower provider abrasion, fewer appeals, and ultimately, less administrative burden for our clients.

Certified Coding Professionals

HMS currently employs 32 full-time Certified Coding Specialists (CCSs), whose responsibility is to review medical records to collect data, ensure appropriate billing, and follow up on questions or concerns raised by nurse and physician reviewers or healthcare providers. All of our coders must hold current RHIA, RHIT, CCS licensure or accreditation and possess a minimum of three years' clinical coding experience, including experience with DRG, APG, or other prospective reimbursement systems as well as with ICD-9-CM, ICD-10, and CPT coding for the clinical area under evaluation for the specific contract to which the coder is assigned.

Further, our coders must demonstrate the ability to analyze and evaluate the medical information necessary to collect specific healthcare information and have experience in medical review, chart audits, and quality improvement processes.

Résumés for Advisory Personnel

HMS's executive advisors will provide guidance throughout the contract and will offer their national Medicaid and healthcare expertise to project and DHS personnel as needed, assuring that all necessary resources are brought to bear to maximize results for DHS.

HMS Advisors	► Maria Perrin, Executive Vice President, Government Services ► Stephen Vaccaro, Senior Vice President and General Manager, Program Integrity ► Alexandra Holt, Vice President, Corporate Compliance ► Edith Marshall, Esq., Vice President, General Counsel ► David Schmid, Senior Vice President, Human Resources ► Thomas Schultz, Permedion VP, General Manager Clinical Services ► David Sand, M.D., Chief Medical Officer ► Christie Watson, Program Audit Manager

Executive Advisory Team

Maria Perrin

Program Integrity Advisor

Government Relations and Client Service Executive

Medicaid and Medicare RAC / 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

Executive Vice President, Government Markets, 2009–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 Veterans Administration
- 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

Maria Perrin

Program Integrity Advisor

that that 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 that contract resources are appropriate skilled

Career History

Health Management Systems, Inc

Senior Vice President, Government Relations, 2007–2009

- Responsible for developing comprehensive federal government relations programs to serve as a vehicle for supporting legislation and programs that promote healthcare expansion and efficient government healthcare spending
- Managed state government affairs efforts to support good public healthcare policy development in Medicaid, Children's Health Insurance Program (CHIP), Medical Support Enforcement, Universal Healthcare, and other state and local programs
- Served as key executive and business manager on HMS's contracts with the Centers for Medicare & Medicaid Services, 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
- Managed General Services Administration contract

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
- Executive sponsor for two contracts with the Centers for Medicare & Medicaid Services
- Managed the full operations of the CMS contracts and VFI student loan call center business
- Implemented and operated the Medicare Recovery Audit pilot program

Vice President, Business Development and Marketing, 2004–2005

- Launched rebrand 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

Maria Perrin

Program Integrity Advisor

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

George Weston, LTD, 2000–2004

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
- Managed overhead budget and reduced expenses by 10% via distribution route elimination and reconfiguration, reducing G&A and vendor pricing, outlet relocations/closures, and alternative distribution channels

Director of Business Planning

- Developed business analyst positions that drove the use of quantitative analysis in sales and marketing decision making including pricing, trade promotion, overhead and distribution expense
- 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

Bestfoods, 1998–2000

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
- Partnered with Sales and Marketing to develop annual plans and updated 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
- 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, FL, 1997*

Maria Perrin

Program Integrity Advisor

- *B.A., Economics, University of California, Los Angeles, 1991*

Partial Client List

- Centers for Medicare & Medicaid Services
- General Services Administration
- 40 Medicaid agencies, including Colorado Department of Health Care Policy and Financing, California Department of Healthcare Services, New York Office of the Medicaid Inspector General

Professional Affiliations

- National Governors Association
- New York Citizens Budget Commission
- National Association for Medicaid Program Integrity

Stephen Vaccaro

Program Integrity Advisor

Program Integrity, Utilization Review, and Provider Audit Executive

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

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

Health Management Systems, Inc

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 Administration
- 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

Program Integrity Advisor

Résumé Continued

- 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 DHS of Louisiana Physician Healthcare Network

Health Management Systems, Inc

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%

Partial Client List

New York Office of the Medicaid Inspector General, New York Elderly Pharmaceutical Insurance Coverage, North Carolina Dept of Health & Human Services, California Dept of Health and Human Services, New Jersey Dept of Human Services, Iowa Dept of Human Services, Virginia Dept of Medical Assistance Services, Missouri Dept of Social Services, Louisiana Dept of Health & Hospitals

Education

- *Master's Certificate in Project Management, George Washington University, Washington, D.C*
- *MBA, Hofstra University, Hempstead, NY*
- *B.S., State University of New York at Stony Brook*

Stephen Vaccaro

Program Integrity Advisor

Certifications/Accreditations

- America's Health Insurance Plans (AHIP)

Résumé Continued

- Health Insurance Associate (HIA)
- HIPAA Professional (HIPAAP)
- National Association of Subrogation Professionals
- Certified Subrogation Recovery Professional (CSRP)

Professional Affiliations

- National Association of Subrogation Professionals

Corporate Advisory Team

Alexandra Holt, CHC

Security Advisor

Systems and Data Management Specialist, Corporate Compliance Specialist

Business & Contract Development / Technical Process Documentation / Data Management & Control / Standard Operating Procedures / Quality & Compliance / Federal Security & HIPAA Requirements / Training / Operational Deliverables / MMIS Systems / Provider Relations / Yield Management / Recovery Opportunity Identification & Maximization

Current Practice

Vice President, Chief Compliance Officer, 2008–Present

- Oversees and monitors the company's Corporate Compliance program
- Oversees employee compliance training, policy development, and compliance reporting and tracking procedures for the company
- Supervises all final compliance resolutions
- Reports to the Audit and Compliance Committees 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 compliance activities
- Chairs the HMS Security Committee
- Designing and implementing HMS's "HMS University," an electronic knowledge repository and training facility
- Implementing HMS's Continuous Improvement management training
- Developing and maintaining TPL Standard Operating Procedures and technical documentation for all project types

Career History

Health Management Systems, Inc

Director of Quality Assurance and Training, 2003–2008

- Worked with Senior Management to ensure that HMS adheres to strict quality and compliance standards
- Managed both Quality and Training Units, ensuring that 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 compliance reviews
- Developed and implemented Quality Review techniques and practices, across the organization
- Developed and maintained Standard Operating Procedures and technical documentation for all project

Alexandra Holt, CHC

Security Advisor

types

- Developed and delivered training programs for all staff categories
- Designed and implemented HMS's "Knowledge Central," an electronic knowledge repository and training facility
- Implemented HMS's Continuous Improvement management training

Executive and Operational Management roles, 1983–2004

- Acquired wide-ranging industry and discipline expertise, including:
  - Federal and state regulations and requirements regarding coordination of benefits, processing Medicaid subrogation claims, and revenue maximization opportunities
  - Medicaid MMIS systems and HMS's proprietary processing systems
  - Yield management and provider relations
  - Financial reporting and controls

Director of Contract Operations

- While serving as Director of Quality and Training, acted as Director of Contract Operations in the above time frame and was 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

Corporate Communications

- Executive leading multiunit function responsible for all HMS and affiliate marketing, operational documentation, training, investor communications, and strategic planning

Human Resources

- Executive creating human resources function, including recruiting, training, performance evaluation, and human resource information systems

Alexandra Holt, CHC

Security Advisor

HHL Financial Services, Inc.

Corporate Operations

- Executive leading development and implementation of Standard Operating Procedures, technical documentation, and training for multi-region, national hospital accounts receivable firm
- Performed these responsibilities under terms of a management services contract between HMS and HHL

Partial Client List

- University of Massachusetts Medical School (MassHealth program) and the Medicaid programs in California, Florida, Georgia, New Jersey, New York, Pennsylvania, West Virginia

Education

- *M.A., The Cornell University, Ithaca, NY*
- *B.A., Oberlin College, Oberlin, OH, 1973*

Certifications/Accreditations

- AHIP Health Care Compliance Certification (CHC)

Edith Marshall, Esq.

Legal Counsel

General Counsel and Healthcare Legal Expert

Legal Research and Counsel / Medicaid / Medicare / Estate and Trust Recovery / Revenue Maximization / Program Integrity / Cost Avoidance / Project Implementation and Project Management / Data Matching / Claims Processing / Credit Balances

Current Practice

General Counsel, 2010–Present

- Provides legal counsel to State Medicaid Agencies, Medicare providers, and other healthcare entities
- Advises on regulatory matters affecting HMS's business and clients
- Provides legal advice to HMS Strategic Business Units and Operations/IT

Career History

Arnold & Porter

Counsel, FDA/Healthcare Practice Group, 2008–2010

- Focused on counseling and representation of drug manufacturers with respect to federal government pricing programs, including determination of Medicaid rebates and related pricing metrics

Safety Net Hospitals for Pharmaceutical Access

Director of Legal and Regulatory Affairs, 2006–2008

- Assisted in the qualitative and quantitative analysis of mutual fund performance

Powers Pyles Sutter & Verville, PC

Senior Counsel (Part-time), 2006–2008

Law Firm Partner, 2000–2006

United States Attorney's Office

Deputy Chief of Civil Division, 1994–1998

- Retained personal responsibility complex litigation and supervised other AUSAs, handling matters that ranged from employment discrimination to alleged healthcare fraud
- Recognized through her appointment as Deputy Chief of the U.S. Attorney's Office Civil Division

Assistant United States Attorney, 1984–1994

- Handled civil litigation in federal district court and the United States Court of Appeals for the D.C. Circuit, as well as certain criminal appeals
- Maintained oversight responsibility caseload involving Medicare and Medicaid programs
- Worked closely with CMS's attorneys to coordinate and supervise the defense of healthcare litigation against the federal government in the D.C. Circuit

U.S. Department of Justice

Senior Trial Attorney, Office of Special Litigation, Civil Rights Division, 1983–1984

- Conducted investigations and litigation involving state penal and healthcare institutions

Edith Marshall, Esq.

Legal Counsel

- Received special recognition for role in bringing about reforms and improved patient care in a state-run psychiatric hospital

U.S. Department of Health And Human Services

Attorney, Office of the General Counsel, 1977–1983

- Developed expertise in both Medicaid and Medicare reimbursement matters

Education

- *J.D., University of Michigan Law School*
- *A.B., Harvard University*

Certifications/Accreditations

- Member of the Bar, District of Columbia
- Member of the Bar, Commonwealth of Massachusetts
- United States Supreme Court, admitted to practice
- U.S. Court of Appeals for the District of Columbia Circuit, admitted to practice
- U.S. Court of Appeals for the Fourth Circuit ,admitted to practice
- U.S. Court of Appeals for the Fifth Circuit, admitted to practice
- U.S. Court of Appeals for the Eighth Circuit, admitted to practice
- U.S. Court of Appeals for the Ninth Circuit, admitted to practice
- U.S. Court of Appeals for the Tenth Circuit, admitted to practice

David Schmid

Human Resources Advisor

Human Resources and Personnel Manager

Professional Staffing / Resource Allocation / Medicaid & TPL Recovery / Training / Performance Management and Assessment

Current Practice

Senior Vice President of Human Resources, 2007–Present

- Senior executive for corporate Human Resources function, responsible for establishing strategic human resources and people development direction for HMS and its operating subsidiaries
- Direct three tower leads and associated staff of Recruiting, Talent Management and Core HR Services
- Lead the human resource function during exponential growth while integrating the multiple facets of strategic and tactical HR
- Influence leadership through HR analysis and standard reporting
- Execute the acquisition/transition of new business from start-up to on-going support
- Equip current and new corporate leaders in all aspects of an associate life cycle including on-boarding, talent management, performance management, compensation education, benefits and other HR programs including implementation of Peoplesoft 90

Career History

Perot Systems, Inc

Global Associate Relations, North American HR Delivery Leader/Business Partner, 2002–2007

- Led an internal strategic and tactical organization integrating all aspects of field HR into one composite group consisting of North American field business partners, Global associate relations, transition management, and HR operations
- Business partner to the Executive Vice President - Field Sales, Chief Financial Officer, General Counsel, and the Chief People Officer
- Directed 10 Regional/Global Business Unit Directors and associated staffs worldwide in all business unit towers and disciplines

Senior Human Resources Business Partner

- Responsible for overall Human Resources functions for Perot Systems' largest global business units (composed of multiple towers in the United States, Europe and Asia) including Healthcare Services, Business Process Services, Sales, Infrastructure Services, and all corporate services (HR, Finance, and Legal); included associate relations, performance management, leadership development, training, organizational development, compensation, and talent management
- Directed seven Regional/Global Business Unit Directors and associated staffs worldwide
- Managed enhanced talent management program to emphasize career pathing and succession planning in support of rapid organic growth initiatives

David Schmid

Human Resources Advisor

Fleming Companies, Inc

Vice President of Human Resources, Fleming Retail Group, 2001–2002

- Responsible for overall Human Resources functions for three Retail Divisions and two Distribution Divisions nationwide
- Strategic growth plans involved 200% to 400% expansion over three to five years through both acquisition and ground up development; included Associate Relations, Performance Management, Leadership Development, Training, Organizational Development, Compensation, Talent Management and Policy Development
- Directed a staff of six Regional HR field Directors/Managers, Payroll Manager, and associated staffs
- Coordinated the Organizational Development and Recruiting for the infrastructure required to support rapid expansion, including centralization of major support activities leading to enhanced efficiencies in all departments

Office Depot, Inc

Director of Human Resources, 1998–2001

- Responsible for overall Human Resources functions for four Retail Divisions, the SW/Central Supply Chain Division and the Business Services Division (five distribution facilities and associated satellites supporting six Regional Sales Districts and Customer Service Centers) in 21 states and Canada; total sales volume was $4 billion with an employee count of 14,000
- Directed a staff of four Regional HR Managers, 6 Generalists/Trainers and indirectly coordinated 30 District Trainers and their associated staffs
- Directly supported integration of all business units (Retail, Supply Chain, and Contract Sales) into a “one company” organization
- Coordinated execution of enhanced development modules and Leadership Skills training in the field

Summers Group, Inc

Director of Human Resources, 1996–1998

- Responsible for organizational development, policy development, overall administration of human resource policies and benefits, employee services, payroll, recruiting/pre-employment selection and testing, orientation and training, safety, risk insurance and legal actions for a 74 location, 1,300 employee, wholesale distribution company with $600 million in sales in 12 states
- Senior HR leader on the steering committee to review and select new benefit/compensation programs
- Improved turnover from 20% to 14% through leadership enhancements including orientation and training, branch interaction, management philosophies and compensation theories

Caradon, Inc, 1987 – 1996

Human Resources Director, 1994–1996

- Assisted in a plant closure and relocation from Irwindale, CA, to New Braunfels, TX; recognized for operational leadership

David Schmid

Human Resources Advisor

- Member of the Executive Steering Committee for strategic planning and key initiative/business development

Human Resources Manager, 1993–1994

- Responsible for development and administration of human resources policies, employee benefits, payroll, employee services, pre-employment selection and testing, and all legal actions for a performance-based manufacturing company of 3,000+ employees in 42 nation-wide facilities

Regional Plant Manager (Multistate), Senior Plant Manager (Multifacility), Plant Manager, 1987–1993

- Responsible for all aspects of plant manufacturing operations, including profit and loss accountability, human resources, budget preparation, sales coordination, performance management, customer service, quality assurance, safety, and Just-In-Time inventory practices
- Recognized as a top performer in operations through increased responsibility and associated promotions in rapid growth/acquisition environment

Education

- *Texas A&M University, BS, 1979*
- *United States Navy, 1979–1987, Lieutenant – Surface Warfare*

Clinical/Pharmacy Advisory Team

Thomas Schultz

Program Integrity Advisor

Strategic Planning / Operations Management / Contract Implementation / Liaison to Government, Healthcare Constituents, Partners and Community Leaders / Financial Management / Program Planning and Development

Current Practice

Permedion, Inc

Vice President and General Manager, 2007 to present

- Directs implementation of Permedion contracts from contract award until operational goals are met, including oversight of facilities, information systems, recruiting, and training
- Responsible for all client/contract performance tied to clinical review services performed by Permedion
- Builds and manages a tiered/matrixed organization designed for succession and long-term stability
- Negotiates and manages all Permedion subcontractor relationships
- Develops core product strategy and sustainable growth plans
- Plays a significant role in improving, developing, and expanding Permedion clinical review and auditing service lines
- Represents Permedion, an HMS Company, to current and prospective clients, governmental agencies, vendors, and the general community

Career History

Permedion, Westerville, Ohio

President, 2000–2007

- Led strategic planning functions, established short and long-range objectives, plans, and policies, subject to Board of Directors approval
- Ensured the adequacy of fiscal and human resources to meet operational requirements
- Directed operations and business development activities through leadership of the Executive Management Team
- Reported to the Board of Directors on all aspects of operations, contract performance, financial status, and business activities
- Represented Permedion to customers, members, government, healthcare constituencies, vendors, partners, and the general community

Permedion, Westerville, Ohio

Vice President of Finance, 1985–2000

- Participated in strategic financial and business planning
- Reported corporate and unit financial position and results

Thomas Schultz

Program Integrity Advisor

- Managed finance department staff, including payroll functions
- Invested excess cash in accordance with Board policy
- Negotiated contracts and leases
- Coordinated preparation of annual budgets
- Managed annual audit, pension audit, federal agency audits, and other ad hoc audits
- Developed and maintained financial institution relationships
- Responsible for continuously improving the system of internal financial controls
- Administered all corporate insurance and risk management policies

Convalescent Management Co, Inc Columbus, Ohio

Controller, 1984–1985

- Managed all accounting, administrative, and data processing functions for a closely held company that managed 10 skilled nursing facilities

The Flexible Corporation, Delaware, Ohio

General Supervisor, Payroll and Accounts Payable, 1978–1984
Systems and Procedures Analyst, 1975–1978
Production Supervisor, 1974–1975

Education

- *University of Utah, Salt Lake City, Utah, MBA, 1974*
- *Otterbein College, Westerville, Ohio, BA Mathematics, 1970*

Certifications/Accreditations

- CPA, 1986, State of Ohio Health Insurance Associate (HIA)

David Sand, MD

Chief Medical Officer

Program & Project Management Leader & Strategist Quality of Care, Peer Review, and Clinical Expert

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

Certifications/Accreditations

- Unrestricted Medical License in Ohio
- Board Certified: American Board of Otolaryngology
- Diplomate, American Board of Medical Examiners
- Diplomate, American Board of Otolaryngology
- Diplomate, American Board of Quality Assurance and Utilization Review Physicians (CHCQM)
- Fellow, American College of Surgeons (FACS)
- Fellow, American Academy of Otolaryngology-Head and Neck Surgery
- Fellow, American Academy of Facial Plastic and Reconstructive Surgery
- Fellow, American Institute of Healthcare Quality

Current Practice

HMS

Chief Medical Officer, 2009–Present

- Manages all aspects of nationwide physician reviewer panel including: recruitment, credentialing, education and training, and quality assurance
- Provides clinical perspective and input to Corporate strategic development
- Coordinates activities of Contract Medical Directors
- Provides clinical expertise and support to Corporate clients
- Key leader in new market development

Career History

Permedion, Westerville, Ohio

Medical Director, 2005–2009

- Supervises physician reviewer panel and interacts to clarify clinical issues, administrative issues, and scientific issues as they apply to a specific review(s)
- Assists in developing processes to monitor quality of reviewers and reviews for timeliness, completeness, and processes, while assuring appropriate levels of productivity and efficiency
- Provides clinical expertise to contract and project teams as requested
- Manages the physician reviewer recruitment process to insure the availability of qualified physicians to perform reviewer activities for Permedion contracts and projects
- Provides determinations regarding medical necessity and quality of care in Ohio and Colorado Medicaid cases of hospitalization

David Sand, MD

Chief Medical Officer

- Provides technical assistance, evaluations, and recommendations to Ohio Department of Jobs and Family Services regarding coverage policies for evolving treatments and technology
- Represents State clients in Fair Hearings
- Provides clinical expertise and utilization determinations for the Ohio Department of Rehabilitation and Correction
- Represents the Ohio Department of Rehabilitation and Correction in conferences with The Ohio State University as a member of DHS team
- Provides consultation to the institutional providers of the Ohio Department of Rehabilitation and Correction
- Provides executive oversight and summaries for clients on quality of care issues
- Member of the corporate Executive Management Team

Consultant, Insurance, Forensic, and Industrial Sectors, 1990–Present

- Utilize expertise in the application of evidence-based and contractual criteria to consult and counsel physicians regarding practice patterns and other activities

Interim Medical Director, Commercial Division, 2004–2005

- Supervised physician reviewers working on DHS of Washington contract and analyzed physician practice patterns
- Formulated recommendations to DHS of Washington regarding mitigation of patient care quality issues and physician practice – all recommendations were accepted by DHS of Washington without any modifications

Mid-Valley Hearing and Balance Clinic

Private Practice, 2003–2004

- Practicing Otolaryngologist providing care to patients of all ages; specializing in the evaluation and treatment of hearing and balance disorders
- Served as the referral center for Western Colorado for the follow-up of Universal Newborn Hearing Screening

Hearing Healthcare Management, Inc

Medical Director, 2001–Present

- Supervises clinical activities of approximately 200 audiologists and hearing aid dispensers in 16 states
- Has responsibility for risk management, HIPAA, Medicare, and Medicaid issues
- Developed and implemented the HIPAA and OSHA compliance programs; serves as HIPAA privacy officer
- Developed the company's first outcomes measurement program, which included selecting measurement tools, developing a training program, and analyzing outcomes

David Sand, MD

Chief Medical Officer

- Assisted in the development of the Company Policy and Procedure manual

Avada Audiology and Hearing Care

Medical Director, 2000–2001

- Supervised audiologists and hearing instrument specialists
- Provided medical expertise and instituted Quality Improvement Program

Cosmedic Laser Centers

Medical Director, 1999–2000

- Supervised physician and non-physician providers

Private Practice

1988–1999

- Practicing Otolaryngologist providing medical and surgical care to patients of all ages
- Provided comprehensive hearing evaluation, treatment, and rehabilitative services to patients of all ages including infants failing hearing

Helene Fuld Medical Center

Chairman, Department of Otolaryngology, 1989–1994

- Had responsibility for the professional conduct of six other otolaryngologists, including oversight responsibilities for the quality of the care they provided

Temple University Hospital

Clinical Instructor, 1988–1994

- Taught physicians the techniques of upper aerodigestive endoscopy and associated procedures, along with use of lasers in medicine, including the appropriate physics, safety, and techniques involved

Committees

- Chairman, Laser Committee, Helene Fuld Medical Center,
- Trenton, New Jersey, Pharmacy/Formulary Committee,
- Helene Fuld Medical Center, Trenton, New Jersey
- Ohio Health Quality Improvement Institute, Columbus, Ohio

Education

Regis University, CO, 3333 Regis Boulevard Denver, Colorado 80221-1099

- *MBA with honors, Healthcare, 2003*

Temple University Hospital, 3401 N Broad Street, Philadelphia, PA 19140

- *Surgery Residency, June 1983 – June 1984*
- *Otolaryngology, June 1984 – June 1988*

Pennsylvania Hospital, 210 W Washington Sq, Philadelphia, PA 19106-3514

- *Surgery, Internship, June 1982 – June 1983*

Brown University, 244 Thayer Street, Providence, RI 02906

- *Doctor of Medicine, 1982*

David Sand, MD

Chief Medical Officer

Brown University, 244 Thayer Street, Providence, RI 02906

- *ScB Biology, 1979*

Christie Watson, CPA

Behavioral Health Advisor

Current Practice

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 QA 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, 525 S Main St, Ada, OH 45810, BSBA, Accounting and Management, 1994*

Résumés for Project Personnel

HMS brings DHS extensive experience in the Medicaid arena. Our staff possess the knowledge and expertise to successfully implement a productive payment integrity program; their resumes follow.

HMS Staff	▶ Kevin McDonald, Accountable Executive ▶ Michael Tully, Project Director ▶ May Rifka, Project Manager ▶ Brad Hill, CPA, Payment Integrity Executive Advisor ▶ Dennis Gramlich, Clinical Review Services Executive Advisor ▶ Russell Dates, Pharmacy Services Executive Advisor ▶ Chuck Anderson, Asset Verification, COBNow, and COBManager Executive Advisor ▶ Josh Frankel, Medicaid Manual Oversight Director ▶ Thomas Mueller, Data Analytics Manager ▶ Mike Klinkenberg, Data/Information Systems Manager ▶ Michael Hostetler, Data Analytics Director ▶ Henry Lefcourt, Manager of Financial/Billing Analytics ▶ Jennifer Sparks, Statistician ▶ Kyung Lee, Financial Audit Director ▶ Tenna Behm, Financial Audit Manager ▶ Maureen Riley, RN, Clinical Review Services Manager ▶ Julie Cowher, RHIA, CHC, Bill Audit Manager ▶ Erwin Acuna, Pharmacy Operations Manager ▶ Joe Drapalik, COBNow Senior Developer ▶ Elise Wade, COBManager Development and Operations Lead ▶ Cynthia Jones, Asset Verification Product Manager ▶ Joshua Houston, Technology Manager

Project Management

Kevin McDonald

Accountable Executive

Provider Audit Management and Results Expert

Medicare/Medicaid Coordination of Benefits / Business and Product Development / Project Management / Conceptual Analysis / Information Systems / Technology Planning & Development

Current Practice

Health Management Systems, Inc

Vice President, Government Services

- Senior accountability for state agency contracts throughout the Midwest, including those in Minnesota, Iowa, Michigan, Illinois, Indiana, and Wisconsin
- Responsible for sales and operations of HMS's service offerings including third party liability billing and recovery, Medicaid RAC, cost avoidance, casualty, estate recovery, Medicare identification, credit balance and provider auditing, pharmacy auditing, and program integrity services

Kevin McDonald

Accountable Executive

- Manages teams dedicated to servicing Midwest clients and coordinates the efforts of teams in New York City; Des Moines, IA; Lansing, MI; Irving, TX; Boston, MA; Indianapolis, IN

Vice President, Provider Audit Services, 2009 – Present

- Leverages nine years of Medicaid overpayment experience
- Responsible for HMS's nation-wide payment integrity initiative; leads HMS overpayment audits in more than 20 states
- Identifies TPL lead sources from data obtained through audits and payment reviews
- Applies eight years of direct provider finance experience including reimbursement and revenue responsibilities
- Utilizes three years of experience managing state-wide multi-provider come-behind billing unit; focus of unit was resolving difficult and specialized claims
- Developed the provider overpayment identification and recovery product line
- Leads revenue recovery and enhancement initiatives to supplement client's Central Billing Office, with a primary focus on the collection of aged accounts and identification of previously unknown payors with annual recoveries exceeding $4 million
- Facilitates the design, rollout and implementation of real-time TPL identification product
- Provides operational and financial expertise to public sector healthcare clients

Director, New Product Development 2006 - 2009

- Spearheaded the design, implementation and operations of new TPL insurance identification initiative (COBMatch)
- Completed project from conceptualization to implementation in one year Initiative resulted in 11 new clients and/or expanded scope of existing clients
- Leveraged initiative to expand into two new market segments – SCHIP eligibility and small/medium Medicaid managed care organizations
- Led development of strategic positioning of product for new client sales

Career History

Public Consulting Group, Inc

Senior Consultant, 1999 - 2006

- Managed subrogation unit for a multi-state Medicaid HMO and identified opportunities to increase case leads and reduce processing time
- Provided operational and financial expertise to public sector healthcare clients
- Developed the provider overpayment identification and recovery product line
- Identified new TPL lead sources by utilizing access to provider data obtained through audits and

Kevin McDonald

Accountable Executive

payment reviews

- Managed a third-party billing unit that focused on the collection of aged and bad debt claims for a statewide mental health system
- Re-engineered healthcare provider billing processes, including easy to use PDAs that interfaced with proprietary software

Corporate Health Dimensions

Vice President Primary Care Operations, 1997 - 1999

- Managed client-sponsored medical clinics and pharmacies with a staff of 60 clinicians and support employees Responsibilities included all operational, financial, and staffing decisions; as well as client relations
- Completed feasibility studies and provided consulting expertise for potential clients and assisted in the establishment of new medical centers from groundbreaking through staffing as member of the company's new business development team

Director of Analytical Services, 1995 – 1997

- Led analytical team providing senior management and clients' quantitative recommendations for improvement of operational and financial processes
- Led sourcing initiative for referral laboratory vendor resulting in a 50% savings

St Mary's Hospital

Analyst, 1992 - 1995

- Provided management support for senior administrative community hospital staff
- Analyzed hospital and clinic programs for opportunities to decrease costs and increase revenues, including managed care contract analyses
- Led hospital-wide productivity benchmarking initiative resulting in catalyst for department heads to close the productivity gap between hospital and "best-in-class"

Albany Medical Center Hospital

Senior Financial Analyst, 1991 - 1992

- Provided cost/benefit and revenue maximization analyses to senior management for tertiary care hospital Analyzed provider reimbursement for revenue enhancement opportunities
- Analyzed hospital programs cost/benefit structure Uncovered cost savings by monitoring hospital services' payor utilization

Education

- *Union College MBA, Health Systems Management*
- *Union College, BA, Economics and English*
- *Kansai University of Foreign Studies (Japan), Economic Studies*

Michael Tully

Project Director

Client-Centered Program and Project Specialist

Medicaid & TPL Recovery / Medicare / Technical Support / Revenue Maximization / Cost Avoidance / Data Matching / Client Satisfaction / Pharmacy Services Recovery / Business Solutions / Claims Processing / Contract Compliance

Current Practice

HMS

Regional Director, 2008–Present

- Responsible for managing state agency contracts throughout the Midwestern region of the U.S., including Wisconsin, Indiana, Illinois, and Minnesota
- Former Regional Director over the Ohio TPL contract from 2008 – 2010
- Responsible for identifying new sales opportunities and managing operations of HMS's service offerings including billing, cost avoidance, casualty and estate recovery, Medicare identification, credit balance and provider auditing, and Program Integrity services
- Manages staff operations for Midwest clients and coordinates the efforts of teams in New York City and Irving, TX supporting HMS's client base

Career History

HMS

Program Director, 2006–2008

- Managed daily systems and operations processes for third-party liability (TPL) identification and recovery project on behalf of Ohio Department of Job and Family Services
- Coordinated operations including Commercial Insurance Identification and Recovery, Casualty Recovery, and Medicare recovery
- Managed daily operations for third-party liability (TPL) cost avoidance and recovery project on behalf of Indiana Office of Medicaid Policy and Planning, including commercial and Medicare recovery identification and recovery
- Implemented Indiana's state-wide cost avoidance at enrollment process, including the receipt of daily enrollment files and monthly full eligibility reviews
- Managed TPL recovery project on behalf of New York Elderly Pharmaceutical Insurance Coverage (EPIC) program
- Implemented Medicare Part D and Drug Discount Card recovery efforts for the EPIC program

Public Consulting Group

Consultant, 2004–2006

- Coordinated internal operations for TPL project on behalf of New York Medicaid, including weekly and quarterly client reporting, staff supervision, quality assurance, and systems management for cost

Michael Tully

Project Director

avoidance and recovery efforts

- Managed Medicare recovery initiatives for New York, including provider recoupment and auditing activities and Part B billings (both electronic and paper)
- Supervised all accounts receivable functions resulting from Medicare initiatives for New York including accounts receivable staff
- Implemented full-scope cost avoidance process for New York Medicaid, including commercial insurance, Medicare, and TRICARE
- Managed firm-wide rollout of proprietary TRACER tool and directed the development for information tracking and data entry application utilized for verifications, accounts receivable, and Medical Support Enforcement (MSE) activities
- Conducted TRACER training sessions for staff, supervisors, and clients

Business Analyst, 2001–2003

- Implemented commercial identifications and MSE activities for the South Dakota IV-D and Medicaid populations
- Managed insurance data matching and verification operation processes on behalf of DHS of South Dakota
- Established and implemented quality control procedures for all cost avoidance and MSE leads issued to South Dakota
- Managed identification and verification of all insurance leads processed for Massachusetts TPL project
- Coordinated Massachusetts project staff and systems to process insurance leads, including data matches running in production, ad-hoc matches, and the processing of all other paper or electronic referrals
- Supervised the Massachusetts customer service call center
- Analyzed data and ensured QA for all data matches and file transfers to Massachusetts. Identified and implemented initiatives to increase identifications
- Created and presented monthly update reports to Massachusetts regarding project status

Partial Client List

Wisconsin Department of Health Services, Ohio Department of Job and Family Services, Indiana Office of Medicaid Policy and Planning, Illinois Department Healthcare and Family Services, Minnesota Department of Human Services

Education

- *MBA, Clark University*
- *BA, Bates College*

May Rifka

Program Manager

Client-Centered Program and Project Specialist

Implementation Management / Contract Compliance / Product Development / Project Management / Liaison to State Leadership / Third Party Liability

Current Practice

HMS

Program Director, 2010 – Present

- Work closely with HMS clients, including the State of Minnesota, to develop a complete understanding of their business and operations; facilitate accurate identification of specific recovery projects that will best meet clients' fiscal and programmatic needs
- Serves as the principal technical and contract support contact between HMS technical staff and the client to ensure client satisfaction, including the timely management of project operations, implementing new projects, deliverables, release of billing cycles, performing analyses, maintaining compliance with state and federal agency regulations, managing client relationships, and ensuring client satisfaction.

Career History

EDS/HP

Provider Relations Manager, Indiana Title XIX, 2007 – 2010

- Planned, directed and coordinated provider relations activities related to a provider base that approaches 45,000. Included managing provider enrollment, a customer assistance center and provider representatives in the field. The entire focus was on providers and their needs.
- Implemented four major system changes to provider services as part of the new contract for Indiana. The project was completed on time and on budget.

Implementation Claims Manager, Connecticut Title XIX Implementation, 2005 – 2007

- Implemented scanning for all claim types and all other correspondence, including all provider documents and all financial-related papers and checks.
- Managed the transition of front-end functions from existing Connecticut Medicaid operations to the operational activities of the new system, and all related hardware and software turnover.

Senior Business Services Analyst, Medicaid Implementation Services, interChange MMIS Implementations, 2001 – 2005

- Managed the claims testing effort for the implementation of the interChange MMIS in Tennessee and the design and testing for TennCare Reform.
- Served as training coordinator for the Kansas interChange MMIS implementation.

Executive Director, Indiana Title XIX, 2000 – 2002

- Planned and directed contract delivery for the State of Indiana Office of Medical Policy and Planning.
- Directed delivery of contracted services according to contract terms and customer satisfaction.
- Managed and coordinated resources satisfying contract terms. Served as EDS' liaison to the state,

May Rifka

Program Manager

working to improve the success of the customer's business

Account Manager, Alabama Title XIX, 1998 – 2000

- Successfully implemented the new Alabama Medicaid Management Information System
- Directed an implementation team of 100 employees that included system engineers, business analysts and other support staff. On implementation, directed delivery of contracted services and ensured Alabama Medicaid's satisfaction with those services
- Served as EDS liaison to the State of Alabama Medicaid and the governor, and was assigned to the Medicaid Oversight Commission.

Additional Experience

- ***Account Manager, Provost Technical Support Center, 1996 – 1998***
- ***Deputy Director/Implementation Manager, Indiana Title XIX, 1993 – 1995***
- ***Deputy Project Manager/Cost Containment Manager, Indiana Title XIX, 1991 – 1992***
- ***Implementation Manager, Indiana Title XIX, 1991***
- ***Executive Director, Women, Infants and Children (WIC) Projects, 1989 – 1991***
- ***Deputy Executive Director, WIC Projects, 1988 – 1989***
- ***Systems and Programming Manager, Georgia Title XIX, 1986 – 1988***
- ***Project Manager, Indiana Medicare Part B Project, 1986***
- ***Deputy Director/Systems and Programming Manager, Indiana Title XIX, 1985 – 1986***
- ***Project Operations Manager, Indiana Title XIX, 1984 – 1985***
- ***Systems Team Leader, Indiana Title XIX, 1984***
- ***Systems Programmer Analyst, Indiana Title XIX, 1982 – 1984***
- ***Project Manager, Indiana Title XIX, 1981 – 1982***
- ***Supervisor, Alabama Title XIX, 1980 – 1981***
- ***Recruiter/Trainer/Supervisor, Illinois Medicare Part B Project, 1980***

Education

- *Graduate, EDS Insurance Development and Systems Engineering Development Programs*
- *B.S., Biology and Education, Beirut College for Women, Beirut, Lebanon, 1970*

Bradley Hill, CPA

Payment Integrity Executive Advisor

Program Integrity, Provider Audit , TPL Operations Specialist

Data Analytics / Third Party Liability Recoveries / Coordination of Benefits / Cost Containment

Current Practice

Vice President, 2009–Present

- Operations executive responsible for management of multiple key state engagements and personnel oversight for all on-site employees and key project managers
- Responsible for the promotion and development of HMS Program Integrity services including clinical and financial cost containment analysis and solutions for government sponsored health care payers
- Key senior strategy executive responsible for responding to RFPs in markets in which HMS already has a presence and also looking for new markets for these services This program and initiative represents a strong and visible strategic emphasis within HMS

Career History

AIM Healthcare Services, Inc

Vice President, 2006–2009

Assistant Vice President, 2004–2006

- Promoted in 2006 to Vice President over all data mining services and divisions which included over 100 commercial payer clients and a staff of 300 individuals
- Oversaw the creation of a new operational division, dedicated to Enrollment Integrity, Prepay Services, COB Clearinghouse, and Government Solutions
- Operational oversight of one of three geographic data mining regions

Advanced Health Strategies, LLC

Principal/Independent Consultant, 2002–2004

- Member of independent consulting team engaged to evaluate the performance and develop revenue enhancing and cost saving opportunities for large health insurance provider
- Analyzed provider contracts by comparing contract provisions to internal payment policies noting discrepancies totaling more than $25 million
- Identified non-compliance issues related to improper coordination of benefits resulting in an additional $20 million in savings

ProMedCo, Inc

Regional Vice President, Operations, 2001–2002

- Directed the operations of 11 multi-specialty clinics generating combined gross revenue of $150m Collaborated with management and physician leadership of each, overseeing operations and performance initiatives
- Member of restructuring team charged with the valuation and sale of company assets in accordance with bankruptcy proceedings working with the trustee to maximize liquidation proceeds

Bradley Hill, CPA

Payment Integrity Executive Advisor

PhyCor, Inc

Vice President, 1999–2001

Director of Financial Operations, 1998–1999

- Oversaw the financial operations of a portfolio of 40 multi-specialty medical clinics and 2 hospitals located throughout the country with revenues in excess of $450 million
- Served as a member of the Board of Directors for each organization helping to form and direct strategic decisions, maximize best-practices initiatives, and develop physician compensation plans

Berwind Industries, Inc

Corporate Controller, 1994–1996

- Responsible for monthly consolidation and reporting of over 75 worldwide manufacturing subsidiaries with annual revenues exceeding $700 million
- Oversaw all of the financial operations of the local management and holding companies including budgeting, forecasting, data processing and treasury as well as the coordination of the external audit

Senior Financial Analyst, 1993–1994

Financial Analyst, 1991–1993

Cherry, Bekaert and Holland, CPAs

Staff/Senior/Supervisor Accountant, 1986–1991

Education

- *Murray State University, BS, Accounting, 1986*

Certifications/Accreditations

- Certified Public Accountant

Dennis Gramlich

Clinical Review Services Advisor

Market and Business Development Executive

Operations / Customer Relationship Management / EQRO Specialist / Utilization Management Healthcare Quality Improvement Strategist and Leader / Medicaid Quality Assurance Program Development and Management / Managed Care Quality Assurance Evaluations DRG Evaluation Services / Quality Strategies in Managed Care Environments

Current Practice

Permedion, Inc

Vice President, 1999–Present

- Oversees and directs contract activity on all contracts, including utilization management, coding review, and claims error identification; manages contract budgets, oversees preparation of deliverables, monitors/ensures customer satisfaction and shares experience and lessons learned across all contracts to benefit each of our clients
- Directs implementation of clinical review functions for new contracts, ensuring that clinical review staff are recruited in sufficient numbers and are trained according to Permedion-HMS standards and the specific procedures of the contract
- Provides oversight of clinical review services for utilization management contracts in Ohio (Medicaid and Department of Rehabilitation & Corrections), Colorado, Virginia, and New Jersey
- Manages corporate growth through a process of identifying and anticipating business opportunities and positioning Permedion to effectively respond to them
- Maintains current knowledge of both federal and state government health issues, as well as health issues affecting corrections departments, providers and potential business partners
- Serves on Permedion's Executive Management Team, which sets strategic direction for the corporation, and other corporate teams, including Business Development Team and Operations Team

Career History

Permedion, Westerville, Ohio

Vice President, Marketing and Business Development, 1995–1999

- Identified and pursued new opportunities to promote and develop health care quality improvement activities
- Served as Corporate EQRO Director for EQRO contracts with DHSs of Minnesota, Oregon, Ohio, and Delaware
- Served as Member, URAC Accreditation Committee, representing the American Medical Peer Review Association (AMPRA)
- Served as Confidentiality Officer from 1991-1996; responsible for related policies and procedures and all releases of PRO information

Statewide Director of Health Information Management, 1989–1995

- Served as Project Director for contracts with ODJFS (1992-1995) to perform annual QA evaluations of

Dennis Gramlich

Clinical Review Services Advisor

HMOs serving Ohio's Medicaid population Also served as Project Director for the EQRO portion of the QARI demonstration project in Ohio Projects involved review of provider sites, patient visit records against medical protocols, and HMO corporate offices, and resulted in comprehensive reports on each HMO and statewide reports and presentations

- Served as Project Director for contracts with Tennessee, Minnesota, Oregon and Delaware to perform QA evaluations of the HMOs serving those state's Medicaid population
- Responsible for overall management of the DRG coding validation process, supporting services, and HMO review for contract with HCFA to perform utilization/quality review for Ohio's Medicare population This included developing educational programs regarding DRGs and coding for nurses, physicians, hospitals, and special interest groups, writing articles and proposals, and occasional public speaking
- Chairman of Information Systems/PRO Committee and Internal Management Committee

Franciscan Health Systems of Central Ohio (St Anthony Medical Center and St Anthony Mercy Hospital)

Director of Medical Records, 1972–1989

- Responsible for medical records, medical transcription, medical library, utilization review, DRG management, social services, and coordination of all hospital QA activities In early 1988, assumed responsibilities as Director of Medical Records at St Anthony Mercy Hospital
- Other areas of involvement included hospital accreditation process (chaired committee) and hospital-wide information systems' evaluation, acquisition, and implementation

Education

- *The Ohio State University, Columbus, OH, MBA, 1982*
- *The Ohio State University, Columbus, OH, BS, Allied Health, 1972*

Certifications/Accreditations

- American Health Quality Association, Member, 2002 – Present
- URAC Accreditation Committee Member, 1995 – 2000
- Ohio Health Information Management Association, Chairman, Job Bank, 1977 – 1980, Chairman, Nominating Committee, 1980
- St Anthony Hospital Chapter of the National Management Association, Director, 1973 – 1974, President (Outstanding Service Award), 1974 – 1975, Chairman of the Board (Leadership Award), 1975 – 1976, Director, 1977 – 1978

Russell Dates

Pharmacy Services Advisor

Pharmacy Audit Services Executive

Pharmacy Audits / Pharmacy Benefit Manager Audits / Project and Program Management Operations Management / Third-Party Claims Processing / Client Relations / Quality Assurance

Current Practice

Permedion, Inc

Vice President and General Manager, HMS Pharmacy Audit Services, 1994–Present

- Oversees all business operations of the HMS Pharmacy Audit Services unit
- Establish strategic relationships with Managed Care Organizations, State Medicaid Organizations, Accounting and Legal firms across the nation
- Executive oversight of service and software development
- Manage diverse staff of pharmacy specialists, auditors, certified fraud examiners, and healthcare professionals

Career History

Wellpartner

Founder, Advisory Board Member, 1999–2000

- Developed initial business strategy
- Developed initial business model
- Executive level participation in securing “Angel” & A-series funding rounds
- Recruited initial management team

Caremark

Vice President, Retail Services Division, 1991-1994

- Managed prescription drug benefits for approximately 20 million lives
- Responsibility for Claims Processing Operations including:
    - On-line claims adjudication
    - Pharmacy contracting & networks
    - Pharmacy Help Desk
    - Pharmacy Claims Payment
    - Client Administration & Billing
    - Finance, Admin, H/R, and Facilities
    - Information Technology

Russell Dates

Pharmacy Services Advisor

Prescription Health Services

Vice President, Information Systems, 1987–1991

- Managed Information Systems operations for 3rd largest PBM in the United States
- Developed first on-line claims eligibility engine for pharmacy
- Developed PBM industry's 1st ad-hoc, real-time, decision support system for pharmacy claims

Education

- *University of California Los Angeles, Los Angeles, CA BA, 1980*

Chuck Anderson

Asset Verification,* COB*Manager,* COB*Now Executive Advisor

Current Practice

Vice President of Corporate Development, 2008 - Present

- Responsible for product development—internal development, partnerships, and/or acquisitions
- Provides leadership, vision, and development direction of HMS's real-time cost avoidance offering
- Directs HMS's Eligibility Integrity product suite (including HIPP services) and drives Pharmacy Audit Services performance
- Serves as our Subject Matter Expert in the areas of HMS's Enrollment Services and Pharmacy Point of Sale product development and implementation
- Leads integration efforts for **COB***Express* and **COB***Manager* applications into our client's systems to meet TPL requirements

Vice President, Eligibility Services, 2005 - 2008

- Directs HMS's Eligibility Services Group, responsible for the acquisition, verification and reporting of commercial eligibility
- Directs Carrier Relations activities, comprising carrier recruitment, including obtaining eligibility information and accessing carriers' verification websites, data intake and reformatting to HMS standards, monthly master file update process, including quality assurance
- Directs Product Development activities, comprising harnessing eligibility information for efficient delivery to our clients, cost avoidance information, enabling verification inquiries, facilitating identification of medical support enforcement (MSE) policies
- Serves as subject matter expert in the arena of pharmacy product management overseeing the assessment of current core competencies and the development and validation of product concepts

Vice President, Commercial Insurance, 2003-2005

- Responsible for oversight of HMS's Commercial Insurance TPL effort
- Guided CI product development, from concept through client delivery

Vice President, Corporate Development, 2002 – 2003

- Coordinated HMS's acquisition research and development and assisted HMS senior executives with channel partner development
- Assessed corporate core competencies, developed and validated product concepts, and guided product development within HMS

Career History

National Medical Health Card Systems

Consultant, 2000 – 2002

- Reengineered core systems in several departments, including formulary management and new member benefit cards and booklets
- Chaired weekly best practice meetings with representatives from sales, customer implementation,

Chuck Anderson

Asset Verification,* COB*Manager,* COB*Now Executive Advisor

provider networks, operations, and IT

First DataBank

Consultant, 2000 – 2002

- Responsible for staff of 140 technical, editorial, and sales personnel Decreased product delivery-lag time by 50%
- Wrote business plan for a new division, based on clinical reference content, which was funded

XCarenet

Consultant, 2000 – 2002

- Created business plan, marketing plan, and functional requirements for apothecarenet, a startup multi-wholesaler exchange for pharmaceuticals and medical supplies Obtained funding

The Pharmacy Fund, Inc

Senior Vice President, Planning and Information Services, 1998 – 2000

- Built on-line, drill-down tools that guided investigators to collect $120 million from 300 payors and insurers and 2,000 pharmacies

Senior Vice President, Cash Operations, 1997 – 1998

- Responsible for collection and application of 25 million pharmacy claims/month
- Initiated major reengineering efforts—providing investigative support, receivable management, and accounting controls within a workflow environment
- Reduced costs by $700k/year, and error rates from 15% to 01%

Consultant, 1995 – 1996

- Developed and executed company's initial marketing plan: created award-winning marketing collateral; opened new marketing channels, which resulted in $193 million of new revenue within 18 months
- In IT role, created sales and installation system

National Prescription Administrators, Inc

General Manager / Senior Vice President – Operations, 1996 – 1997

- Started business unit based upon an affinity credit card, with "miles" applied to future prescriptions
- Created and executed marketing campaign
- Established business relationships and partnerships

Medical Economics Data Company

Vice President, Database Services, 1994 – 1995

- Led electronic sales for Red Book and Physician Desk Reference sales for Medical Economics, a division of Thomson Corp Responsible for staff of four
- Hired consultative team to grow 5% market share

Chuck Anderson

Asset Verification,* COB*Manager,* COB*Now Executive Advisor

- Increased revenue by 22% for Red Book, and 90% for Physician Desk Reference
- Created application that matches filled prescription to the drug's stored electronic image Signed leading vendor of mail order software and in-store dispensing equipment to same
- Selected by Reuters as content base for their Internet physician portal

The Hearst Corporation

Vice President, Operations, 1992 – 1994

- Planned product and operation consolidation for three health care acquisitions
- Increased product demand by leading industry development of EDI standards
- Developed two major packages: rebate analysis for pharmaceutical manufacturers and formulary design for managed care

Assistant General Manager, Operations, 1985 – 1991

- Created 18 clinical modules, ie, patient drug monographs, printed with most new prescriptions dispensed today
- Developed software toolkit to ease customer implementation efforts
- Designed four products, including tool to analyze price trends, compare brands and generics, and support investment buy-in through leader-follower analysis and price increase forecasting

Business Unit Consulting, 1983 – 1984

- Worked with business units to reengineer their systems and processes Typical project: introduced systems into manual environment, supporting 13,000 mail orders per day Increased efficiency by 25% with new list revenue

Manager, Corporate Systems, 1982

- Created tax consolidation programs that reduced preparation time by 50% Analyzed and selected corporate financial consolidation packages

Education

- Golden Gate University
- City College of New York

Professional Affiliations and Honors

- National Council of Prescription Drug Programs (NCPDP), past DUR Co-chair; Member 1994 – Present
- New York New Media Association, Member, 1998 – Present

FWA

Josh Frankel, CPC

Medicaid Manual Oversight Director

Compliance Management, Certified Professional Coding

CPT Coding/ICD-9/Cirius/Siemens/Meditech/IDX/Medicorp/Medisoft/Acermed/Medic

Current Practice

HMS

Compliance Manager, 2010–Present

- Supervise a staff of 25 Medicare and Medicaid edit researchers and oversee all work to ensure accuracy
- Review federal and state regulations identifying potential edits to be integrated into our company system
- Delegate assignments and special projects to team research members who incorporate monthly and annual updates to state Medicaid regulations
- Work on special projects that include Evaluation and Management Coding audits and client specific edit audits in coordination with the Special Analytics Department
- Interact with Database and Data Analysis Department to ensure edit accuracy and special project efficiency

Career History

Duke University Health Systems

Medical Coder II, 2007–20088

- Research and resolve patient claims dealing with coding and diagnosis errors
- Amend claims by inserting proper Modifiers, CPT, ICD-9, Condition and Procedure Codes
- Instrumental in helping lower editing department's outstanding unpaid balance from $10 million to an unprecedented $1 million
- Work with team members and insurance company representatives to resolve insurance denials
- Created training manual used for new employees

Saddleback Physicians Services

Medical Coder/Biller, 2005–2007

- Accurately applied CPT and ICD-9 codes to surgical procedures performed by physicians
- Management of coding, billing and computer data input for multiple specialists
- Reorganized filing system to ensure accuracy of client accounts
- Created innovative spreadsheet program utilized by entire office maximizing company efficiency
- Assisted other employees with coding issues

Josh Frankel, CPC

Medicaid Manual Oversight Director

Mission Internal Medical Group

Medical Biller, 2004–2005

- Administered accounts by applying payments to personal records
- Input insurance and/or personal payments resulting in accurate daily balances
- Exceeded management's expectations by applying knowledge effectively and efficiently
- Promoted from Extern to full-time Medical Biller for exceptional work ethic

Diagnostic Products, Inc

Document Control Specialist, 2001–2003

- Reviewed procedures for accuracy and medical compliance
- Passed regular audits by troubleshooting reports and testing procedures
- Reorganized and restructured archive system streamlining retrieval and audit processes
- Created simplified worksheets and databases ensuring maximum quality assurance
- Promoted from Document Control Associate to Specialist within six months

Education

- *Everest College, Anaheim, California, Medical Insurance Billing/Coding – Diploma of Completion, 2004*

Certifications/Accreditations

- Certified Professional Coder

Affiliations

- American Academy of Professional Coders

Thomas Mueller

Implementation & Production Manager

Client Implementation, Database Management & Administration

Microsoft SQL Server/Data Mining/Technical Support /Hardware & Software/ Programming/Database Management/SQL based rule engine/Client Implementation/ Database Developer/Database Programmer/Data Analyst/ Report Designer

Current Practice

HMS

Database Administration Manager, 2004–Present

- Responsible for implementation of new client data into system database
- Improve flexibility and scalability of the system database backend by federating
- Simplify updates and eliminate redundancy by normalizing existing database tables and adding referential integrity
- Reduce the impact of reporting and ad-hoc querying by separating those functions from the OLTP side using real-time replication
- Improved database security by utilizing views, stored procedures, functions, triggers, logins, users, and roles
- Enable exponential data growth by scaling and tuning the hardware and software as well as extensive performance tuning and query optimization
- Improve overall server performance by switching from internal storage to Direct Attached Storage (DAS) and then to Storage Area Network (SAN) and moving from local commodity hardware to enterprise grade servers in a data center/colocation
- Utilize the latest features by upgrading all SQL Servers from Microsoft SQL Server 2000 to SQL Server 2005 and then to SQL Server 2008 after defining upgrade paths
- Reduce human involvement and increase processing speed by automating the extraction, transformation and loading of data using SQL Server DTS and SSIS
- Enable upper management and clients to make better decisions by supplying them with advanced statistics and complex reports utilizing Crystal Reports and SQL Server Reporting Services (SSRS)
- Eliminate hours of downtime every week for 25 concurrent users of an Access application by moving the data from Access to SQL Server to improve reliability and performance
- Increase data quality using best practices and procedures

Career History

Intel Corporation

Localization & Quality Assurance, 2004

- Responsible for localization and quality assurance, testing and correcting software

Claremont Graduate University

Research Assistant/Technical Officer, 2003–2004

Thomas Mueller

Implementation & Production Manager

- Managed research and technical activities, including, electronic information processing, data systems and computer programming
- Responsible for troubleshooting and repair work
- Allocated resources based on project needs and applied data structure and algorithm expertise to build information platforms

Innovative Communication Technologies

Computer/Audio Visual Expert, 1998–2002

- Implemented a CRM, ERP and inventory management system
- Managed the installation of audiovisual systems

Education

- *Furtwangen University of Applied Sciences, Furtwangen, Germany, BS, Digital Media & Computer Science, 1999*
- *Claremont Graduate University, MS Information Systems, 2004*

Certifications/Accreditations

- Certificate in Data Mining from University of California, San Diego
- Certificate in Business Intelligence and Data Warehousing from University of California, Irvine

Mike Klinkenberg

Data Information Systems Manager

Business Intelligence Strategist

Data Warehousing / Project Management / Contract Compliance / Employer Relations / Technical Support / Financial / Client Satisfaction / Business Solutions

Current Practice

HMS

Senior Director, Business Intelligence, 2011–Present

- Lead HMS BI organization in evolving business intelligence strategy and architecture to maintain market leading capabilities in program integrity reporting and analysis
- Evolve HMS data warehouse solutions as part of an over-arching data management strategy, to provide advanced data mining and robust analytic capabilities

Career History

PepsiCo

Senior Manager, 2008–Present

- Managed the Enterprise Data Warehouse (EDW) Program initiatives to integrate existing data warehouse solutions with varied capabilities and implementation approaches across the different divisions of PepsiCo (Frito-Lay, Quaker, Gatorade, etc) into a more cohesive, and flexible data management and information delivery environment
- Provided thought leadership and best practice insights to evolve the strategic roadmap, solution design and overall data architecture for the Enterprise Data Warehouse, Master Data Management and Enterprise Business Intelligence programs

Teradata

Vice President, 2005–2008

- Managed program initiatives to sell and implement business intelligence of acquired and developed workbench software

Infowise Solutions

Founder and President, 1998–2005

- Founder and majority owner of self-funded, boutique consulting company specializing in enterprise data warehouse/business intelligence implementations for Fortune 500 companies
- Served as the “face” of Infowise, responsible for securing the confidence of Fortune 500 leaders to entrust their large, complex EDW/BI projects to our boutique consulting group of industry experts
- Evolved client’s business intelligence vision, by partnering to learn their business and unique analytic needs and then proposing flexible data designs (multi-dimensional schemas) and implementation approaches to grow their analytic capabilities

MicroStrategy

Director, Professional Services, 1996–1998

- Started Southwest consulting practice for MicroStrategy prior to initial public offering

Mike Klinkenberg

Data Information Systems Manager

- Hired and mentored professional services personnel out of the Dallas office
- Managed more than 25 data warehouse/decision support initiatives for various Fortune 500 companies Duties included business requirements, strategic multi-dimensional data modeling, prototyping, and rapid application development using the MicroStrategy toolset and architecture

BNSF Railroad

Manager, Application Development, 1994–1996

- Managed employees in the design, development, implementation, and support of data warehouse and business intelligence solutions Major challenges included the integration of multiple data marts and cleansing data with the use of new master files

Ernst & Young

Manager, Management Consulting, 1992–1994

- Responsible for the sale, planning, and management of the various phases of large data warehouse projects (i.e., tool evaluation/selection, data preparation/loads, consensus-building across multiple user groups on standardized metrics and guided analysis process, training, etc)
- Led category management initiative for a large Midwest grocery retailer, advising and reporting directly to the grocer's CIO and CEO

Frito-Lay

Analyst, Information Technology, 1984–1992

- Project manager for reporting initiatives for sales organization using one of the first data warehouses implemented in the world Reporting systems developed included: route sales analysis, line item distribution, returns analysis, and promotion analysis

Education

- *Indiana University, Bachelor of Science in Quantitative Business Analysis, 1980 - 1984*

Data Mining

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

Health Management Systems, Inc

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:
  - Overpayment targeting analysis and recovery process development
  - Cross-state utilization analytics development
  - 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
  - Development/expansion of HMS's Medicare COB capabilities, including:
    - Pharmacy/DME (Medicare Part B and Medicare Part D)
    - DME (Medicare)
      - Medicare home health appeals

Michael Hostetler

Data Analytics Director

- Medicare SNF COB
- SSI Retro Identification and recovery issues

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

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,

Michael Hostetler

Data Analytics Director

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 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

Project Manager, 1991–1993

- Executed contracts for five TPL clients

Career History

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

Partial Client List

New York Office of the Medicaid Inspector General, New York Elderly Pharmaceutical Insurance Coverage, Arkansas Department of Human Services, California Department of Health Care Services, Connecticut Department of Social Services, Maryland Department of Health and Mental Hygiene, MassHealth, Michigan Department of Community Health, District of Columbia Medical Assistance Administration, Missouri Department of Social Services, New Jersey Department of Human Services, Kentucky Department for Medicaid Services, Virginia Department of Medical Assistance Services

Education

- *St Lawrence University - BS*

Henry Lefcourt

Director of Overpayment Recovery

Date of Death Overpayment Specialist

Operations Management / Cost Avoidance / Data Matching / Date of Death Overpayment

Current Practice

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 TACTiC™ 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

Health Management Systems, 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

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

Henry Lefcourt

Director of Overpayment Recovery

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 non-core 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

- *St Mary's University of San Antonio, MA*
- *NY State College of Ceramics at Alfred University, BFA*

Certifications/Accreditations

- Professional training, Miller/Heiman Large Account Management

Partial Client List

- Colorado, Texas, Maryland

Jennifer Sparks, MAS, CPHQ

Statistician

Claims Analysis / Medicaid / Utilization Review / Targeted Approach / Data Mining / Project Study Design / Quality Studies / SAS / Descriptive Statistics

Current Practice

Health Research Analyst II, 2004–Present

- Designs and conducts analysis of health care databases using SAS statistical analysis software and other relevant tools for multiple health care projects Analyses include descriptive statistics, hypothesis testing, linear, logistic and proportional hazards regression, and sample size calculation

Career History

OSU Medical Center, Columbus, Ohio

Senior System Developer/Engineer, 2001–2004

- Compiled and analyzed data to support quality improvement, clinical research, and resource evaluation activities in cardiovascular and critical care services
- Provided database management of local cardiopulmonary arrest, cardiac procedure, and cardiothoracic surgery registries
- Educated hospital administration and staff in the use of statistical process control
- Actively participated in several inter-disciplinary committees, including the Heart Services Quality Management Committee and the Code Blue Continuous Improvement Team

Ohio Health Group, Worthington, Ohio

Statistician, 1998–2001

- Monitored medical utilization and expense for actionable trends in support of senior medical and risk management staff
- Tracked member and physician populations for significant changes in demographic distribution
- Developed database applications using Microsoft Access for numerous departments throughout the company to help them better use and understand their data

Columbus State Community College

Adjunct Faculty, Department of Mathematics, 1999–Present

Health Power HMO, Columbus, Ohio

Data Analyst, 1998

Survey Solutions, Columbus, Ohio

Project Manager, 1996–1998

Education

- *West Virginia University, Morgantown, West Virginia, BS in Statistics, 1995*
- *The Ohio State University, Columbus, Ohio, Masters in Applied Statistics, 1997*

Certifications/Accreditations

- Certified Professional in Healthcare Quality

Credit Balance Audits

Kyung Lee

Financial Audit Director

Payment Integrity Services Leader

Provider Relations / Credit Balance Review / Automated Overpayment Review / Program Integrity and Longitudinal Data Analysis / Medicaid State Plan and Provider Reimbursement Methodology Analysis / Quality Assurance and HIPAA Compliance /Large-Scale Project Implementation and Management / Provider Third Party Review and Disallowance /Carrier Relations /Data Matching / Cost Avoidance Solutions / Health Insurance Recovery (Medicare/Private/TRICARE) / Workers' Compensation Subrogation

Current Practice

Divisional Vice President, Payment Integrity, 2010–Present

- Responsible for HMS's nation-wide Payment Integrity Services including credit balance audits Leads HMS overpayment audits in over 20 states
- Primary focus on collection of aged accounts and identification of previously unknown overpayments with annual recoveries exceeding $80million
- Oversees Irving, TX based and field operations staff responsible for conducting onsite and desk audits
- Responsible for development of new Payment Integrity Services including e-Review and Provider Portal
- Leads analysis to identify previously unknown overpayments and root causes through longitudinal paid claims data analyses
- Provides operational and financial expertise to public sector healthcare clients

Career History

Health Management Systems, Inc

New York State Regional Director, 2008–2010

- Oversaw delivery of services to New York State Office of Medicaid Inspector General (OMIG) and Elderly Pharmaceutical Insurance Coverage (EPIC) clients
- Responsible for timing, volume, and quality of results for all aspects of project including F-SHRP/Program Integrity Initiatives, Credit Balance Review, Provider Self-Disclosures, Automated Overpayment Reviews, Data Mining, Provider Portal, Provider Third Party Review, Workers' Compensation Subrogation, PPIV Process, Medicare/Medicaid Coordination of Benefits, Direct Carrier Billing and Accounts Receivable Management, and all additional Consulting and Research Analysis
- Responsible for identifying and implementing project enhancement and yield management opportunities
- Managed Albany, NY based consulting and operations staff dedicated to New York State projects
- Lead analysis, identification and implementation of program and payment integrity service offerings, including: forensic, longitudinal data analysis; unit billing errors, outlier payment analysis; duplicate

Kyung Lee

Financial Audit Director

billing detection; unbundling; readmissions; COB-related overpayment review; LTC bed-hold days review; LTC dual-eligible rate review; onsite credit balance review

- Collaborated effectively with Corporate Quality Assurance Department to ensure compliance and quality of all work products

Consultant, 2005–2008

- Lead implementation of recovery initiatives on behalf of New York State, including workers' compensation, overpayment audit, credit balance, hospice, and skilled nursing facility
- Implemented and managed commercial, TRICARE and New York state-known recovery initiatives
- Coordinated data exchange with commercial insurance carriers for the purposes of identifying third party insurance coverage for New York Medicaid recipients
- Generated provider audit reports and professional and drug billings, both electronic and paper
- Streamlined recovery processes by developing electronic billing and electronic provider audit initiatives
- Oversaw all accounts receivable functions resulting from commercial, TRICARE and New York state-known third party resource recovery initiatives
- Supervised New York project accounts receivable staff

Business Analyst, 2002–2005

- Assisted with the implementation of Medical Support Compliance Form (MSCF) and National Medical Support Notices (NMSN) initiatives on behalf of North Carolina Division of Medical Assistance and Social Services
- Mined data from the North Carolina data warehouse using multi-dimensional database query tools
- Analyzed data and identify cases where MSCF and NMSN should be generated on behalf of North Carolina Division of Medical Assistance and Social Services
- Assisted with quality control initiatives by checking all MSCF and NMSN against the North Carolina data warehouse

Academic Background and Degrees

- *Clark University, MBA*
- *Economics, Swarthmore College, BA*

Tenna Behm

Financial Audit Manager

Medicare and Medicaid Provider Audit Expert

Commercial Insurance / Managed Care / Medicaid and TPL Recovery / Accounts Receivable Medicaid Compliance / Provider Relations / Program Integrity / Financial Analysis

Current Practice

Regional Director, Provider Audits, 2010–Present

- Management and supervision of all auditors in the Southeast, West, and Northeast U.S. regions to achieve revenue and productivity goals
- Comprehensive oversight of audits performed within each audit region
- Ensures internal and external client communication and project deliverables
- Performs provider communications and re-education training to avoid future overpayments
- Customizes audit infrastructure to meet client needs
- Ensures that multiple state Medicaid client regulations and requirements are being met

Career History

Phoenix Physicians

Vice President of Managed Care Contracting and Enrollment, 2006–2010

- Developed and managed enrollment department taking on hold revenue from $47 million to less than $50,000 a month
- Managed three billing companies to increase accounts receivable collections
- Negotiated more than 200 contracts across the country, in addition to coordinating several payor settlement negotiations
- Implemented and oversaw Managed Care Contracting department
- Designed and implemented technology program to automate enrollment processes
- Reviewed patient account receivables data to ensure contract compliance
- Monitored compliance with State, Federal and Department of Insurance regulations
- Ensured that billing policies and procedures for all payors including Medicare/Medicaid were accurately implemented and compliant

New Vistas Behavioral Health Services

Director of Contracting, Accounts Receivable, Enrollment, 2003–2006

- Served as Compliance Officer responsible for establishing and implementing confidentiality policies and procedures
- Negotiated multiple client managed care contracts
- Managed all aspects of credentialing and re-credentialing licensed staff

Tenna Behm

Financial Audit Manager

- Reviewed patient account receivables data to ensure compliance with contracts
- Directed and maintained oversight of billing department staff and daily operations

Cigna Healthcare, Inc

External Provider Relations Representative, 2000–2003

- Provided educational presentations, servicing and contractual recruitment for several counties in Western North Carolina region
- Liaised with more than 600 physicians and 12 hospitals to respond to inquiries and resolve issues as needed
- Conducted seminars and focus groups to improve customer perception
- Implemented and promoted the use of internet interface for customers and providers which increased efficiency for physician staff
- Supervised Internal Provider Relations Representatives

Memorial Mission Hospital

Managed Care Patient Account Representative, 1997–2000

- Coordinated and collections of past-due balances from managed care contracted payors
- Served as insurance carrier and patient liaison obtaining and update accurate patient data
- Resolved issues with insurance companies for payment and reimbursement errors
- Maintained updated patient account information
- Monitored Medicare and Medicaid regulations to ensure compliance

Jefferson-Pilot Insurance

Provider Relations Service Representative, 1993–1997

- Provided educational presentation, servicing and contractual recruitment for 18 counties in Western North Carolina
- Resolved claim and reimbursement issues for providers and/or employer groups
- Ensured accuracy of enrollment and credentialing materials received
- Maintained positive relationships with providers and employer groups and ensured their understanding of JP-PPO healthcare delivery process
- Oversaw operations and administration of provider relations office

Education

- *South College, Asheville, NC, BS, Computer Science, Marketing and Accounting, 1992*

Clinical Review

Maureen Riley, RN

Clinical Review Manager

Director of Clinical Review

Complex Audit / Medicare/Medicaid COB / Quality Improvement / Provider Education and Training / Complex Project Management / Billing / Results Analytics / Contract Implementation

Current Practice

HMS

Director of Clinical Review, 2009–Present

- Ensures that contracts are effectively managed, established timelines are met, and high quality deliverables are provided
- Serves as a clinical consultant during contract implementation, including utilization management and clinical review contracts with the Massachusetts Executive Office of Health and Human Services, the South Carolina Department of Health and Human Services, and the Virginia Department of Medical Assistance Services
- Provides clinical expertise and guidance while targeting business opportunities
- Supervises service line managers and other staff, setting clear performance expectations

Career History

Permedion

Utilization Review Service Line Manager, 2004–2009

- Project manager/oversight for multiple Utilization Review programs including Ohio Department of Job and Family Services, Ohio Department of Rehabilitation and Correction, Colorado Department of Healthcare Policy and Financing, Virginia Department of Medical Assistance Services (DRG Project and Behavioral Health), South Carolina Overpayment Project and Audit MIC Task Orders # 2 and 3
- Managed the development and execution of all project/contract activities
- Worked closely with contract managers during new contract implementation to provide orientation, training, and to establish effective review procedures
- Supervisory duties for more than 25 employees
- Prepared outcome reports from projects
- Served as a resource to assist in quality improvement activities

Utilization Nurse Reviewer, 2002–2004

- Reviewed Medicaid claims for home health care services
- Reviewed requests for precertification of surgical and diagnostic procedures
- Functioned as the lead nurse reviewer for two precertification programs
- Clinical resource to other staff members

Laurel Gardens of Hamden

Maureen Riley, RN

Clinical Review Manager

Assistant Director Wellness Services, 2000–2001

- Provided wellness services to elderly residents in an assisted living setting, including assessments, medication management, teaching, and emergency intervention
- Case management provided to coordinate health care with families, health providers and insurance providers
- Supervised and evaluated nurse aides and part time nursing staff
- Responsibilities included staff scheduling and quality assurance

Middlesex Hospital Homecare

Primary Care Nurse, 1994–2000

- Independently managed caseload of home health clients
- Facilitated all insurance types (private, managed HMO's, Medicare, traditional and managed, Medicaid and private pay)
- Expertise gained in case management techniques and IV therapy skills as utilized in the home

Upper Valley Joint Vocational School of Practical Nursing

RN Instructor, 1989–1993

- Instructor for PN students in the areas of Mental Health Nursing, Nursing Principles, and Medical-Surgical Nursing
- Supervisory duties in both classroom and clinical settings, which included Long-Term Care and acute care settings

Midwest Nursing Concept/Midwest Home Health

Home Health Nurse, Staff Nurse, 1985–1989

- Managed caseload of home health clients for private pay and Medicare
- Worked as relief staff nurse at local hospital as census warranted

St Vincent Charity Hospital

Education Coordinator, RN Instructor, 1979–1984

- Planned, developed and coordinated all education programs for a 425-bed hospital

The Cleveland Clinic Hospital

- Staff Development Instructor, 1978–1979

Partial Client List

Ohio Department of Job and Family Services, Ohio Department of Rehabilitation and Correction, Auditor of State of Ohio, Colorado Department of Health Care Policy and Financing, Virginia Department of Medical Assistance Services

Education

- *Bloomsburg State College and Case Western Reserve University, MS in Nursing (in progress)*
- *D'Youville College, BS, Nursing*

Maureen Riley, RN

Clinical Review Manager

Professional Affiliations

- National Association for Healthcare Quality
- Ohio Association for Healthcare Quality

Julie Cowher, RHIA, CHC

Bill Audit Manager

Bill Audit Manager

Bill Audit / Staff Recruitment and Oversight / Staff Training and Development / Client Satisfaction / Compliance

Current Practice

Permedion, an HMS company

Bill Audit Manager, 2009--Present

- Manage remote auditors
- Develop reports to meet internal and external customer needs
- Assist in developing Web-based bill audit tool
- Train new auditors (in-person and remote)
- Develop auditing resources
- Review, examine, and authorize primary claims and medical records to determine extent of coverage and validity of claim
- Perform line item audits of assigned cases, comparing the hospital bill to the medical record to determine billed charges were administered and are reimbursable per client contract

Hospital Bill Auditor 2008--2009

Career History

University of Cincinnati

Assistant Professor of Clinical, 2006--2008

- Developed, instructed and facilitated distance education courses: Project Management, Quality Management and Performance Improvement, Applied Reimbursement Methodologies, Statistics and Research, Clinical Data Management, and Health Data Management
- Ensured the curriculum meets requirements through ongoing evaluation and dialog with faculty and affiliations
- Recruited, advised, counseled and evaluated students
- Designed online new student orientation to the HIM program and Blackboard technology
- Created and published bi-annual program newsletter
- Established an HIM alumni ambassador program

OSU Internal Medicine, LLC

Senior Compliance and Education Specialist, 2005--2006

- Responsible for auditing and evaluating physician documentation and billing practices (inpatient and outpatient) to ensure compliance with resource utilization for specialty divisions within the Internal Medicine Practice (Infectious Disease, Endocrinology, Digestive Disease, Pulmonary, Critical Care Services and Hematology/Oncology)
- Provided compliance guidance and education to physicians/clinicians that met with legal and

Julie Cowher, RHIA, CHC

Bill Audit Manager

regulatory standards, including CMS and the OIG

- Data mined reports to identify patterns and trends
- Developed, with assistance of practice plan attorney, the organization's compliance plan

Compliance and Education Specialist, 2004--2005

Berger Health System

Director of Patient Information, 2000--2004

- Directed employees in an efficient manner by planning, organizing, and controlling all activities in the areas of Patient Information (Medical Records) and Patient Registration
- Facilitated workflow, procedures, and productivity of assigned areas to ensure processes are functioning and the Health System is receiving maximum benefit
- Provided oversight, guidance, and education to assigned areas to ensure all legal and regulatory standards were met or exceeded (HIPAA, Joint Commission, CMS and the OIG)
- Participated in, which involved auditing clinical documentation, reviewing billing claims and analyzing reimbursement, a variety of committees such as HIPAA, Medical Record Review, Medical Necessity and Chargemaster
- Directed the preparation of various statistical reports as required and accumulated data to report to state and federal regulatory agencies
- Developed, secured approval of, and administered a budget which provided for the attainment of agreed upon goals and objectives

Lexicode Corporation

Health Information Management Consultant, 1999--2000

- Analyzed clinical documentation and accurately assigned ICD-9-CM, CPT-4 and HCPCS codes to accounts to ensure maximum reimbursement for nationwide clients
- Knowledge and understanding of documentation and reimbursement guidelines/regulations
- Updated ongoing skills in accordance to AHIMA, CMS, AHA and AMA approved coding guidelines

Fayette County Memorial Hospital

Medical Records Director, 1997--1999

- Supervised all departmental activities such as coding, transcription, and correspondence
- Responsible for records management (auditing and analyzing clinical documentation to ensure timeliness, accuracy and compliance) for the facility's inpatient, outpatient clinic, rehab center, and home health services
- Chaired or attended committees such as Medical Staff Monitoring, Clinical Pertinence, Medical Necessity, Chargemaster TaskForce, Information Management Team and others
- Responsible for the hiring, training, and evaluating of personnel

Julie Cowher, RHIA, CHC

Bill Audit Manager

- Accountable for overseeing coding compliance and audits and analyzing reimbursement
- Familiar with AS/400 operating system and the McKesson/HBOC information system
- Successful Joint Commission surveys, which included the development of hospital information management plan
- Ensured compliance with state and federal rules and regulations as well as Joint Commission standards for health information in an acute care facility

Education

- *Bachelor of Science, Medical Record Administration, The Ohio State University, June 1995*
- *Associate Degree, Health Information Management Technology, Columbus State Community College, March 1994*

Certification

- Certified in Healthcare Compliance (CHC) by the Health Care Compliance Association (HCCA) September 2005
- Certified as a Registered Health Information Administrator (RHIA) by the American Health Information Management Association (AHIMA), October 1995
- Certified as a Registered Health Information Technician (RHIT) by the American Health Information Management Association (AHIMA), October 1994

Pharmacy Review

Erwin Acuna, TCH, CFE

Pharmacy Operations Manager

Director Of Pharmacy Audit Operations

Pharmacy Audit / PBM Audit / Reporting / Contract Compliance / Data Analyst / Program Integrity Cost Avoidance / Project Implementation and Project Management / Client Satisfaction / Contract Compliance Proposal Preparation / Quality Assurance / Rebate Audit / Medicare Part D Audit / Medicaid Pharmacy Audit / 340B Compliance

Current Practice

HMS

Director of Pharmacy Audit Operations, 2008–Present

- Lead Auditor for Medicare Part D, 340B, Mail Order, Specialty Pharmacy and all Rebate audits
- Responsible for oversight of all audit operations and staff
- Responsible for managing PBM Audit team and all related audit projects
- Develop and implement client audit programs
- Responsible for collecting, interpreting, and applying industry related information (CMS, PBM, MCOs, etc) to internal processes
- Perform continuous quality improvement of PBM Audit Program
- Lead Auditor for all PBM or Health Plan internal process reviews
- Special Investigations Unit team member
- Oversee PBM Team activities, including management of client reporting process

Career History

City of Hope Medical Center

Pharmacy Technician, 1996–2008

- Responsible for all inpatient technician duties
- Led Continuous Quality Improvement team
- Performed revenue audits from outpatient pharmacy service
- Audited drug samples provided by pharmaceutical manufacturers

Kaiser Permanente

Pharmacy Technician, 1985–1986

- Responsible for all inpatient technician duties
- Developed and maintained Clinic Drug Stock-to-Standards inventory Management System
- Purchased drugs for Inpatient and Outpatient facilities

Partial Client List

Acumen LLC, AvMed Health Plan, State of Delaware, Excellus Blue Cross Blue Shield, State of Georgia, Hawaii

Erwin Acuna, TCH, CFE

Pharmacy Operations Manager

Medical Service Association, Inland Empire Health Plan, Presbyterian Health Plan, SCAN Health Plan, State of West Virginia, State of New Jersey, Blue Shield of California, State of California (Rebates), Texas Employee Retirement System, Contra Costa (340B)

Education

California Polytechnic State University, BS, Accounting, 2001

- *University of California at Berkeley, Certificate in Project Management, 2002*

Certifications/Accreditations

- Certified Fraud Examiner

Joe Drapalik

COB*Now Senior Developer*

Experienced Programming Professional

Software Design / Information Systems Development / Analyst Team Manager

Current Practice

HMS

Current Practice

Director, Applications Development, 2006–Present

- Direct and coordinate all activities within DHS including design, programming, and testing of all eCenter applications.
- Responsible for providing effective computer service to both internal and external users
- Assist in determining business requirements for various application changes through personal experience and interviewing end users
- Make determination as to project feasibility through knowledge of system capacity
- Control and assign work to programmers, business analysts, and QA analysts
- Recommend, document, and implement operating policies and procedures
- Analyze department production and redesign internal workflow where appropriate
- Forecast budgetary needs and periodically perform budget analysis to ensure effective spending
- Provide general management of all employees and consultants.
- Ensure successful and timely implementation and roll-outs of all eCenter applications including:
    - Provider Portal Self-Audit
    - Provider Portal Disallowance
    - National Eligibility Database
    - COBMatch
    - Socrates
    - Provider conversions (new/existing clients)
    - Phoenix
    - Cost avoidance (including referrals)

Career History

Health Management Systems, Inc.

Systems Analyst II, 2004–2006

- Supervised all Business and Programmer Analysts in the Dallas Service Center responsible for eCenter, MDS, and Access Line
- Managed large IT projects requiring advance planning and coordination with both internal and external

Joe Drapalik

COB*Now Senior Developer*

clients

- Performed both Business and Systems Analysis & Design on eCenter applications. Examples included:
  - COBManager - a solution that allows Medicaid to save millions of dollars by submitting claims over the same network pharmacies use to submit their own claims
  - Provider Self-Audit - Allows providers to access claim data previously submitted to Medicaid, make corrections, and resubmit to the appropriate agency
  - Consolidated Claim Data Base - A warehouse of claim data that can be shared by all eCenter applications

Discover Financial Services

Senior Systems Analyst, 2001-2003

- Served as Release Manager for the Java-based business application Orion, responsible for planning, organizing, and implementing all aspects of monthly software releases
- Designed and developed software solutions to incorporate new laws and regulations as they pertained to the financial industry specific to credit and debit cards
- Researched and implemented new tools and hardware to support software development
- Coordinated multiple software developers in development and maintenance of project plans

Health Management Systems, Inc.

Project Team Manager, 1990-2001

- Planned and directed activities of multiple Project teams in order to maximize customer satisfaction and meet team objectives
- Responsible for managing resource allocation, development of budgets, as well as project plans and milestones
- Responsible for management of several health insurance projects including:
  - Managed ITS upgrade for Blue Cross/Blue Shield of Western New York
  - Developed Web-based eligibility system using a relational database for its data repository
  - Rewrote TPL front-end system used for Medicaid payment recovery

Illinois Air National Guard

Communications Officer, 1984-2004

- As a Major in the 217th E&I Squadron, responsible for managing 70 military personnel whose primary function is the engineering, installation, and maintenance of communications and computer equipment.
- Coordinated with other areas within the military to provide logistical requirements in support of team deployments both within and outside the United States
- Managed 50 engineering and Installation personnel at Al Udeid AB, Qatar, for a period of seven months. Managed such communications projects as the Combined Air Operations Center (CAOC),

Joe Drapalik

COB*Now Senior Developer*

Intelligence, Surveillance, and Reconnaissance Division (ISRD), Technical Control Facility (TCF), and the base fiber and copper communication infrastructure

Education

- *Northern Illinois University, BS*

Professional Certification

- Project Management Institute: Project Management Professional Certification

Elise Wade

Development and Operations Lead

Current Practice

HMS

Manager of Software Development, 2007 – Present

- Manage software development of real-time claims processing for third party liability assessment and billing
- Support the internal ticketing system, AR reports in Crystal and automated claim analysis. Programming done in Java with Weblogic and JBoss, utilizing Spring, Crystal Reports, DB2 databases, linux scripting, and ETL tools

Career History

Credera

Contract Architect, 2007

- Analyzed the current billing system for Blockbuster Online, producing reference documentation with UML style diagrams and detailed descriptions of the system as well as executive summaries

Vicor/Metavante

Senior Developer, 2006 – 2007

- Designed and built Distributed Capture Application with Java EE technologies including EJB 3.0 including Entity, Stateful, and Stateless beans

Eliassen Group

Contract Architect, 2005 – 2006

- Revised the Management System (EMS) and revision of this system to include management of hazardous material several sites. Included conversion of data from legacy system. EMS system is written in Java with a Websphere deployment and an Oracle database

Matrix

Contract Architect / Developer, 2004

- Designed and implementation of an application to transfer transactional data from text files into a database using Java/EJBs, stored procedures and load balancing techniques

Tactical Learning Software

Software Architect, 2002 – 2004

- Designed and developed game solution for educational software, including the selection and modification of specialized development technologies, risk analysis, requirements and business analysis, logical and physical models, quality assurance and control, and prototype development

Targetbase, Inc

Senior Software Developer / Architect, 2000 – 2001

- Designed and developed private web sites using PHP on an Apache web server to support internal marketing efforts at targeted fortune 100 companies
- Revised web site written in Java/ATG Dynamo and using a database in Oracle 8i for necessary maintenance and enhancements

Elise Wade

Development and Operations Lead

Sprint

Senior Software Engineer, 1999 – 2000

- Led team producing client software for large-scale call-center application to integrate billing from different sources. Project included extensive use of UML and use cases in Lotus Notes and Rational Rose, as well as CMM compliant documentation. Implemented in Visual Smalltalk with Versant, Oracle and VTAM data sources

Bank of America

Senior Systems Engineer/AVP, 1995 – 1999

- Led team developing and deploying an application used by more than 2500 banking officers to track client profitability Included architectural issues, resolution of development problems, scheduling, interfacing with other departments and third party vendors, and some personnel issues
- Designed and developed a loan pricing application for a dozen products
- In a Microsoft environment, used a Smalltalk V OLE Automation Server (COM/DCOM) to implement business rules and an OLE controller written in Delphi 3.0 to display results and generate reports

Baylor Medical Center

Senior Information Specialist, 1994 – 1995

- Analyzed, designed (including the data model) and implemented a payroll database application in Oracle using PL*SQL

Texas Instruments, Inc.

Software Engineer, 1989 – 1994

- Developed a system to track the reliability and maintainability of semiconductor manufacturing equipment written with Visual Smalltalk using a Gemstone database
- Developed a software-testing framework in Visual Smalltalk, which allowed real-time monitoring in a factory production environment of the equipment control software
- Developed a process typing application in Visual Smalltalk with a Gemstone database, allowing systematic classification of semiconductor manufacturing processes

Education

- *University of Texas at Austin, Masters of Business Administration*
- *Vanderbilt University, Nashville, TN, Bachelor of Arts, Mathematics*

Asset Verification Services

Cynthia Jones

Product Manager

Healthcare / Managed Care Project Management Specialist

Enrollment Services / Enrollment Integrity / Case Management / Application Processing / Eligibility Determination / Asset Verification / Quality Assurance / Medicaid Managed Care / Healthcare Process Improvement / Corporate Development / Project Management / Strategic Planning / Change Management / Contract Compliance & Negotiation / IT Enhancements / Data Analysis / Financial Modeling / Third Party Liability / Claims Processing / Market Assessment

Current Practice

HMS

Senior Director, Enrollment Services, 2009–Present

- Serves as product manager for enrollment services product offering.
- Provides project services implementation coordination and oversight for all new projects including project management, operational installation and IT enhancement.
- Serves as the subject matter expert for enrollment services including: eligibility determination and HIPP.

Career History

HMS

Director, Enrollment Services, 2008–2009

- Served as Implementation Manager for Texas HIPP project.
- Successful coordination of resource to bring up a new system, hire new management and train staff in 90 days.
- Met and exceeded all performance measures in first month of operations and ongoing.
- Designed and led the development of the HMS IntegriMatch product.
- Designed and implemented our internal HIPP audit process used in Texas.

Program Director, 2002–2008

- Served as the principal technical and contract support contact between HMS technical staff and the client to ensure client satisfaction, including the timely management of project deliverables, release of billing cycles, performing analyses, maintaining compliance with state and federal agency regulations, and managing client relationships.
- Directed SCHIP, Medicaid , MCO, Pharmaceutical Assistance programs
- Directed TPL Recovery Projects for IA, MI, IN.

MMC 20/20, Inc.

Consultant, , 1999–2002

- Project Manager, Accutraq Software Implementation, for UnitedHealthcare, Inc.

Cynthia Jones

Product Manager

- Created and managed all work plans involved for a software installation taken on contingency basis for revenue realization estimated at $50 million.
- Led training and staffing of 50 employees during software installation and testing phases.
- Developed all internal and external testing criteria to determine implementation feasibility.
- Wrote and revised administrator and user guides based on learned expertise.
- Project Lead, Revenue Realization for Aetna U.S. Healthcare and Coventry Health Plan.
- Led an $8 million recovery effort on behalf of two Medicare+Choice plans for members with End Stage Renal Disease (ESRD) and institutionalized members.
- Devised new analyses of claims to better identify ESRD and institutionalized suspects.
- Redesigned Access Database recovery tools including calculations, tracking, and reporting.

Director, Indirect Payment Procedure (IPP) for Kaiser Permanente, 1999–2000

- Led a $10 million initiative on behalf of Kaiser Permanente commercial HMO to recover reimbursement owed by Medicare for services rendered to beneficiaries.
- Developed IPP data warehouse, including reporting, tracking, and identification tools for use at future clients as a new company product.
- Developed and maintained business relationship with client regional locales, Medicare Carriers, and CMS (HCFA) Regional and Central Offices to facilitate data needs and government buy-in.

Towers Perrin

Consultant, Health Industry Consulting Practice, Strategy and Operations Div., 1998–1999

- Negotiated 30 hospital and PHO provider contracts on behalf of UniCare PPO in Ohio.
- Prepared Medicare risk PSO/HMO feasibility studies for Blue Cross/Blue Shield of Illinois, Carelink, and Avera Health Plans.
- Calculated pro forma financial projections and analyzed the impact of proposed reimbursement methodologies for physician practices and health systems.
- Assisted with Medicare+Choice application process for Blue Cross/Blue Shield of Delaware, including development of grievance and appeals policies and procedures, forms and letters, and Evidence of Coverage documentation to comply with new CMS standards.

Catholic Health Partners

Contract Analyst, Departments of Managed Care and New Business Development, Columbus Hospital , 1997–1998

- Modeled contracts financially and analyzed/wrote contract language for negotiation.
- Prepared presentations explaining Medicare full-risk contracts.
- Tracked physician credentials for a Medicare full-risk contract physician panel.

Cynthia Jones

Product Manager

Family Medical Network (St. Joseph PHO)

Financial Analyst, 1996–1997

- Constructed an automated physician incentive and bonus system.
- Automated assignment of primary care physicians by zip code, age, and total members.

Rush Presbyterian St. Luke's Medical Center

Project Manager for Quality of Obstetrical Care Services Project, Department of Health Systems Management, 1995–1996

- Authored final report, budgeted government fund, and formulated budget projections.
- Designed and maintained multiple databases for all project data.

Education

- Rush University, M.S.
- Northwestern University, B.A.

Professional Affiliations and Certifications

AHIP Continuing Education, Managed Care Certification, 2003

Josh Houston

Technology Manager

Information Technology Management and Implementation

Project Management / Product Implementation / Business Development / Web Development / Application Design / System Automation

Current Practice

Technology Manager of Eligibility Services, 2008–Present

- Responsible for development and implementation for HMS' Eligibility Services product line, which includes the PIER case tracking system used to administer premium assistance programs; Management of Eligibility Services business analyst and application development teams.
- Texas Medicaid Buy-In for Children (MBIC) Web Service Implementation.
  - Interacted with state stakeholders to understand requirements for the program. Created business requirements and detailed system design specifications to develop functionality needed to accommodate MBIC.
  - Served as primary technical contact for HMS, which included coordination with several external entities through design, development, testing, UAT, and production implementation.
    - Implementation involved web service technology to transmit MBIC referrals for HIPP investigation. Modifications were made to the PIER system to process new referrals, changes to existing referrals, and transmit case decisions to the MBIC department via real time web services.
- PIER Implementation for North Carolina HIPP.
  - Managed multiple technical teams during project implementation, including all application developers, database administrators, EDI specialists, and business analysts.
- PIER Implementation for Kentucky HIPP.
  - Managed multiple technical teams during project implementation, including all application developers, database administrators, EDI specialists, and business analysts.
- PIER Implementation for Louisiana HIPP.
  - Interacted with state stakeholders to understand eligibility requirements for the HIPP program. Created detailed system design specifications to develop functionality needed to administer the program.
  - Managed multiple technical teams during project implementation, including all application developers, database administrators, EDI specialists, and business analysts.
  - Implemented web service technology to transmit correspondence to client business units when eligibility determination is made by customer service representatives.
  - Manage analysts performing data mining activities that target populations for outreach to support enrollment growth expectations from DHS.
- PIER Implementation for Texas HIPP and IPPA.

Josh Houston

Technology Manager

- Key supervisory and client facing role during 90-day large-scale implementation, charged with acquiring all operational and technical data from previous contractor and assimilating information into technical specifications and procedural manuals.
- Defined all business rules and functional design in State deliverables for proprietary software implementation in Texas to manage the HIPP and IPPA premium assistance programs.
- Managed all technical aspects of the Texas PIER implementation including supervision of the development team to ensure that all system modifications were in place to meet and exceed the client's expectations for the go-live date.

- PIER Implementation for MassHealth Premium Assistance.
  - Performed thorough analysis on all business procedures as well as legacy software to create technical design specifications for development of a new proprietary enterprise application that is currently managing four different Premium Assistance programs for MassHealth.
  - Defined new processes in the PIER application to automate and streamline the eligibility determination for MassHealth Premium Assistance enrollment.
  - Integrated an interface to a robust proprietary verification product to accurately ensure that state enrollment requirements are continuously met.
  - Managed imaging software implementation to run parallel with the PIER application in Massachusetts, defined operational workflow, and fully trained Operations management and staff.

Career History

Health Management Systems, Inc.

Business Analyst, 2007

- SPIDER Implementation for Provider Credit Balance Review Department.
  - Designed and fully developed a secure system (SPIDER) for auditors to capture and manage identified credit balances on claims.
  - Developed custom provider recovery deliverables generated from the system to each client for whom HMS is performing credit balance audits.
  - Managed software implementation for 20+ auditors nationwide. Implementation included supervision of all training exercises to auditors.
- Medicare Recovery Audit Contractor (RAC).
  - Project development and project management for high-profile Medicare Secondary Payer contract for Florida and New York.
  - Required design and development of new systems to automate manual processes.
- Integrated individual systems to provide a more efficient work flow.

Data Analyst, 2006

- Managed all verification processes for Americhoice and Keystone Managed Care clients; Both

Josh Houston

Technology Manager

Managed Care Organizations span multiple states.

- Developed automated processes to improve accuracy and dramatically decrease the time taken to prepare complex datasets for client deliverables.
- Provided strong support to Program Directors.

Data Specialist, 2005–2006

- Developed EOB verification system for West Virginia Medicaid client.
- Automated manual processes to improve efficiency of data management for several Medicaid clients.
- Automation included data preparation for Tracer, a web-based verification tool.
- Developed and supervised verification QA process for client deliverables.
- Maintained verification website used as a resource tool by ALL verification centers

Academic Background and Degrees

- *Appalachian State University, Boone, North Carolina*
  B.S., Business Administration in Information Systems, 2007
- *Caldwell Community College*
  A.A.S, Business Administration, 2000

Professional Affiliations and Certifications

- PMI, Project Management Professional Certificate Program
- Microsoft, Microsoft Certified Professional Certificate
- CompTIA, A+ Hardware/Software Certificate
- CompTIA, Network+ Networking Certificate

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Table of Contents – Tab 4.F - 4.L: References

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Tab 4: Subject Matter Category

Tab 4.F – L References

F. For responders submitting proposals to subject matter categories #1 through #11, a detailed description of data analytics services provided to two or more public sector organizations of similar size and scope to the State of Minnesota within the past three years ("engagements"), specific to the category(ies).

G. For responders submitting proposals to subject matter category #12, a detailed description of data analytics services provided to two or more public **or** private sector organizations within the past three years ("engagements") specific to the work intended under this category.

H. For each engagement, provide contact information for the individual responsible for the project from each public sector organization (or private sector for category #12, if applicable) that can provide additional information regarding the project and verify any representations made. Specifically, include the name of the organization; name and scope of project; dates of engagement; and name of contact person, including the individual's e-mail address and direct telephone number.

I. For each engagement, describe the efficiencies or results gained by implementation of the data analytics and, if applicable, any cost savings determined to be directly attributable to the project.

J. For each engagement, describe how any such cost savings were calculated and how compensation for the work was structured.

K. For each engagement, detail whether any disagreements as to savings generated or fees owed were encountered and if so, how resolved.

L. For each engagement, to the extent compensation was based on a percentage of savings attributable to the effort; describe how the parties distinguished the amount of savings attributable to the work of the contractor versus savings realized from the efforts of the organization.

With more than 25 years of experience performing healthcare-related services in more than 40 states, HMS has demonstrated its ability to apply innovation and best practices to fulfill complex project goals. All HMS clients can attest to our:

- In-depth knowledge of the Medicaid program and claims processing services
- Positive working relationship with the provider community, focused on minimizing burden and maximizing education
- Dedicated expert staff—available to serve clients and always go "the extra mile"
- Ability to comply with HIPAA and other security and privacy regulations
- Excellent customer and stakeholder service
- Data processing capabilities

Reference 1

RFP Requirement	HMS Response
4. H Customer Name	New York State Office of the Medicaid Inspector General (NYS OMIG)
Name and Scope of Project	**Medicaid Match and Recovery Contract** HMS has collaborated with the NYS OMIG since 2006. The objective of this ongoing Program Integrity 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, and MCOs. The current service scope includes, but is not limited to, the following overpayment reviews: ► **Hospital overpayment reviews**. HMS performs more than 150 onsite reviews and 330 desk reviews of New York State hospitals each year, during which the following has analyses have been undertaken: ■ Provider Self-Disclosure and Reverse Data Analytics: Actively engage and assist providers in self-reporting Medicaid overpayments. Conduct reverse data analytics to identify root causes and potential intra- and interprovider trends to detect previously unknown Medicaid overpayments. ■ Credit Balance Overpayment Review and Recovery: Review providers' Aged Trial Balance reports to identify and recover Medicaid overpayments. Results are analyzed to detect root cause issues that may be causing additional overpayments. ■ Balance Bill: Use data mining to identify Medicaid paid claims where the provider incorrectly reported third party payment and/or patient liability amounts, resulting in Medicaid's paying up to the allowed amount in excess of its true liability as the secondary payor. Review claims with providers to verify overpayment and recover excess payment. ■ Office of Alcohol and Substance Abuse Services (OASAS) DRG/Per Diem Review: Monitor Medicaid policy and reimbursement changes through ongoing policy analysis to identify potential issues. Conduct data analysis to identify potential Medicaid overpayments and review targeted claims. This specific review focuses on Diagnosis-Related Group (DRG) payments for Medically Managed Detoxification hospital stays. A New York State policy change required providers to bill observational stays at the per diem rate rather than at the DRG rate. HMS recovers the difference between the two amounts. ■ Graduate Medical Expense/Fee-for-Service Overlap: Review of Graduate Medical Expense (GME) supplemental payments for Medicaid Managed Care Organization (MMCO) enrollees and "carved-out" inpatient Fee-for-Service (FFS) payments. Since the GME rate is built into inpatient FFS rates, supplemental GME payments are recovered. ■ Inpatient Encounter/Inpatient Fee-for-Service Overlaps: Review of claims paid as primary by an MMCO and FFS for the same stay. New York Medicaid policy allows certain inpatient services, such as newborn services, to be carved out. In cases in which the provider inappropriately bills both MMCO and FFS and receives two payments, HMS recovers the FFS payment. ■ Third Party Disallowance Soft-Denial Follow-up: Review of claims initially identified through provider-based third party billing requests to primary carriers and denied on appealable grounds. Overturned denials resulting in primary carriers' payments are recovered. ■ Medicare Part A Benefit Period Analysis: Conduct a longitudinal data analysis of providers billing history to re-create Medicare Part A benefit periods. Claim-based review of inpatient claims for which Medicare Part A benefits were available but not

RFP Requirement	HMS Response

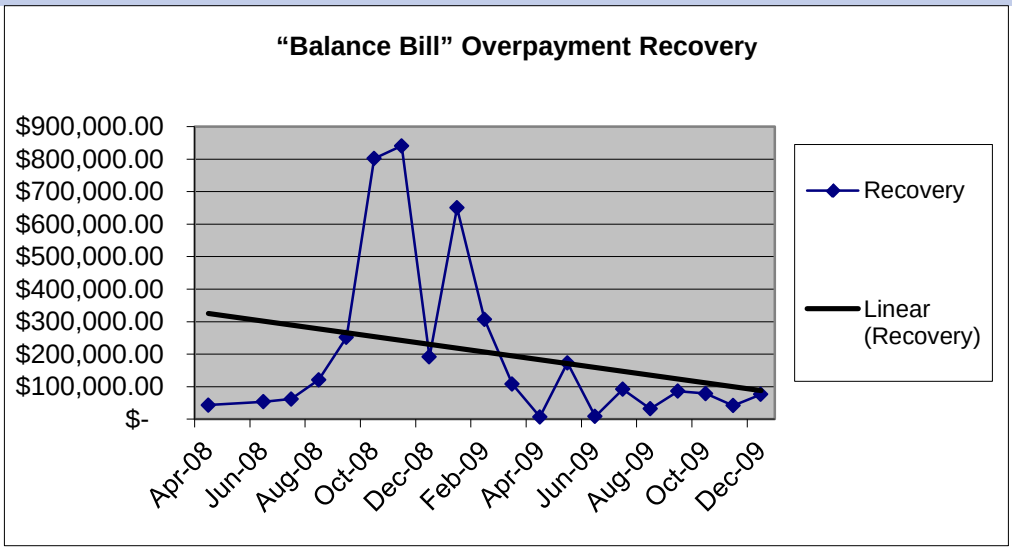
utilized by the provider. Providers are required to bill Medicare and draw down Part A benefits to minimize Medicaid liability.

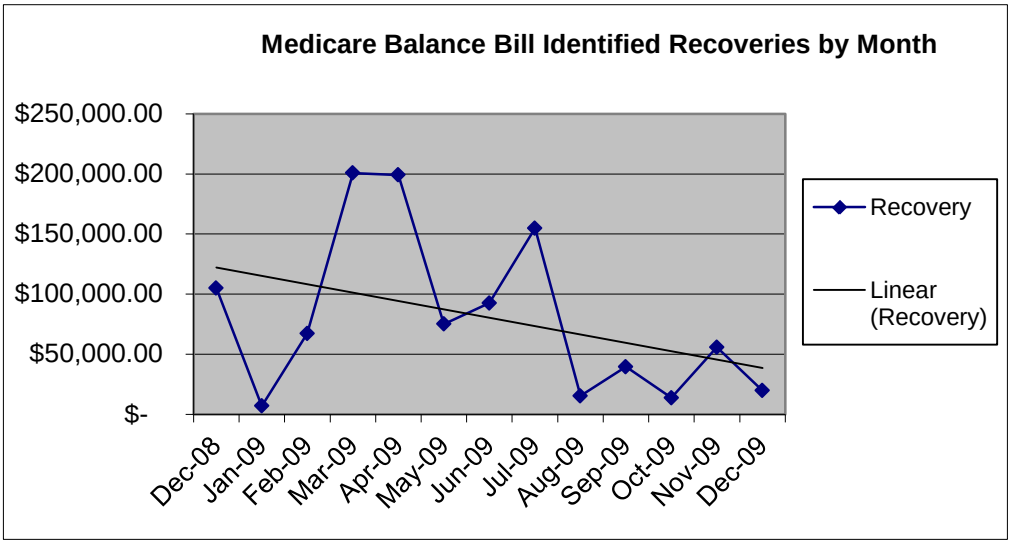
- **Pharmacy overpayment reviews**. We conduct various data analytics to detect potential Medicaid overpayments. Review targeted claims with pharmacies to verify findings and recover overpayments, including:
  - Coordination of Benefits (COB) Potential Duplicate Payment Review: Review of claims initially identified through HMS billings to primary carriers and denied for reasons indicating that the servicing pharmacy had been paid by the carrier. Recovery occurs after verification of duplicate payment.
  - Incorrect Third Party Patient Liability Review: Review of third party patient liability reported by pharmacies to identify improper reporting, leading to Medicaid's overpaying. Recover Medicaid overpayments by "repricing" the claims down to Medicaid's true liability.
- **LTC overpayment reviews**. HMS initiated LTC reviews in October 2009 and conducted more than 200 reviews in 2010. We identified more than $9 million in overpayments through July 2010, which we are actively recovering. HMS reviews claims on a number of criteria, including, but not limited to, the following:
  - Net Available Monthly Income (NAMI) Review: Income resource available to nursing residents that must be exhausted before Medicaid assumes liability. Unapplied NAMI amounts are recovered by being offset against appropriate Medicaid payments.
  - COB: Ensure that LTC facilities are accurately reporting third party payments, such as Medicare Part A payments for skilled nursing care. Recover Medicaid overpayments resulting from misreporting of third party payments.
  - Dual Eligible Rate Review: Ensure that the LTC facilities are billing for the correct rate based on the resident's Medicare eligibility status.
  - Bed-Hold Days: Review LTC provider rosters to ensure that they are properly billing for bed-hold days. Employ data analytics to create time-series occupancy rate reports and detect systemic billing issues that may have existed at a given point in time.
  - Estate Referrals: Ensure that decedent's assets that are being held by the LTC facilities are returned to Medicaid
- **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.
- **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 MMCOs' compliance with the New York State 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.

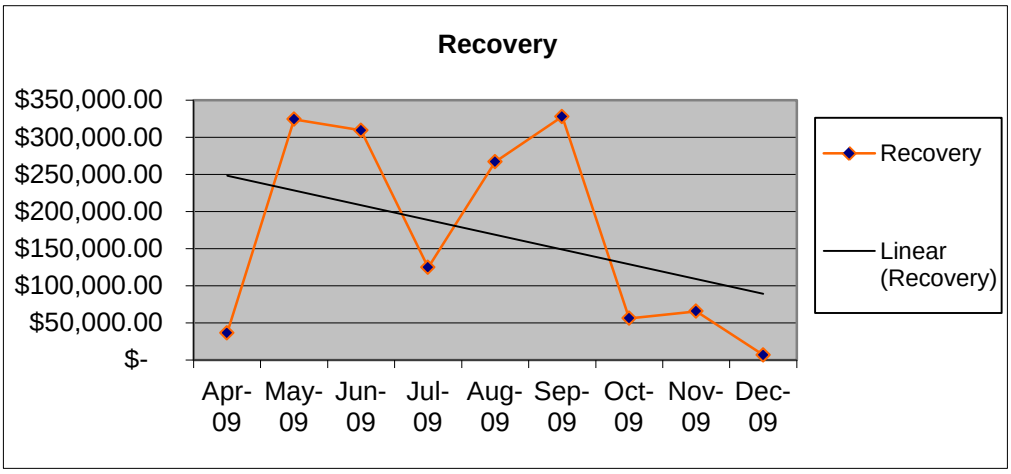
In 2010, HMS began assisting the NYS OMIG in transforming and expanding its program integrity projects to meet Affordable Care Act (ACA) mandates, including enforcing mandatory provider self-disclosure and establishing a Medicaid RAC program. As part of these efforts, HMS is implementing a coordinated 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. The approach is predicated on two principles: 1) providers are responsible for the self-identification and disclosure of Medicaid overpayments (as dictated by the ACA); 2) the state must have the ability to enforce policy and compliance by leveraging data analytics to detect waste and abuse that are not self-disclosed by providers. Key developments related to this approach include:

RFP Requirement	HMS Response
	► **e-Review**—matching of New York State commercial carriers paid claims against New York State 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 providers' data. This affords New York Medicaid pinpoint accuracy in detecting overpayments, which enables it to validate the overpayment amount at the point of identification. ► **Provider Portal**—website to allow providers an online application to report overpayments while providing NYS OMIG with real-time explanations on the causes of each reported claim, thus enabling detection of trends. The Provider Portal also acts as a single-point entry for various types of reviews in which providers are asked to review potential overpayments identified through data analytics. HMS initiates recovery based on the review of provider responses received through the portal. ► **TRAC**—central hub of our activities. Each review is coordinated with all past and present reviews to eliminate duplication of effort while maximizing recovery. TRAC also syncs with other applications and data analytics platforms to expedite and streamline the workflow. ► **Provider scoring—**multiple-point scoring system based on a number of factors such as billing history, adjustment activity, data analytics, review history, and frequency and density of findings. Allows for identification of "frequent fliers" and focused review of suspect providers. ► **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, transportation providers, and physicians.
Dates of Engagement	January 7, 2009–January 6, 2015
Contact Individual and Title	Jeff Flora, Director, Bureau of Third Party Liability
Email Address	Joseph.Flora@omig.ny.gov
Telephone	518.402.0045
4. I Efficiencies or Results Gained by the Project	HMS recovered more than $106 million for the NYS OMIG since 2006, with no appeals. In addition to actual recoveries, our activities create sentinel effects that minimize future overpayments. The charts below offer real-life examples of efficiencies created by our activities. The "Linear" line depicts the trend in our recovery of overpayments caused by a specific issue that was identified through data analytics. On average, the decline captured by the trend line reflects savings to the state at any given point in time. In other words, the area above the trend line represents total savings to the state.

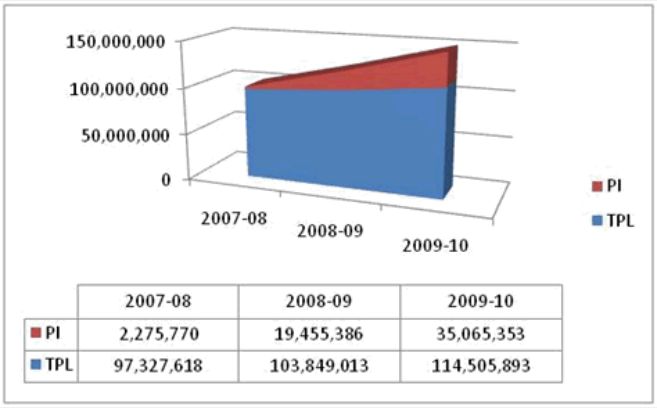
RFP Requirement	HMS Response







4.J Cost Savings and Their Calculation	**Since 2006, HMS has more than doubled its program integrity recoveries every year, recovering more than $106 million for the state.** Beyond these immediate recoveries, HMS's provider education outreach and consultation with NYS OMIG on various overpayment prevention edits has a sentinel effect that leads to improvements in provider billings and generating prospective savings for the New York Medicaid program. The following table shows the growth in actual recoveries for NY Medicaid since 2007.



	2007-08	2008-09	2009-10
PI	2,275,770	19,455,386	35,065,353
TPL	97,327,618	103,849,013	114,505,893

Compensation Structure	Contingency fee based on actual dollars recovered for NY Medicaid
4. K Disagreements Regarding Fees	None
4. L Extent to Which Compensation Was Based on Percentage of Savings Attributable to the Effort; How These Savings Were Distinguished from Savings Realized	Compensation is based on the percentage of actual dollars directly recovered by HMS. Ongoing savings through sentinel effects generated by our reviews and education of providers on root cause issues are not separately compensated. However, over time, the cumulative impact of the sentinel effect is significant and likely even greater than the direct savings attributable to HMS. . This is because our process is designed to identify the root cause of the overpayment, after which we work with the NYS OMIG to implement the appropriate corrective action. Our process then measures the effectiveness of the corrective action plan to ensure that the problem is truly resolved. This methodology prevents the state from continuously overpaying claims for the same reasons.

Reference 2

RFP Requirement	HMS Response
4. H Customer Name	Ohio Department of Job and Family Services (ODJFS) (Ohio Medicaid)
	Permedion, an HMS company, holds the contract to perform Utilization and Quality Management services for ODJFS. Beginning in 1997, we established and implemented a process to review 1,000 claims retrospectively each month for medical necessity, coding, billing compliance with Ohio Medicaid regulations, and quality of care. Permedion re-won the contract in 2005 and again in 2011. Our health data analysts and biostatisticians perform data mining to identify new targets, and our quality studies provide additional information from which to add or modify selection and review methodologies. Permedion's modification of review targets is based on a regular analysis of case mix and review results, discussions with our client, patterns noted in quality study results, and close monitoring of changes in healthcare practice. Our team of experienced healthcare professionals reviews the analysis and discusses targets to add or drop from the methodology. Frequently, potential targets are tested on a small number of cases to determine their yield. With a fixed number of cases to review each month, we determine the most productive targets and select the majority of cases from those categories. Some of the targets are mandated by OAC rules, and 100% of those cases are reviewed. Low-yielding categories of cases are purged from the eligibility file, but these categories are also reviewed occasionally to determine their relevance as targets. For example, several years ago, all newborns were excluded from the sampling eligibility file. However, after discussion with ODJFS, Permedion added newborn transfers to our targets and identified new cases with billing errors.
Name and Scope of Project	Permedion uses SAS programs to select the set of cases that are to undergo medical record review as part of the retrospective review activity. The application consists of a set of complex algorithms that examine available paid claims to determine the most likely candidates for review. **The addition of remote review tools and state-of-the-art analytical software has enhanced our ability to develop, test, modify, and implement new methodologies quickly and efficiently.** At contract initiation, ODJFS anticipated returns of $18 million annually from our services. Instead, we continually exceed this goal, returning an average of $42 million (ROI 42:1) annually to the Ohio Medicaid program over the past five years. In the past State Fiscal Year (SFY), we identified more than $55 million in overpayments made by Ohio hospital providers. In the upcoming SFY, we will increase the number of monthly reviews to 1,500, and we will add outpatient hospital reviews to the inpatient reviews. We also provide prior authorization for select surgical procedures and use our proprietary Gemini system to document the results of the prior authorization reviews. Gemini ensures that reviewers obtain and input all required information associated with prior authorization requests in a consistent manner. The system flags inconsistent data entry as the reviewer is working, thus allowing correction at the error source. Gemini allows staff to accurately produce letters and reports associated with the prior authorization activity on an as-needed basis and to monitor the progress of prior authorization requests to make sure that they are completed within the required time periods. Prior authorization can be requested through a web-based option, which is very convenient for the provider community. We provide analysis regarding prior authorization usage yearly and

RFP Requirement	HMS Response
	make recommendations for changes to the required procedures. Hysterectomies, spinal surgery, and inpatient gall bladder surgery are examples of surgeries that require authorization. We also review special requests for "non-covered" services, such as bariatric surgery, otoplasty, and augmentation/reduction mammoplasty. Beginning in mid-2011, we will begin to perform our prior authorization reviews in ODJFS's new claim system, the Medicaid Information Technology System (MITS). We have worked closely with this client to provide guidance related to the use of MITS vis-a-vis the prior authorization process. Finally, Permedion performs medical bill audits and retrospective reviews of inpatient healthcare facilities, including rehabilitation stays in acute care hospitals and chronic/rehabilitation facilities. We use our proprietary Mars and Orion systems to administer and perform retrospective inpatient and outpatient review services. MARS provides an efficient way to administer and monitor the activities associated with the retrospective review activity, allowing the ongoing review to be monitored to ensure that all activities are completed within required time frames. Orion, a companion to MARS, ensures that our reviewers collect complete and accurate information as they perform the medical record reviews required for the retrospective review activity. Permedion performs 12,060 reviews annually for this contract. Initially, Permedion performed about half of our monthly reviews onsite, and we performed the other half as desk reviews. **With the advent of electronic medical records, scanning, and imaging systems, we are finding that most providers prefer desk audits, and the number of onsite reviews has declined to the point where we are currently transitioning to 100% desk audit reviews.** However, we still have nurse reviewers working at various locations around the state and have the ability to perform onsite reviews as necessary. Our sensitivity to provider abrasion is reflected in our success in obtaining medical documentation from providers. We request 1,005 records per month for this contract. Our compliance rate for record requests is more than 99%, a direct result of our long-standing excellent working relationship with Ohio providers. Providers are comfortable calling us if they are having problems finding records, and if we have not received the records within one week of the due date, we give the provider a courtesy call as a reminder. As part of our Provider Relations initiative, we receive approximately 1,000 calls per year from providers seeking information or guidance. Additionally, the quality of our determinations, combined with our provider education program, has resulted in an extremely low rate of overturns to our review decisions for the Ohio Medicaid contract. In FY 2010, we reviewed more than 12,000 records, with only a 16.6% reconsideration rate. Approximately 29% of those reconsiderations were reversed because the provider sent additional information. In SFY 2010, only 138 (1.2%) of our reviews were appealed to the state, and 80% of our decisions were upheld.
Dates of Engagement	New contract: July 1, 2011–June 30, 2013
Contact Individual and Title	Linda McCabe, Supervisor and Contract Manager, ORAA, Bureau of Audit, Surveillance and Utilization
Email Address	mccabl@odjfs.state.oh.us
Telephone	614.466.6972
4. I Efficiencies or Results Gained by the Project	Throughout the years, Permedion has fine-tuned its target selection so that we select only good cases for review. Intimate knowledge of the billing regulations has also led us to the identification of many overpayments. It is this knowledge that has consistently resulted in positive findings.

RFP Requirement	HMS Response
4.J Cost Savings and Their Calculation	For the past five years, Permedion has identified an average of more than $44 million annually in overpayments for ODJFS. Despite the fact that providers could rebill some of these denied claims, only approximately 40% of the recouped dollars were rebilled. Additionally, we maintain an extremely low rate of overturns to our review decisions for the contract. In FY 2010, we reviewed more than 12,000 records, with only a 16.6% reconsideration rate. Approximately 29% of those reconsiderations were reversed because the provider sent additional information. In SFY 2010, only 138 (1.2%) of our reviews were appealed to the state, and 80% of our decisions were upheld.
Compensation Structure	Fixed fee for past contracts; with the new contract, the fee structure will be per review.
4. K Disagreements Regarding Fees	None
4. L Extent to Which Compensation Was Based on Percentage of Savings Attributable to the Effort; How These Savings Were Distinguished from Savings Realized	Compensation was not based on the percentage of savings. Even though this was in fact a fixed-fee contract, we continued to increase the annual savings; these savings are represented by the net savings figure that is calculated annually after providers have rebilled their denied claims (according to policy).

Additional Experience Examples

We provide the following as additional demonstrations of our payment integrity expertise:

Pharmacy Claims

Customer Name	Indiana Office of Medicaid Policy and Planning
Name and Scope of Project	**Pharmacy Audit Services** Since 2002, HMS has provided pharmacy claims audit services for the Indiana Medicaid program, administered by Department of Family and Social Services Administration (FSSA) and the Office of Medicaid Policy and Planning (OMPP). We analyze all paid pharmacy claims submitted to the fiscal agent and perform daily real-time reviews (concurrent reviews). We notify pharmacies when a questionable point-of-sale claim was submitted to determine the adjustment measures required. Quarterly, HMS conducts a more detailed review of all claims to identify overpayments. We annually perform onsite audits of no less than 2.5% of the pharmacy providers based on a risk assessment. We also perform LTC returned medication audits, and we provide audits to verify that pharmacies accurately submit as part of their billings the same usual and customary charge to OMPP as they offer to the public. In all cases and types of audits, when an overpayment is identified, HMS notifies the pharmacy provider, answers questions, and attempts to resolve any issues. Should the provider appeal the overpayment claim, we support OMPP throughout the appeals process. In June 2009, HMS was re-awarded this contract. Under a fixed-fee contract, we provide 2,600 desk audits and 42 onsite audits (representing 2.5% of enrolled pharmacy providers annually). To date, we have recovered $11.76 million. To provide these services, we maintain: ► High-end SQL server hardware and databases that house terabytes of information. ► UNIX-based hardware and software solutions supporting automated communications with pharmacies, chains, PBMs, and other business partners. Proprietary software applications were developed using Microsoft .NET and Microsoft Access. ► Enterprise-scale Windows-based servers, along with other enterprise-level networking hardware and software from recognized industry leaders. ► High-end back-up technology as well as up-to-date anti-viral software from leading manufactures such as Symantec, SonicWall, and McAfee ► Our proprietary algorithms span multiple data sources and perform complex pattern recognition and data-mining to identify potential billing issues as well as waste and abuse. These algorithms are driven by our sophisticated infrastructure and dedicated data center, ensuring a quick turnaround time while processing massive volumes of data. In addition, the availability of legacy data helps us to perform necessary trend analysis over multiple audit cycles. Our certified fraud examiners ensure the viability of these algorithms by performing ongoing research. Our staff of highly experienced data analysts also support the continual development and refinement of fraud-detection tools.
Dates of Engagement	October 1, 2009 –September 30, 2012

Contact Individual and Title	Nehru Motilal, Policy Analyst
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Telephone	317.232.2022

FWA

Customer Name	**Cook Children's Health Plan**
Name and Scope of Project	FWA Investigations Cook Children's Health Plan provides coverage to low-income individuals qualifying for government-sponsored programs. The Health Plan is an MCO established by Cook Children's Health Care System in 1998 that provides services to more than 53,000 members, offering medical, dental, pharmacy, and vision services. Our approach to this client is to focus on obtaining high-quality data and using that data to provide a comprehensive pre-payment editing solution offering prospective review and the ability to conduct FWA investigations. The highly customized solution applies federal, state, and plan-specific edits, including NCCI edits. The client chose to use the editing, investigation management, and Special Investigation Unit services that we offered. We customized our services to meet the client's needs—both CHIP and STAR regulations were incorporated along with NCCI, Medicare, and Medicaid edits. The Medicare edits that we use for this client include inpatient and outpatient procedures; compound procedures (service code pairs that generally should not be reported billed together); mutually exclusive procedures (medical impossibility or improbability that the procedures billed could be performed during the same session); Medically Unlikely Edits for physicians, hospitals, and DME; and edits regarding age, sex, and other characteristics.
Dates of Engagement	April 1, 2007–April 30, 2012
Contact Individual and Title	Kathleen Roman, Regulatory Compliance Manager
Email Address	kathy.roman@cookchildrens.org
Telephone	682.885.2866

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Table of Contents – Tab 4.M: Reporting Platform

All information contained within this section is trade secret, as defined by the State of Minnesota statute. This information provides detailed descriptions of the technology and reporting tools that enable us to provide our proposed data analytics services. Disclosure of this information would cause substantial injury to the competitive position of HMS.

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