MAXIMUS®

Proposal to Provide

Provider Management System

Prepared for
Arizona Healthcare Cost Containment System (AHCCCS)

Solicitation No. YH18-0033
March 15, 2018 by 3:00 p.m.

MAXIMUS

HELPING GOVERNMENT SERVE THE PEOPLE®

March 13, 2018

Alice McLain
Procurement Manager
Arizona Healthcare Cost Containment System
701 E. Jefferson, MD5700
Phoenix, Arizona 85034

Dear Ms. McLain:

MAXIMUS Human Services, Inc. (MAXIMUS) is submitting our proposal for the Provider Management System for AHCCCS/Med-QUEST. Our Provider Management Module is in production and supporting Medicaid agencies in Tennessee, Nebraska, and the District of Columbia. We are currently leading the modular certification reviews in Nebraska and the District of Columbia. Nebraska expects certification in the spring of 2018, and the District of Columbia in mid-2018. MAXIMUS, as the only vendor to have implemented multiple Provider Management Modules specifically designed for the Medicaid program, stands alone in our experience.

For Arizona and Hawaii, our Provider Data Management System (PDMS) enables enhanced application automation and data sharing across all trading partners. Our intuitive and easy-to-use web portal enables Providers to complete a paperless Medicaid enrollment application that includes integrated data quality checks to increase the speed accuracy of the overall process. Our solution is fully aligned with the Medicaid Information Technology Architecture (MITA), and meets the Seven Standards and Conditions for enhanced Federal Funding Participation.

MAXIMUS has been operating large-scale, effective solutions for health services clients since 1992, and has delivered Medicaid solutions since 1995.

Per RFP Uniform Instructions Section 3.8 Disclosure, MAXIMUS 1) has not been debarred, suspended, or otherwise lawfully precluded from participating in any public procurement activity; 2) has not been disapproved as a subcontractor with any federal, AHCCCS/Med-QUEST, or local government; and 3) does not have any such public procurement activity currently pending.

Per RFP Special Instructions 12.4 Request for Confidential / Proprietary Determination, MAXIMUS requests that Section 2.4 (pages 2-16 through 2-32) and Sections 4.1, 4.2, and 4.3 (pages 4-1 through 4-55) of our proposal be kept confidential by the State. Our analysis from legal counsel follows this Cover Letter.

Assumptions and Clarifications. MAXIMUS does not take exception to the terms and conditions in the RFP. MAXIMUS does note the following Clarifications and Assumptions.

(1) As a clarification to the *RFP Special Terms and Conditions, Section 16 Ownership of Information and Data*, the MAXIMUS software, documentation, and manuals (collectively, the Software) were developed by MAXIMUS outside of the proposed contract resulting from this RFP. The Software is proprietary to MAXIMUS and MAXIMUS shall retain exclusive ownership of the Software.

1891 METRO CENTER DRIVE | RESTON, VA 20190 | 703.251.8500 | 703.251.8240 FAX | WWW.MAXIMUS.COM

(2) MAXIMUS requests the opportunity to negotiate mutually acceptable changes to certain insurance terms to align them with the specific language in our corporate policies, provided the final terms meet the RFP's required coverage types and amounts.

(3) MAXIMUS accepts the obligation to comply with applicable state and federal laws and regulations, but we cannot price the obligation as to future as yet undefined changes in applicable laws and regulations that may require changes to the solutions and services MAXIMUS is offering. If such changes in applicable laws and regulations increase the cost of or time for providing the solutions and services, or change other material terms or conditions, the parties will negotiate an equitable adjustment to the contract price, schedule, and other affected terms.

(4) MAXIMUS has relied on the information provided by the State in the solicitation. Incomplete or erroneous information may require an adjustment to the proposed prices, schedules, or other affected terms.

We look forward to your review of our proposal. For clarifications on our proposal, please contact Patrick Aguilar, Senior Vice President at PatrickDAguilar@maximus.com or 505.301.3797.

Sincerely,

Charles K. Sweeney II

Charles K. Sweeney II
Vice President – Contracts
Assistant General Counsel
303.285.7557
charlesksweeney@maximus.com
MAXIMUSHumanSvProposals@maximus.com

OFFER AND ACCEPTANCE

OFFER

The undersigned Offeror hereby agrees to provide all services in accordance with the terms and requirements stated herein, including all exhibits, amendments, and final proposal revisions (if any). Signature also certifies Small Business Status.

Arizona Transaction (Sales) Privilege Tax License No.:

07654776

Federal Employer Identification No.:

45-0553376

E-Mail Address: MAXIMUS HumanSvProposals@maximus.com

MAXIMUS Human Services, Inc.

Company Name

1891 Metro Center Drive

Address

Reston Virginia 20190

City AHCCCS/Med-QUEST Zip

For clarification of this offer, contact:

Name: Patrick Aguilar

Title: Senior Vice President - Professional Services

Phone: 505.301.3797

Charles K. Sweeney II

Signature of Person Authorized to Sign Offer

Charles K. Sweeney II

Printed Name

Vice President - Legal

Title

CERTIFICATION

By signature in the Offer section above, the Offeror certifies:

1. The submission of the offer did not involve collusion or other anti-competitive practices.
2. The Offeror shall not discriminate against any employee or applicant for employment in violation of Federal Executive Order 11246, AHCCCS/Med-QUEST Executive Order 2009-09 or A.R.S. §§ 41-1461 through 1465.
3. The Offeror has not given, offered to give, nor intends to give at any time hereafter any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant in connection with the submitted offer. Failure to provide a valid signature affirming the stipulations required by this clause shall result in rejection of the offer. Signing the offer with a false statement shall void the offer, any resulting contract and may be subject to legal remedies provided by law.
4. The Offeror _____ is / X is **not** a small business with less than 100 employees or has gross revenues of $4 million or less.
5. The Offeror is in compliance with A.R.S. sec 18-132 when offering electronics or information technology products, services, or maintenance; and
6. The Offeror certifies that it is not debarred from, or otherwise prohibited from participating in any contract awarded by federal, AHCCCS/Med-QUEST, or local government.

ACCEPTANCE OF OFFER (to be completed by AHCCCS)

Your offer, including all exhibits, amendments and final proposal revisions (if any), contained herein, is accepted. The Contractor is now bound to provide all services listed by the attached contract and based upon the solicitation, including all terms, conditions, specifications, amendments, etc., and the Contractor's Offer as accepted by AHCCCS.

The Contractor is cautioned not to commence any billable work or to provide any material or service under this contract until Contractor receives purchase order, contact release document or written notice to proceed.

This contract shall henceforth be referred to as Contract No. _____.

CONTRACT SERVICE START DATE: _____.

AWARD DATE: _____

_____

MEGGAN HARLEY,CPPO, MSW, AHCCCS Chief Procurement Officer

Executive Summary

To meet the Arizona Healthcare Cost Containment System (AHCCCS) and Hawaii Medicaid program (Med-QUEST) requirements for a Provider Management System, MAXIMUS is proposing our DecisionPoint™ for Provider Data Management Solution (referred to as the PDMS in our proposal) which we will integrate, configure and deploy to meet all RFP requirements. We will deploy our solution using a Software as a Service (SaaS) model, which includes all costs in a single subscription. Our subscription includes our proven base system; hosting the infrastructure in the Amazon Web Services (AWS) cloud; integration of a number of industry leading COTS products for reporting, rules engine, content management, and correspondence management; and providing sophisticated enterprise level monitoring software and tools. We will also provide maintenance and operations support and support enhancement requests made by AHCCCS/Med-QUEST throughout the life of the project.

Our solution addresses all Provider enrollment, screening, and data update functions required by federal regulations (42 CFR 455 Subpart E) along with the security, privacy and interoperability requirements required by CMS, NIST, HIPAA and other state and federal regulations. PDMS is designed to support the goals of the Seven Standards and Conditions for Enhanced Funding by fostering better data sharing and integration, reducing unnecessary paperwork, opening new communication channels and focusing attention on the key elements of success for modern systems development and deployment. It offers Providers an intuitive, easy-to-use web portal for all of the interactions with Medicaid including electronic submission of new applications, re-enrollments, and revalidations enabling states to gain greater MITA maturity levels through automation. It allows Providers to update their data directly without the need to call a support center or complete a paper update request. Our solution provides a sophisticated screening module that prevents ineligible Providers from enrolling and/or remaining enrolled in the State's Medicaid program and workflows that guide the screening workers through all steps depending on a Provider's risk level.

MAXIMUS is the first vendor to have implemented a modular Provider Management Solution for State Medicaid and the only vendor to have successfully implemented a modular solution for multiple states. We are currently operating our solution in Tennessee, Nebraska, and the District of Columbia. In Tennessee, we implemented our system in a standalone fashion where the State performs the Provider Management operations. In Nebraska and the District of Columbia our system is provided using a SaaS model coupled with MAXIMUS-provided full customer service and call center functions.

MAXIMUS also brings current experience in the new modular certification process being used by CMS. We are supporting modular certification reviews in Nebraska and the District of Columbia. Nebraska has undergone all IV&V and CMS reviews and is in the final stages of the certification process with the expectation of certification this spring. The District of Columbia recently began the certification process and has started the IV&V reviews. We expect certification in mid to late 2018. No other vendors have the depth of experience in both implementation and modular certification and we will use our experience in both to deliver a successful project for AHCCCS/Med-QUEST.

MAXIMUS and Provider Management

MAXIMUS has been operating large-scale, effective solutions for government health services clients since 1992, and has delivered Medicaid and customer service solutions since 1995. The passage of the Patient Protection and Affordable Care Act (ACA) in 2010 and the subsequent shift to modularity supported by MITA presented states with new challenges and a new paradigm for the modernization of their Medicaid Management Information System (MMIS). Since the enactment of the ACA, MAXIMUS has been involved in the realization of the Medicaid provisions by working with Medicaid programs to

implement Provider Management Systems and deliver all aspects of customer support, including Provider services, outreach, and education.

Customer Service

MAXIMUS designed PDMS with the Provider community in mind. With a record of excellence in serving our government clients, MAXIMUS became the first company to develop and implement an independent Provider Management solution that moved key aspects of the enrollment and management business functions out of the traditional MMIS environment. Our solution enabled a transition into standalone business services components governed by service level agreements (SLAs) and technology requirements. Since our initial implementation for Tennessee in 2011, MAXIMUS has continued to lead the Provider Management modular solutions market by extending our solution to include the full slate of operational services in Nebraska and the District of Columbia. These three projects are the first modular Provider Management implementations in the country, and have helped us fine-tune the MAXIMUS solutions to work within the larger Medicaid Enterprise.

did you know MAXIMUS

- Has been serving Medicaid Providers for 19 years, validating their information and enrolling them in State Medicaid Programs
- Was the first vendor in the country to implement a modular Medicaid Provider Management System outside of the traditional MMIS
- Has developed a fully CMS-compliant Provider Management and Enrollment System that is operating successfully in Tennessee, Nebraska, and the District of Columbia
- Is currently supporting modular CMS certification in Nebraska and the District of Columbia

Experience

Exhibit ES-1: Relevant Provider System and Services Experience shows the extensive Provider-focused projects we have nationwide. The number and longevity of our projects are a testament to our commitment to our customer's goals, strong past performance and overall customer satisfaction. Our experience spans an array of projects including those based on system-only implementations, service-only projects where legacy systems are used, and projects where MAXIMUS brings both system tools and services to support our customers.

Relevant Provider System and Services Experience

MAXIMUS Project	Number of Years in Operation	Provider Screening and Enrollment	Provider Data Management System	Web Portal Development and/ or Operation	Data Collection and Validation	Data Integration
Tennessee Provider Data Management System and Portal	6.5	✓	✓	✓	✓	✓
Nebraska Provider Enrollment and Screening	3	✓	✓	✓	✓	✓
District of Columbia Provider Data Management System and Provider Services	2	✓	✓	✓	✓	✓
Iowa Medicaid Enterprise Provider Services	12	✓			✓	
Massachusetts MassHealth Customer Services	19	✓			✓	✓
New York State Physician Profile	15		✓	✓	✓	✓
New Jersey Health Care Provider Profile	13		✓	✓	✓	✓

Exhibit ES-1: Relevant Provider System and Services Experience. *MAXIMUS has a successful history and significant experience relevant to this project through our operation of numerous similar contracts. Our project experience is current and staff brings hands on experience to this Provider Management System Project.*

We are one of the only vendors that offers our customers the ability to “pick and choose” the services that are right for their State and the Program initiatives that are being undertaken. In addition, MAXIMUS has been successfully implementing modular solutions before CMS mandated the approach. By choosing MAXIMUS as your Provider Management vendor, you will receive a team of experienced staff and a proven solution for realizing a modularized Provider Management System.

The MAXIMUS Team: Proven Expertise in Provider Management Solutions

Our system and project management approach is delivered by a team of highly skilled staff with the variety of functional and technical skills needed to support this project. We selected the project team for this engagement specifically for the skills and abilities they possess. We are veterans of working alongside government agencies in highly dynamic and political environments. We offer AHCCCS\Med-QUEST valuable, real-world understanding of how modernization efforts improve healthcare availability and outcomes. We also bring an important understanding of the Provider community, the functionality of the Medicaid support systems (including the MMIS) and federal policy regarding the Medicaid program. Our team also includes staff knowledgeable with the systems and business processes used by AHCCCS\Med-QUEST.

Expertise

To make the Provider Management System project a success, MAXIMUS will bring experienced and qualified staff for each major component of the solution. We are pleased to be able to offer senior staff members with extensive experience with our PDMS in multiple states. **Patrick Aguilar**, PMP, the Contract Manager, was the original architect of our PDMS solution and in his current role is responsible for the long-term satisfaction of our customers and successful delivery of our services. Mr. Aguilar keeps close contact with all our clients, managing the relationships from the executive level. Our Project Manager, **Kelly Micka**, JD, PMP, is currently managing the certification efforts in both Nebraska and the District of Columbia. Our Phoenix-based Business Lead, **Teresa Stanfill**, has been working with our PDMS since it was originally implemented in Tennessee. In addition to bringing over 15 years of Medicaid business experience to the project, Teresa also brings practical hands-on experience with AHCCCS/Med-QUEST, which will be extremely beneficial as we review the RFP requirements and determine how to update workflow configurations within the system. Our Technical Lead, **Aneesa Thomas** has been instrumental in developing the latest version of PDMS that we bring to AHCCCS/Med-QUEST. As a key member of our product team, she has been closely involved in the integration of Corticon as the rules engine, updating the user interface to a modern approach and in furthering our SOA-integration processes. We are also assigning **Jon Puckett**, PMP, our PDMS Solution Architect to support the project. His support will help align this project with our other installations and bring fresh new ideas to the project. In addition to our key staff, each assigned team member has the requisite skills and is a veteran of our modular PDMS implementations.

Our project team brings skills in project management, requirements definition, business process analysis, and operations, giving us a strong foundation that will help the project to be successful. A host of experienced managers and delivery staff will support our leadership team to complete the MAXIMUS scope of work. We understand the importance of supporting both Arizona and Hawaii independently. We have staffed the project with a Business/Testing Lead for AHCCCS and a Business/Testing Lead for Med-QUEST, each reporting to the project’s Business Lead. The Business Lead will keep the solution for both states in alignment. On the technical side, we leverage resources across most technical tasks and focus on single solutions for items such as hosting, data conversion, interfaces, reporting, security, and privacy. The staffing model supports streamlined maintenance and operations and aides the teams as we move forward with the CMS modular certification process. *Exhibit ES-2* shows our proposed organizational chart.

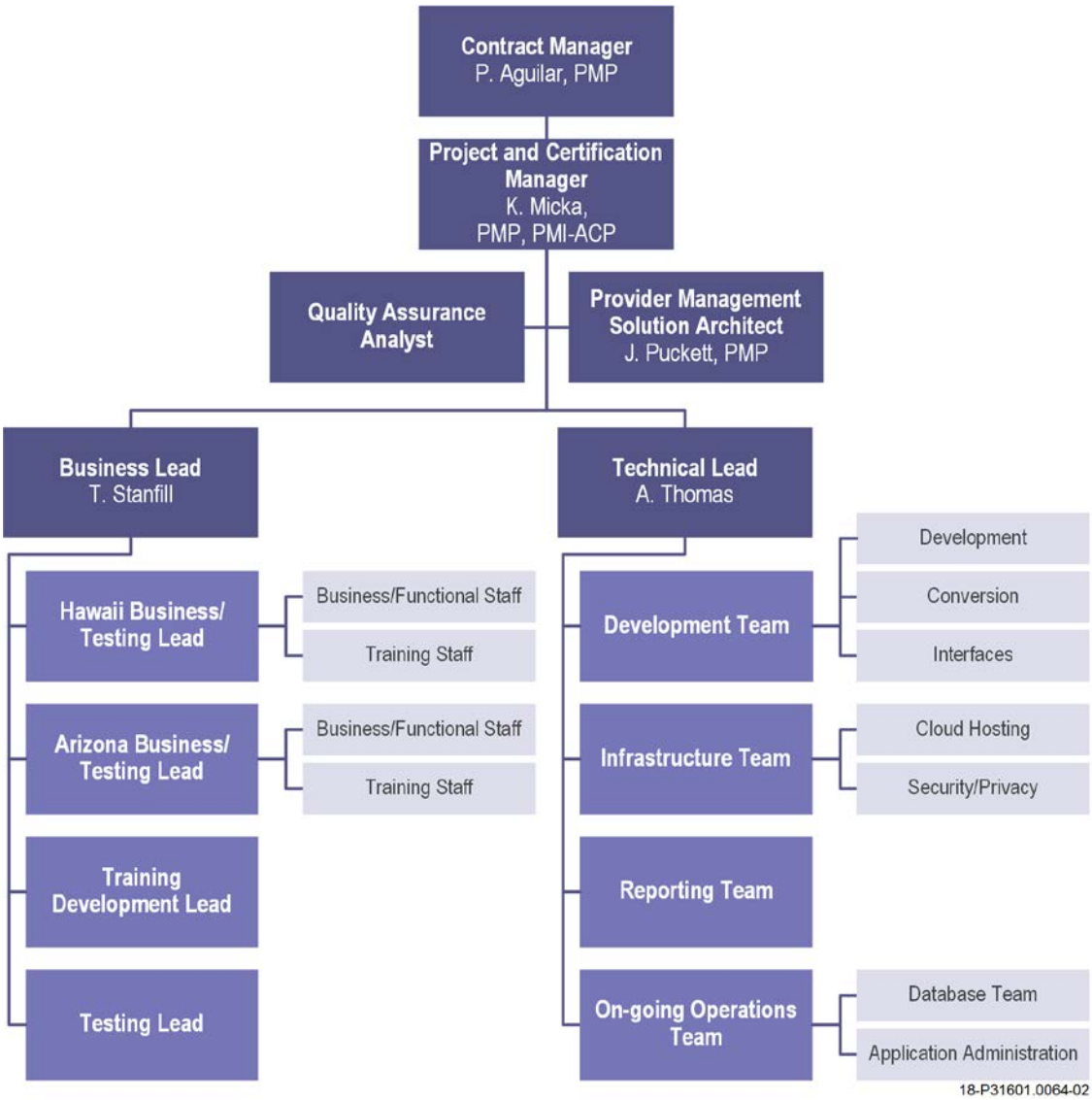

Exhibit ES-2: Provider Management System Project Organization Chart. *The MAXIMUS Project Team offers AHCCCS/Med-QUEST project management, business, and technical experts to meet your goals and expectations for this Project.*

Our experienced project team and unique organizational structure, designed to specifically support both states, should give AHCCCS/Med-QUEST confidence that MAXIMUS has the level of staff necessary to deliver excellent services to AHCCCS\Med-QUEST Providers while enabling new technology and advanced business processes that will increase productivity, speed, and accuracy for key Provider functions.

Our Approach: A Proven Methodology for Modular Implementations

We have designed our implementation plan around the requirements for the Provider Management System taking into account to the need to support both AHCCCS and Med-QUEST independently. After a careful review of the requirements, we determined we could implement the PDMS in ten (10) months using experienced staff and the organizational approach we described in the previous section. *Exhibit ES-*

3: MAXIMUS Provider Management System Implementation Plan shows the high-level schedule we propose for system implementation.

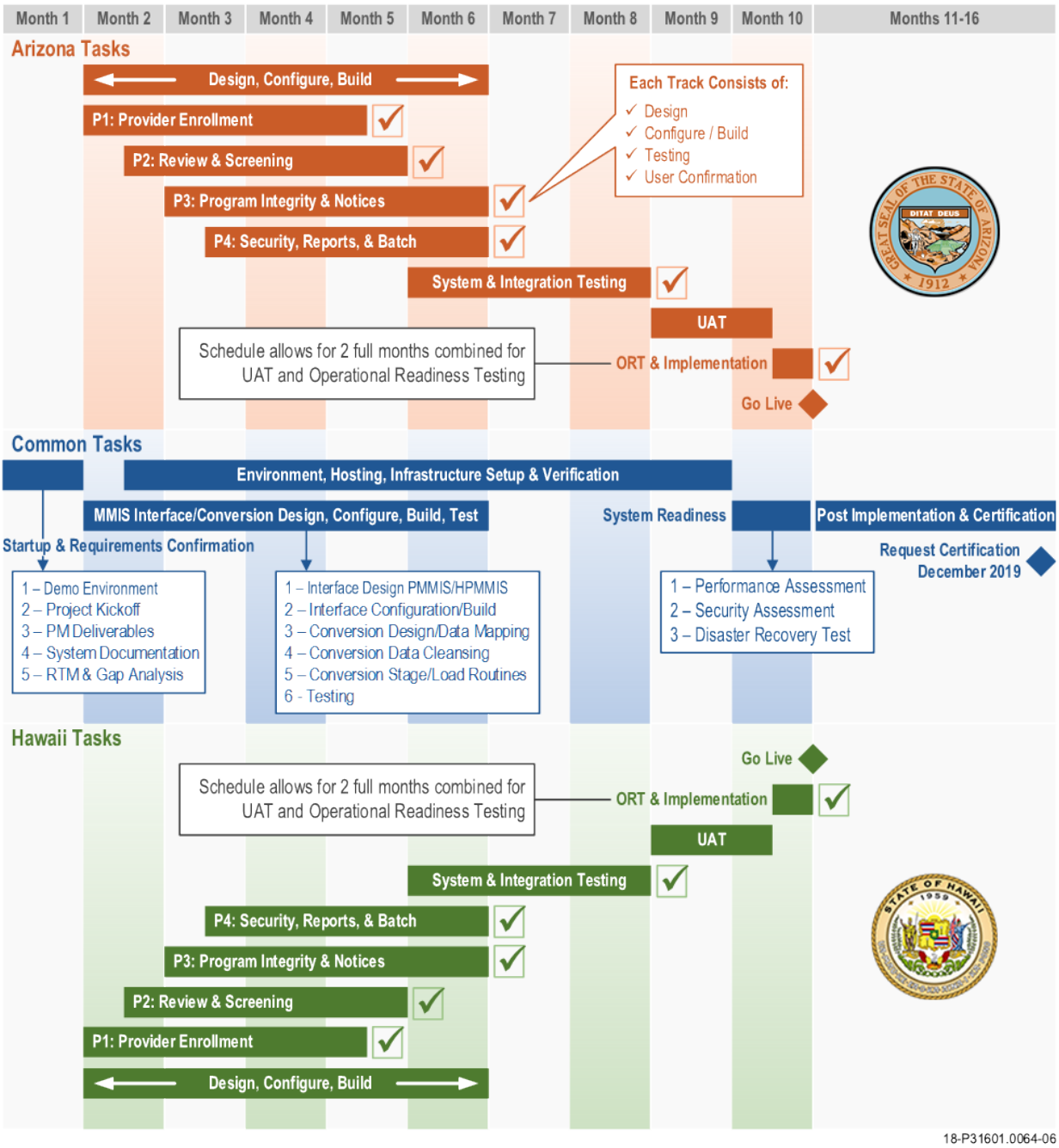

Exhibit ES-3: MAXIMUS Provider Management System Implementation Plan.

Understanding the aggressive nature of this schedule, we are also proposing significant post-implementation support for the two months following go-live as part of our implementation plan. We continue a high level of staffing throughout the entire first year of maintenance and operations to provide warranty support and ensure adequate support as Providers transition to the new system.

Our implementation approach emphasizes user engagement early in the project and continues throughout all remaining phases. Requirements and software configurations evolve through collaboration between State subject matter experts, MAXIMUS Business Analysts, and the development team. We present results of software releases to the user community as soon as they are complete, rather than at the end of the entire development phase. We propose delivery of six incremental packages of application components for the project. Four of the packages focus on the system configurations necessary to support the enrollment and screening functionality while the remaining two are focused on interface and conversion development. This approach allows us to configure the system in manageable pieces, reduces simultaneous reviews for AHCCCS /Med-Quest, allows testing to occur sooner, and provides users with early opportunity to view and work with the application.

We have created an implementation plan that allows the option of AHCCCS and Med-Quest to be implemented on different release schedules. We are able to support this scenario; however, to best leverage project resources we are assuming that both systems will be implemented on the same date as shown in the *Exhibit ES-3*. To build in flexibility for two different implementation schedules, our plan reflects separate tasks and activities for both State implementations, where required during the implementation phase of the project. We also have shown the set of common tasks that we plan to conduct for both states. These tasks enable MAXIMUS to utilize our project management, infrastructure and interface and conversion teams across the entire project for tasks that have the shared use across both states.

We will work with AHCCCS/Med-QUEST to determine the best implementation schedule for each state.

MAXIMUS: The Right Choice for AHCCCS/Med-QUEST

Arizona and Hawaii have an important decision to make — who will become their choice to implement the Provider Management System and deploy the technology platform for the future? We believe the choice is clear. MAXIMUS combines the right solution with the right approach and the right team to provide a low-risk implementation of the Provider Management System. We have established a strong team of professionals with the expertise required to support AHCCCS and Med-QUEST as they begin the modular modernization of the Medicaid Enterprise. We are committed to unqualified success.

As you review our proposal, keep in mind the combination of experience and production-proven solutions that MAXIMUS offers and compare this experience with that of other firms. We believe you will find that MAXIMUS delivers on its commitments, stands behind its services, and provides you with a system in which each State can take great pride. We look forward to working with you on this Provider Management System Project.

1: Method of Approach

1. Proposed Method of Approach – MAXIMUS Solution

1.1 Scope of Work

Throughout our proposal, MAXIMUS describes how we use formal processes and procedures to create an operational and technology solution to support the AHCCCS/Med-QUEST requirements. MAXIMUS has provided a clear, concise description of how our approach and solution meet each of the requirements specified in the RFP. For some requirements, we felt that AHCCCS/Med-QUEST would gain a better understanding of the benefits of our solution by providing additional information about the requirement. In these cases, we refer the reviewer to *Section 4: Additional Information*, where we further demonstrate our capability to meet the requirement.

1.1.1 Overall Requirements

5.1.1: MAXIMUS developed our Provider Data Management Solution (PDMS) as a configurable platform to meet all ACA requirements for provider enrollment and screening. We deliver this platform using a Software as a Service (SaaS) model where the entire solution including hosting and maintenance and support is provided to our customers at a single market price based on the specific project requirements. Our solution uses a variety of industry standard COTS products to support enhanced functions including the Progress Corticon Business Rules engine, MicroStrategy reporting toolset, Hyland OnBase for document management and the Quadient Inspire correspondence management suite. To further enhance our ability to provide a configurable solution, we incorporate a custom-built Business Process (workflow) engine built on the .NET framework. To provide interoperability with other systems, we expose well-defined service components based on SOA interoperability to support data exchanges using any method that a trading partner prefers. Any required customization of our solution is typically limited to specific changes needed for the MMIS interface for a State and/or any State-specific screening/verification sources that may be required.

5.1.2: Our solution enables Providers to enter new enrollments, re-enrollments, revalidations and updates electronically via the web portal. The configurable workflow engine and user interface in our solution allows us to configure the data collection and review processes to meet the requirements and policy set forth by AHCCCS/Med-QUEST. The user interface is designed using Responsive Web Design (RWD), which allows any user to perform self-service web portal tasks using mobile devices, including tablets and cell phones. The RWD features of the user interface allow us to render functional web pages on a variety of devices and window or screen sizes. [Additional Information: Section 4.1.1.3]

Providers also have the option of submitting paper applications and updates. Our solution supports scanning and indexing of paper enrollment forms and data updates and stores them in the Hyland OnBase document repository. Our solution provides a paper application workflow that allows the Data Entry staff to enter the paper enrollment applications directly into the system through the web portal. The imaging solution also directly integrates with the online solution to capture uploaded documents. [Additional Information: Section 4.1.1.2]

The system generates an application receipt notice to the Provider in real-time (via the communication preference selected by the Provider) once the Provider has submitted an application or provided updates. We also create a PDF of the entire enrollment data form so that providers are able to print and see the information submitted. [Additional Information: Section 4.1.1.5]

5.1.3: Our solution is currently in production in three other states and supports an interface to the MMIS in each State. The interface sends the data required to establish the provider account in the MMIS, as well as to support any other required downstream functions. PDMS assigns Category of Service codes to providers (based on Provider Type) and captures all provider data for MCO only providers (including

relationships between individual practitioners and billing providers). We are able to include all data elements that are collected from providers to accommodate additional data that is not currently found in our MMIS interface functions.

5.1.4: Our solution contains edits and validations throughout the application workflow to help confirm that Provider-submitted data meets CMS and Department requirements prior to initiating the internal screening process. The system prevents Providers from submitting applications that have missing, incomplete, or conflicting information. These front-end edits are configured to meet the unique rules and policies required by the AHCCCS/Med-QUEST. Once the provider has established a user account through the web portal, the Provider is able to view the status of all Providers managed under the user account. No transactions are sent to the MMIS until the Provider has been approved and passed the screening checks in PDMS. To assist Providers during the enrollment and revalidation process, the PDMS web portal displays contact information as well as enabling automated communications through a webchat function. We provide links to training materials and other relevant web resources, including State/CMS sites and contact information as required. Using Medchat, Providers have the capability to initiate a dialogue with internal users (Enrollment Specialists and CSRs) in real-time to assist the providers in completing their enrollment, revalidation, or update. [Additional Information: Section 4.1.1.3]

5.1.5: MAXIMUS is proposing to host PDMS using the Amazon Web Services (AWS) cloud-hosting infrastructure. This approach includes cloud-based storage solutions to provide full backup, recovery, and restore capabilities. We are proposing a high availability production environment as well as a fully redundant disaster recovery infrastructure with real-time data replication to provide backup, recovery and refresh functions.

5.1.6: The PDMS automated workflow guides the Provider through the application process using a wizard-based approach that shows the data that must be entered in a logical order. The web portal validates data entry as it is being entered and prompts users for missing or inconsistent data. The enrollment process also requests and validates the upload of required electronic attachments into our document repository. Once we have confirmed that all data necessary for the application has been collected and is correct, we display the agreements to the Provider for review along with contract compliance information. Once all agreements have been viewed and accepted, we require an electronic signature that is designed to meet State and federal requirements. [Additional Information: Section 4.1.1.3]

5.1.7: Our OnBase ECM supports the receipt of documentation in all common file types. For security purposes, we may want to limit the types of files that are accepted but we will review this with AHCCCS/Med-QUEST and update the configuration as necessary. Paper documents are scanned and stored as PDF files. The PDMS is integrated seamlessly with OnBase to allow uploaded documents to be rendered in their native formats.

5.1.8: The vast majority of the reporting capabilities of PDMS are designed to make data accessible to through real-time dashboards and other online reporting functions. PDMS contains a set of integrated online dashboards designed to show the status of all providers in the system. Through these online processes, authorized AHCCCS/Med-QUEST staff and managers have real-time access to all program data including a summary of all providers in the system, regardless of status. Users are able to view the status of new applications and initial/ongoing revalidations, and the dashboard displays the aging of each application based on the workflow step or status of the application. Queue aging columns included on the dashboard provide additional information on the applications in the various queues, including the duration an application or revalidation has been in a queue. At the worker or internal user level, the total number of providers assigned to a specific worker is displayed by type along with the totals for each of the work

queues. Users are able to work through their assigned providers or choose to automatically pick the next provider in the queue for processing.

5.1.9: MAXIMUS is proposing to host the entire Provider Management Solution on the AWS cloud. AWS provides a highly reliable, efficient, scalable, low-cost infrastructure platform with proven capabilities. Our use of cloud-based hosting, coupled with the architecture of our solution, enables MAXIMUS to increase the size of the various environments, add additional servers to each tier, and to scale the telecommunications as needed by the size of each State using our solution.

5.1.10: The MAXIMUS system architecture uses virtualized machines across all system environments and applications tiers. We propose to use Amazon Elastic Compute Cloud (Amazon EC2) for all the virtual machines. The Amazon EC2 gives complete control of computing resources. It enables us to obtain and stand up new server instances within minutes, allowing us to scale quickly to capacity, both up and down, as the computing requirements change. Inside these EC2 instances, the persistent block storage volumes, called Amazon Elastic Block Store (Amazon EBS) are used. Amazon EBS volumes offer the consistent and low-latency performance needed to run the workloads. For resources and static content, MAXIMUS will make use of Amazon Simple Storage Service (Amazon S3). Amazon S3 is designed to deliver high durability and scalability. It also supports data transfer over SSL and automatic encryption thus making it highly secure. Each environment used by MAXIMUS is completely documented. If necessary, MAXIMUS will work with AHCCCS/Med-QUEST infrastructure team to re-host the system in the State's data center. [Additional Information: Section 4.1.3.2]

5.1.11: The PDMS Agreements screen is configurable to meet the State's requirements for the viewing and signing of Provider agreements, including displaying different agreements and contracts based on Provider type. System rules dictate which Providers require which type of agreement. The Provider must first view and acknowledge each required agreement(s) before electronically signing and submitting the application. After signing the agreement, the Provider can submit the new enrollment, re-enrollment, revalidation, recertification or update for review and screening. The system generates a printable PDF that captures all the information entered by the Provider during the enrollment process. The system also sends an email notifying the Provider that the application has been received and is ready for processing. [Additional Information: Section 4.1.1.5]

5.1.12: Our solution includes development, integration/system test, user acceptance test (UAT), training, and production environments, each with its own virtualized processing and storage requirements. As a part of all implementations, MAXIMUS creates Technical Specifications for each environment that describes in detail the configurations of the virtualized servers, memory specifications, and storage requirements we will use to support the PDMS implementation. The details within this technical specification are sufficient to allow AHCCCS/Med-QUEST to create the virtualized environments necessary to house and operate the system in a selected Data Center, if required.

5.1.13: PDMS uses a mixture of industry standard technologies and currently supported COTS products. Our support model is designed to keep the PDMS solution up-to-date and in efficient operating order by ensuring that the hosting and software infrastructure operates on the latest versions available and all software will be supported throughout the life of the project. Our overall hosting solution includes the requirement to keep hardware and software on at least the n-1 version with built in upgrades as new products become available. By using our cloud-based hosting solution, we are assured that the hosting and telecommunications infrastructure is always current and can easily scale for increased user loads and provider volumes.

5.1.14: PDMS is a web-based solution and requires no installation on client workstations. The website is hosted on the IIS web server and is accessible via standard web browsers. All cookies are browser session based and no permanent cookies are stored in the client workstation.

5.1.15: The PDMS architecture documentation is contained in the System Architecture Document. MAXIMUS will prepare and deliver the System Architecture Document including a technical explanation of all aspects of the solution, detailed architectural diagrams, data flows, technical specifications, SaaS specifications, COTS products descriptions, and maintenance/upgrade schedules and hosting environment details. For each required system interface, we produce separate Interface Control Documents (ICD). Through collaboration with the AHCCCS/Med-QUEST and other stakeholders, our team will review each required interface and develop or update the ICD and specifications for processing based on the specific requirements. The ICD will include documentation for the frequency, file transfer method, data layout, inbound/outbound capability, error handling, and audit reporting. [Additional Information: Section 4.1.3]

5.1.16: PDMS includes a consolidated data repository that allows authorized users to store, retrieve, and report on data. The data repository houses all data and information produced during the provider application, enrollment, screening, and maintenance activities, as well as all related data ingested by various State agencies and Trading Partners. The data repository is updated in real-time as providers make updates, enrollment staff makes decisions, screening processes run, and workflows are executed. The consolidated data repository defines the master data for our solution and includes a data model that identifies the data characteristics and schemas that are used by the system.

ICDs will define all inbound and outbound data and detail the origin and use of the data. As web services are published to enable integration with partner systems, we will define all data that is accessible via web services and the rules around how the data is accessed, updated, and used. Our solution has built in standardized service contracts to allow other applications to consume the services we publish.

5.1.17: MAXIMUS stores no data offshore and all data is stored within domestic AWS hosting environments. PDMS uses the latest version of Microsoft SQL Server Enterprise Edition as the database server for the central data repository of the application. The database server hosts SQL Server Reporting Services (SSRS) and SQL Server Integration Services (SSIS) for online reporting and batch processing programs respectively. This tier is also connected to the MicroStrategy reporting environment to enable scheduled and real-time ad hoc reporting. Secure FTP and other file transfer protocols are supported by the database server.

5.1.18: MAXIMUS is proposing completely separate production environments for Arizona and Hawaii providing a physical segregation of production data. As a rule, we segregate each of our customers into their own virtualized environments based on size, performance standards and up time requirements. We do not share data across our customer base. MAXIMUS will deploy a separate access site for each State, each with appropriate branding as required. Should the need arise to transfer data to AHCCCS/Med-QUEST outside of the daily MMIS interface process, MAXIMUS will use secure FTP for the file transfer(s), at no additional cost to AHCCCS/Med-QUEST. MAXIMUS understands that all data will be the property of the state for which its use is intended and will not use the data for any purpose outside of our support of the Provider Management Systems.

5.1.19: MAXIMUS has reviewed the requirements under Section 6.2 of the State of Arizona E-signature policy and our solution is in complete alignment with the requirements set forth under this policy. The electronic signature for providers submitting new enrollments and updated enrollments is captured on the PDMS Agreements screen. *Exhibit 1.1-1: PDMS E-signature Functionality* shows each of the requirements of A.R.S. § 18-106 and how PDMS meets the requirement for E-signature:

PDMS E-signature Functionality

AZ P4070 Requirement of A.R.S. § 18-106	PDMS Functionality
6.2.1a	Requires the authorized user of the provider account to provide the E-signature. Only the authorized user can provide the signature.
6.2.1b	The system records the user that provided the E-signature along with their User ID, password, and the date-time stamp. The system also generates a PDF file of the complete provider enrollment profile, which includes the E-signature of the user.
6.2.1c	Once the signature is provided, the system does not allow the record to be changed. A full audit trail of all E-signatures for the provider account is also kept in the system.
6.2.2	Maintains a full electronic copy of each enrollment and enrollment update submitted by a provider. As mentioned previously, we also generate a printable PDF that reflects the exact contents of the electronic enrollment profile.
6.2.3	MAXIMUS will archive records in accordance with the policies set forth by the Arizona State Library, Archives, and Public Records Division of the Arizona Secretary of State.

Exhibit 1.1-1: PDMS E-signature Functionality. *Our solution meets all the requirements for E-signature in accordance with State of Arizona Policy P4070 - Electronic and Digital Signatures.*

In addition to fully meeting the minimum E-signature requirements specified by the policy, PDMS also meets the optional practices and controls as specified in Section 6.3 of the document. These include a full audit trail of all E-signatures, linking the email account of the user, and a signer authentication challenge. [Additional Information: Section 4.1.1.5]

5.1.20: MAXIMUS is proposing our Provider Management solution using a Software as a Service (SaaS) model for AHCCCS/Med-QUEST. Our solution offers AHCCCS/Med-QUEST a system that meets the State's needs through configuration rather than customization at a single price. While our solution uses a number of COTS products to deliver functional components, we do not procure licenses specific for a state but rather utilize SaaS licensing related to the overall solution. MAXIMUS subscription licensing for our solution includes unlimited access for all users that are authorized by AHCCCS/Med-QUEST to complete necessary business functions. Should the need arise to transfer control of PDMS to the State, will follow the contract to determine specific system components and documentation that is owned by the State and transfer ownership within thirty (30) days of the request.

5.1.21: PDMS is packaged with system controls to tightly control data updates and ensure logging and audit trails. We develop specific data integration processes with user IDs and passwords to ensure only authorized sources can access data. We create secure platforms and specific folders when we transfer data in our out of the system. When the ESB is implemented, we will use subscriptions to verify the appropriate source or consumer of the data. System edits validate both the transactions are correct in terms of format and processing edits verify the data is correct for the business process. MAXIMUS will ensure the data integrity error rate and routing errors of any transaction is less than .001. MAXIMUS will use AWS CloudWatch in conjunction with AppDynamics to manage and monitor the entire Provider Services application ecosystem, from the browser client request through to network, backend databases, applications servers, and interface performance.

5.1.22: PDMS was designed and implemented consistent with the CMS Technical Reference Architecture along with numerous other CMS and industry standard technical guidelines.

5.1.23: PDMS is a modern information system designed to satisfy the applicable MITA 3.0 business areas while using an architectural foundation and data model that is designed to meet MITA technical and data specifications. We built our solution based on the guiding principles of MITA, and equipped it to

support all the provider management functions within the Medicaid enterprise. Our solution uses modern technologies; addresses security to facilitate confidentiality, availability, and integrity; enables support for data integration and interoperability; and our system methodology uses agile principles based on industry standards. The combination of our flexible technical architecture and reliable product implementation methodology brings AHCCCS/Med-QUEST a fully compliant Provider Management System.

5.1.24: MAXIMUS ensures access for the required number of concurrent users according to the Specifications. We have implemented our solution in three states with varying numbers of providers and understand how to size and implement our solution and the associated technical environments. To validate sizing and performance during the project, we use the RADVIEW WebLOAD performance testing tool to simulate thousands of concurrent users. These tests make it possible to test large loads and identify performance problems within an application well before implementing the system in production. We have successfully implemented our PDMS solution in States with provider and user volumes similar to and larger than what will be required for AHCCCS/Med-QUEST. By using our cloud-based AWS hosting solution, we can also easily scale the environments for increased user loads, in the unlikely event that this would be required.

5.1.25: MAXIMUS confirms that the maximum amount of time between the initiation of a transaction and the confirmation receipt of the transaction by the ESB will not exceed two seconds. Please refer to our response to Requirement 5.1.21 for the types of monitoring tools we intend to use for the AHCCCS/Med-QUEST implementation of PDMS.

1.1.2 Documentation and Certification

5.2.1: Maintaining accurate and current system design and system documentation is an integral part of the MAXIMUS methodology. During the implementation lifecycle, we establish a baseline for configuration updates necessary to meet AHCCCS/Med-QUEST requirements. As we implement the system, the finalized documentation forms the basis for future enhancements. MAXIMUS will establish an internal Microsoft SharePoint repository to house all documentation to include deliverables, action items, issues, risks and decision registers, meeting minutes, presentations, design documents, and other project artifacts. SharePoint provides document versioning, backup, and recovery in the event a document becomes corrupted or accidentally overwritten. According to our Project Management Plan, we will update documentation within ten business days of the implementation of a change.

5.2.2: Functional documentation such as training guides, operations and user manuals are maintained to ensure accurate use of the system and to guarantee that all features are used appropriately and user actions align with AHCCCS/Med-QUEST policy. MAXIMUS will update these documents within ten business days of the implementation of a change.

5.2.3: MAXIMUS is proposing our PDMS solution using a Software as a Service (SaaS) model for AHCCCS/Med-QUEST. While our solution uses a number of COTS products to deliver functional components, we do not procure licenses specific for a state but rather utilize SaaS licensing related to the overall solution. MAXIMUS product subscription for our solution includes unlimited access for all users that are authorized by AHCCCS/Med-QUEST to perform the necessary system actions in support of the Provider management business function.

5.2.4: MAXIMUS offers AHCCCS/Med-QUEST a proven solution based on a modern software platform that meets the certification criteria for the Provider Management Module, as released in the Medicaid Enterprise Certification Toolkit (MECT). It includes the Medicaid Enterprise Certification Life Cycle (MECL) published by CMS and updated in July 2017. The MECL implements the modularity standard as required by the standards and conditions for Medicaid IT, as well as critical success factors. MAXIMUS is prepared to collaborate fully with AHCCCS/Med-Quest and their partners to achieve unconditional federal

certification. As part of the efforts to certify PDMS in both Nebraska and the District of Columbia, we have created certification responses to all six of the applicable certification checklists. [Additional Information: Section 4.1.6]

1.1.3 Regulatory System Compliance

5.3.1: Our PDMS contains the data collection and workflow processes to support the provider related business processes defined in Part 11 of the State Medicaid Manual. Our system is in operation in three states with proven MMIS interfaces, which enable all required data to be sent to the MMIS in a seamless manner. Our configurable data model allows for customization of state-specific data based on provider and application type and enables the system to remain in compliance when the State Medicaid Manual is updated. Our system contains a proven set of workflows that meet ACA and State Medicaid Manual requirements. The configurable nature of the system supports alignment with state-specific business processes while providing the flexibility for quick configuration changes to support any updates to the State Medicaid Manual.

5.3.2: Our solution is 508 compliant. We provide before deployment and after deployment reports designed to demonstrate 508 compliance. MAXIMUS uses PowerMapper SortSite to verify and report on application compliance with 508 and WC3 accessibility standards.

5.3.3: Our PDMS collects all required provider enrollment information and supports the data requirements of quality improvement organizations defined in the ACA. At the onset of each project, MAXIMUS validates the data requirements needed by your implementation and we adjust the data model to ensure we are able to support all required business processes.

5.3.4: MAXIMUS experience in the modular certification efforts of two states demonstrates our ability to help states achieve federal certification of the Provider management module. MAXIMUS offers states a proven Provider Services module based on a modern software platform that meets the certification criteria for the Provider Management Module, as released in the Medicaid Enterprise Certification Toolkit (MECT) that includes the Medicaid Enterprise Certification Life Cycle (MECL) published by CMS and updated in version 2.2 released July 2017. [Additional Information: Section 4.1.6]

5.3.5: The PDMS is an ACA-compliant system that supports all the Provider enrollment and screening functions required by federal regulations (42 CFR 455 Subpart E). The system is designed to prevent ineligible Providers from enrolling and/or remaining enrolled in the State's Medicaid program. Included in our solution are automated screening and data matching functions with Social Security Administration's Death Master File (SSDMF), the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), and the Excluded Parties List System (EPLS). We also support automated screening of the Medicare and Medicaid Exclusion files using the PECOS TIBCO/DEX files and support the security requirements documented in trading partner agreements as specified in 45 CFR 162.915. [Additional Information: Section 4.1.4]

5.3.6: Implementation of our solution is done in full compliance with any End User Licensing Agreements or other licensing arrangements. We maintain all licenses as required by our solution for the duration of the project and validate that we meet appropriate permitted usage of each license. This is a corporate standard for which our corporate compliance team confirms we meet.

5.3.7: The PDMS is implemented to comply with all ACA requirements. We are compliant with the applicable recommendations of Section 1561, including verification interfaces, business rules, and privacy and security. We also conform to the confidentiality requirements in Section 1411, the streamlined procedures in Section 1413, the eligibility requirements in Section 1414 and the enrollment simplification requirements in Section 2201. Our streamlined web portal provides a secure, easy to use web interface for providers.

5.3.8: The PDMS is compliant with the Administrative Simplification provisions and operating rules of Section 1104 of the ACA. We include extensive electronic data exchanges in our solution that automate the majority of enrollment and screening processes.

5.3.9: Our solution's web portal complies with state and federal accessibility standards, guidelines related to electronic information resources. The solution is in full American Disability Act (ADA) Section 508 compliance, including accounting for the various forms of colorblindness. Checking for 508 compliance is embedded in the development process of the web portal, thus making it compliant for any new features that are introduced.

5.3.10: The business logic for the application is defined by a configurable set of business and data editing rules that are housed within the Corticon rules engine. It connects to the web server through internal communications and relays the results of the business logic processing to the presentation layer. The application layer also supports the exposure of APIs and web-services messaging that will be used by the ESB. MAXIMUS has formatted the business rules to align with the provider data housed in the system and will work with AHCCCS/Med-QUEST technical staff to understand how we will comply with the core data elements identified through the National Information Exchange Model (NIEM).

5.3.11: Our PDMS was designed as a data integration engine for Medicaid Provider data. It supports extensive data and process sharing using a variety of web service message integrations including XML and JSON supporting a variety of web services types including WSDL, WS-*, SOAP, REST, UDDI, and ODATA. We support a variety of industry standards to allow connections to a various partner systems.

5.3.12: MAXIMUS understands the various requirements included in the Harmonized Security and Privacy Framework. As a long time Medicaid vendor supporting extensive PHI and PII, we meet each of the applicable standards. We will perform a risk assessment during DDI that will validate our compliance with this requirement.

5.3.13: All aspects of systems and software development, particularly designing, testing, and configuration, are governed by our System Development Methodology (SDM). Our approach aligns with industry best practices and the defined deliverables, tracking, and monitoring functions are in line with the processes included in the Information Technology Infrastructure Library (ITIL) standards version 3. We take special effort to validate that our SDM works in concert with our Project Management Methodology (PMM).

5.3.14: The PDMS web portal has been designed to allow the application to be used with any industry standard browser. We have focused on usability and accessibility and we use a variety of open source libraries and industry standard development tools to validate we conform to the World Wide Web Consortium (W3C) standards and practices. MAXIMUS uses PowerMapper SortSite to verify and report on application compliance with 508 and WC3 accessibility standards.

1.1.4 System Architecture

[Additional Information: Section 4.1.3]

5.4.1: Our solution has a business process framework, which we refer to as the Business Process Engine, which enables execution and maintenance of process workflows. The Business Process Engine contains a set of pre-defined workflows that have been implemented in three states reflecting the requirements of CMS to meet ACA and federal certification requirements. We have architected our workflows using Business Process Management enabling the system to automatically execute the appropriate business process model based on the inputs from the business rules engine. The flexible workflow engine allows us to configure and optimize the business processes we support. Configurable business workflows guide users — both Providers and internal operations staff — through the tasks and

activities necessary to complete required processes for reviewing enrollment and screening results and finalizing the enrollment process. We use business service orchestration to enable these workflows, and include external communication processes to allow automated reminders, notices and other documentation to be distributed electronically to Providers based on their actions in the system and the associated status of those actions.

5.4.2: Our solution is based on Open Interface framework and uses SOAP-XML standard messaging formats that comply with the OASIS Web Services Security - Simple Object Access Protocol (SOAP) Message Security Version 1.1 Specifications. We enforce message content integrity and confidentiality through digital certificates, encryption, and digital signatures. All business processes are defined to ensure data integrity and we implement system controls to tightly control data updates and ensure logging, audit trail, and successful completion. We develop specific data integration processes with user IDs and passwords to ensure only authorized sources can access data. ESB integration is implemented using subscriptions to verify the appropriate source or consumer of the data. System edits validate both the transactions are correct in terms of format and processing edits verify the data is correct for the business process.

5.4.3: The architecture of our solution was developed to adhere to MITA principles by incorporating an industry standard business rules engine, Progress Corticon, to enable the management of business rules outside the application. MAXIMUS recognizes the need for separation of business rules from other parts of the application code. Our solution has workflow rules, document/notice generation rules, reference table rules, document upload rules, screening categories, Provider type rules, risk level setting policy rules and MMIS interface preprocessing/validation rules that are defined within Corticon.

5.4.4: Our solution provides a high availability infrastructure designed to meet the uptime as well as disaster recovery requirements. Our solution is architected in compliance with HIPAA and is deployed on AWS infrastructure. To meet the hosting requirements, our solution has a high availability redundant primary site with no single points of failure supported by a replicated disaster recovery site that mirrors the configuration of the primary site. We use different AWS zones so a disaster does not impact both sites, and use the same security scheme and configurations across the environments.

5.4.5: The PDMS has an error-handling module that provides a mechanism for identifying both errors and exceptions, which occur during online and batch processing. Exception processes are directly integrated with each process and allow for processing all successful transactions while putting errors or exceptions in a queue for manual review and intervention. Errors and exceptions are identified separately with error codes and descriptions along with their categories. This allows for reporting and notifications when rules have been violated. The system also has error ‘override’ capabilities available to certain user roles that can be used in specific situations. Each process is designed to complete processing while ensuring all errors or exceptions are accounted for and missing data can be resent or reloaded.

5.4.6: The PDMS was designed as a fully web-based application supported by an n-tier design that separates logical application components into processing layers and tiers, each of which contain specific functionality to manage various aspects of the Provider Services. Each tier contains a set of virtualized computing environments that are able to process in a variety of environments. Our standard solution uses the Amazon Elastic Compute Cloud (Amazon EC2) for all the virtual machines. The Amazon EC2 gives complete control of computing resources. Our complete application is ready for deployment in cloud computing environments, whether public, private, or hybrid.

5.4.7: MAXIMUS developed the storage estimates for AHCCCS/Med-QUEST based on our experience in Tennessee, Nebraska, and District of Columbia. We have come up with a model for the amount of storage based on the individual provider records. We generally create factors for normalization during conversion and taken into account other factors when developing our space estimates. To provide the

greatest flexibility possible, MAXIMUS uses Amazon EBS and Amazon S3 storage based on data types and we generally increase storage by a factor to enable better performance due to the low cost of storage. MAXIMUS is able to provide AHCCCS/Med-QUEST with the storage estimates for all environments and once we have completed the conversion effort, a solid estimate of the total actual space needed.

5.4.8: Our solution uses a service-based architecture, different application layers, and a set of modern tools to implement a loosely coupled modular application. We developed PDMS using a technology platform that is SOA-based, includes an open interface framework, and supports ESB communications to support modern data integration and interoperability functions. Our SOA-based design enables integration with the ESB while still allowing legacy interfaces to continue until they can be replaced. [Additional Information: Section 4.1.3.1]

5.4.9: Our solution has extensive data and process sharing using a variety of web service message integrations including XML and JSON supporting a variety of web services types including WSDL, WS-*, SOAP, REST, UDDI, and ODATA. We support a variety security and authorization services using these integrations and will enable the list of standards defined by the State.

5.4.10: MAXIMUS built PDMS on the guiding principles of MITA, and equipped it to support all of the provider management functions within the Medicaid enterprise. Our solution uses modern technologies; addresses security needs to facilitate confidentiality, availability, and integrity; enables support for data integration and interoperability; and our system methodology uses agile principles based on industry standards. The combination of our flexible technical architecture and reliable product implementation methodology enables us to quickly and efficiently accommodate MITA changes that may occur during the life of the contract.

5.4.11: Data exchange is facilitated by web services utilizing XML; however, we understand the need to support a wide array of trading partners. We support multiple file transfer protocols outside of web services including batch processed flat files, trigger tables and a variety of file processing options including X12 and other industry standard formats. We will work closely with AHCCCS/Med-QUEST technical staff to identify the appropriate standards and ensure they are included in our solution.

5.4.12: Our solution is based on an Open Interface framework and uses SOAP-XML standard messaging formats. Our solution is integrated with other systems in different implementations using SOAP-XML standard messaging format.

5.4.13: MAXIMUS will provide and support all maintenance, upgrades, and updates for any licensed software approved by AHCCCS/Med-QUEST to be used in the System.

5.4.14: We have implemented a comprehensive compliance approach that safeguards mission-critical and confidential data from alteration, loss, theft, destruction, and breach of confidentiality, and meets Federal and State guidelines for security, confidentiality, and auditing, including HIPAA and FISMA. We incorporate our plans and procedures across all components of the solution and validate our staff is trained on the processes, procedures and reporting requirements.

5.4.15: Our PDMS infrastructure contains a high availability redundant primary site supported by a replicated disaster recovery site that mirrors the configuration of the primary site. We use different AWS zones so a disaster does not impact both sites, and use the same security scheme and configurations across the environments. This architecture enables MAXIMUS to meet the required recovery point and recovery time objectives and provide a rapid failover in the event of system interruptions.

1.1.5 Determine Provider Eligibility

5.5.1: Our solution is configured to allow or prevent enrollment based on provider characteristics. The system provides extensive automated screening capabilities to detect providers that may not be eligible for enrollment due to matches found on exclusion databases during the initial screening process and/or by the enforcement of Moratoria. The system validates providers based on type and assigns an applicable risk level which impacts the downstream screening activities required the provider.

5.5.2: In our experience, the definition of a duplicate Provider varies from state to state, but the system is configurable to fit whatever definition is required for AHCCCS/Med-QUEST. When submitting a new enrollment, the Provider user is required to submit initial identifying information to initiate the enrollment process. This initial information consists of Provider Type, Tax ID (EIN or SSN), Name, NPI, primary Taxonomy code, and Zip code/zip extension of the primary practice location. Once the Provider enters this information, the system validates that the Provider does not already exist in the system, per Department defined rules. If the system detects a duplicate Provider exists, an error message is returned to the Provider and the system does not allow the Provider to proceed with the new enrollment.

5.5.3: The system requires the provider to enroll and to specify a primary practice (service) location, but the provider is also able to add additional service locations. Individual providers are able to indicate which billing providers they are associated with and billing providers (Groups, clinics) are able to add/update members to their practices. Providers are also able to enter their billing address, correspondence address, remittance address, and W9 address. [Additional Information: Section 4.1.1.8]

5.5.4: PDMS captures the primary NPI and taxonomy for each enrolling provider but also allows the provider to register additional NPI's. For each NPI entered, PDMS tracks the effective date (start and end date) and allows users to link and de-link NPI's to a provider. Additionally, the system allows the provider to add subpart/Medicare NPIs when entering their Medicare enrollment information.

5.5.5: We have implemented our modular PDMS solution in three states. Each state has had different enrollment requirements, different enrollment forms, and different documentation submission requirements. By leveraging our Workflow Engine and the Business Rules Engine, we have advanced our system to be able to configure the enrollment and data collection processes to be flexible, capable of meeting any unique requirements for each State based on provider type and application type.

5.5.6: The PDMS includes all ACA-required workflows based on provider type and risk level. We have designed the system with a workflow engine that enables workflows to be further configured to meet state requirements. We enable an intuitive, easy-to-use web portal for submitting new applications, revalidations, and updates electronically along with multiple communications channels to inform providers of status, additional requirements, and eligibility results.

5.5.7: MAXIMUS supports data harmonization by bringing data together and storing in our database using national codes and standards. Our solution is the single source of information for provider enrollment and we have enabled data integration with any type of external system. The system is pre-populated with converted data from the legacy MMIS. Ongoing sources of information include the import of data from OIG, MCSIS, SSDMF, SAM/EPLS, PECOS, NPPES and Medicaid IDs from MMIS. Using the PDMS Open Interface Framework, our solution enables the synchronization of Provider data across internal and external data processes to maintain data relationships and integrity. In each of our different state implementations, we have been required to add new screening sources, implement different types of partner data transfers and use all types of data integration functions. The PDMS has a variety of proven data exchange mechanisms that enable the ability to retrieve and utilize data stored in any format.

5.5.8: PDMS contains built-in mechanisms to support the full range of Provider enrollment and screening requirements mandated by the ACA. Our solution provides a data extraction module that is used in

connecting to a number of data sources for purposes of downloading data. When possible we download an entire verification source into the system so that we have flexibility in how we process initial and on-going screening. Our Provider Services Screening module is configured to validate Provider information using both automated and manual methods. In addition to all ACA-mandated screening sources, we are also able to configure workflow for new sources and to implement both automated and manual sources within the same monitoring workflow. Additional verification processes include verification of licenses against state license agencies as well as state exclusion lists. During the Design Phase of the project, MAXIMUS will work with AHCCCS/Med-QUEST to define any State-specific screening sources and incorporate these into PDMS. [Additional Information: Section 4.1.4]

5.5.9: PDMS is capable of performing real-time license database checks with State licensure boards, either through use of real-time web services or via import of license databases. MAXIMUS may need to rely on assistance from AHCCCS/Med-QUEST in order to gain authorization to access available Licensing board data in order to automate the verification process.

5.5.10: Based on responses to vendor questions, by 'Pre-Check' MAXIMUS assumes AHCCCS/Med-QUEST is referring to the types of automated screening available in the system. PDMS provides for automated screening and pre-check against numerous screening sources including OIG LEIE, Medicare Exclusion, SAM/EPLS, SSDMF, Medicaid Terminations (formerly MCSIS), and PECOS. [Additional Information: Section 4.1.4]

5.5.11: The PDMS enrollment workflows are configurable to allow for any type of review step prior to approving an application. In our District of Columbia implementation, all providers are automatically referred from the Enrollment Specialist to a Provider Services supervisor for final review and approval prior to being sent to the MMIS and receiving their Medicaid ID. This review step is a final quality check on the Provider, where all application data and screening results can be verified. Other States have preferred that the Provider be sent directly to the MMIS as approved once the Enrollment Specialist completes the screening step. We can configure our solution to meet whichever method is preferred by the State.

5.5.12: PDMS allows for the prioritization of applications based on provider type and also based on application type. Submitted applications by providers are initially placed in an unassigned queue for Enrollment Specialists. The default policy that is enforced in the system is that providers that have been in the unassigned queue for the longest period are retrieved first. However, the system is configurable to flag certain provider or application types to be retrieved from the queue first, regardless of how long they have been in the queue. For example, in our DC implementation, the client specified that emergency-out-of-state applications be placed at the top of the queue, regardless of aging.

5.5.13: The PDMS does not currently include specific functionality to support the back office processes related to credentialing. However, we have implemented data integration between PDMS and Credentialing Verification Organizations (CVOs). In Tennessee, MAXIMUS has implemented a 2-way interface with Council for Affordable Quality Healthcare (CAQH). CAQH is responsible for credentialing individual Providers and accepting applications, which are then forwarded automatically to PDMS for inclusion in the Medicaid Program. While it not clear how much data integration will be necessary in Arizona, MAXIMUS understands how CVO data is collected and where deficiencies in editing must be addressed. We currently interface with CAQH using XML as well as flat file formats. Data ownership is a critical piece of this process. We will work with AHCCCS/Med-QUEST to build data ownership and update rules based on who owns particular data.

5.5.14: PDMS is built to support the CMS requirements for additional screening activities based on risk level as established by 41 CFR § 455 and sub regulatory guidance in the Medicaid Provider Enrollment Compendium (MPEC). Once an application has been submitted the provider's risk level is set

automatically. If the system detects that a Provider has been previously suspended or terminated, the risk level is adjusted 'up' to a high-risk level. In addition to the automated adjustments made to risk level, the PDMS administrator role is able to change the risk level of a provider to either a higher or lower risk level. Any change requires the user to enter comments explaining the reason for the change. A change to a higher risk level triggers a screening workflow for either a site visit screening for moderate risk providers or criminal background check (followed by site visit if applicable) for newly designated high-risk providers.

5.5.15: Once the Provider submits a new enrollment or re-enrollment for review and screening, the system assigns the risk level to the provider and places the provider into the unassigned queue for the Enrollment Specialist. The system also sends an email notification to the Provider, notifying them that their application has been received and is ready for processing. If a provider is moderate or high risk, the notification includes information about the additional screening that is necessary. In situations where the risk level is manually changed from low or moderate to high, the system automatically initiates workflows related to high-risk providers including the fingerprint-based background check.

PDMS is compliant with CMS regulations, which require individual owners to provide fingerprints as part of the application process. When a high-risk provider reports an individual owner or adds a new owner with a five percent or greater ownership interest, the system triggers the background check process. The system issues a notice to the provider indicating a 30-day deadline for the owner to supply fingerprints and starting the clock. A 10-day reminder notice is also generated if the owner has not supplied fingerprints. If fingerprints have not been obtained by the due date, the system automatically initiates the termination process. As fingerprints are provided in a timely manner and the background check results received, the Enrollment Specialist updates the system with the background check date, results, and who performed the background check (e.g., Medicare if applicable). Then the system moves to either approve or terminate the provider based on the results of the background check. [Additional Information: Section 4.1.4.5]

5.5.16: Providers assigned to moderate and high risk are made aware of the site visit screening requirement as part of the application receipt notification mentioned in Requirement 5.5.15 including showing the nearest three locations to provide fingerprints. Our solution provides a workflow to require the completion of an unannounced pre-enrollment site visit by a Site Visit Specialist for moderate- and high-risk Providers once their preliminary screening and database checks have been completed and passed. The system assigns these Providers to the Site Visit Specialist work queue and the next available Site Visit Specialist will retrieve the task and initiate the site visit process. These Providers will remain in a "Site Visit" review status until all required site visit actions are taken and the system has been updated. If a provider's risk level is manually changed from low to moderate or high, the system automatically initiates additional workflows that must occur based on the risk level. This includes requiring a site visit for the provider. Notices are sent out informing the provider of the additional steps that must be done and the provider is put into the next appropriate workflow to complete the additional processes. [Additional Information: Section 4.1.4.4]

5.5.17: If the system determines that a Site Visit is required for the Provider, the system is configured to display a user-configurable site visit checklist that the Site Visit Specialist must complete and sign during the site visit process. The Site Visit Specialist obtains the signature of the Provider's representative and uploads the signed checklist using the document upload function. All of these activities can be completed in the web portal while the Site Visit Specialist is performing the review at the Provider's site. The required photograph of the Provider location's exterior, including the sign and street address can also be uploaded to the Provider file using the document upload function. These attachments remain a part of the permanent Provider record in the system. The workflow will be configured to meet the site visit aging requirements as specified by both CMS and AHCCCS/Med-QUEST policy. The task will remain in the

Site Visit Specialist's work queue until all required activities have been completed for the site visit as per the checklist. [Additional Information: Section 4.1.4.4]

5.5.18: The system provides a Site Visit Assignment screen with a dashboard view of all pending site visits within the system. Authorized users are able to drill down and view each provider's pending site visit and location (address and zip/zip extension). All addresses in the system are validated using a real time link to the USPS address verification web service. The address verification function also captures the geo-coordinates of the address and stores these to enable Geographical Information System (GIS) search capability. The Site Visit assignment screen allows the user to filter the list of pending site visits by location (e.g. Zip/Zip Extension). The user can bulk assign pending site visits at a certain location(s) to a specific Site Visit Specialist. As mentioned in response to Requirement 5.5.8, our system will perform fully automated screening on all providers and match against any State-specific screening sources such as the States' Do Not Enroll List(s) and Open Investigation List(s). [Additional Information: Section 4.1.4.4]

5.5.19: PDMS provides fully automated screening against both the Medicare and Medicaid excluded provider lists. Monthly refreshes of the databases from TIBCO (soon to be DEX) are imported into PDMS. Newly enrolling, re-enrolling, and revalidating providers are automatically screened against both of these data sources. In addition, these data sources are included in the PDMS Monthly Database Checks process. All active providers and required owners are automatically screened monthly against both Medicare and Medicaid exclusion databases. [Additional Information: Section 4.1.4]

5.5.20: PDMS can meet this requirement either through initial data conversion or through the PDMS Admin function that allows authorized users to update key identifiers for a Provider (including Provider Type). If the State's intent is to handle this through data conversion, MAXIMUS will work with AHCCCS/Med-QUEST during conversion design to create a crosswalk of MMIS Provider Types to converted (desired) Provider Types. Once converted, these Providers will display in the system with the newly assigned provider type. If the intent is to allow authorized users to modify the Provider Type, PDMS provides an admin function (Change Key Identifiers). Using this function, the user is able to update the Provider Type (and other key identifiers) for the provider. MAXIMUS will work with AHCCS/Med-Quest during Requirements Confirmation to understand the true intent of this requirement and configure PDMS accordingly.

1.1.6 Enroll Provider

5.6.1: PDMS tracks the workflow status and the enrollment status for each provider. We typically configure the system to match the types of enrollment statuses that are in place in the MMIS. PDMS supports each of the statuses referenced in this requirement. Statuses are set based on a combination of user actions that have been taken (e.g. provider submits an enrollment) plus any system actions that have occurred (e.g. advancing the provider into the next step of a workflow). As part of configuring the workflows, we will align the various statuses with individual workflows. [Additional Information: Section 4.1.1.3]

5.6.2: As part of the application entry process, PDMS is configured to request the application fee from Providers when applicable and track receipt of the fee before initiating any screening and enrollment activities. Providers are able to make the payment online using an interface with Bill2Pay. The provider can also indicate that payment will be made via paper check, request a hardship waiver, or indicate that payment was already made with Medicare or another State. Providers that opt to pay the fee online navigate to the Bill2Pay payment submission screen. Bill2Pay's specialty is customized electronic payment processing and remittance processing solutions for governmental, commercial, and financial billers. Required identifying information (for example, the unique application ID) is sent to Bill2Pay for tracking purposes. Bill2Pay offers multiple payment modalities including e-Check or credit card. The application fee screen will be changed to inform the Provider as to the lockbox location for the Hawaii

implementation, if paper checks continue to be the only method of payment. Regardless of the payment options selected by the Provider, the system tracks and verifies that the payment has been received (or waiver granted) prior to initiating internal review and screening processes for the Provider.

5.6.3: Our automated Revalidation Monitoring Process will be configured according to current AHCCCS/Med-QUEST policy to alert Providers and agency users when Providers are due for revalidation. Revalidating providers are subjected to the same screening requirements as newly enrolling providers. Revalidation requirements are based on the eligibility end date (revalidation due date) for each Provider in the system. As providers are approved in the system, the end date is set to three years for high-risk providers and five years for all other providers. The PDMS revalidation monitoring process runs daily and selects providers that are within a configurable timeframe from their end date. In the current configuration, providers that are within 90 days of their end date are put into a revalidation workflow and the revalidation notice reminder notices are sent to the Provider at 90, 60 and 30 days. This configurable parameter will be set to meet AHCCCS/Med-QUEST requirements. [Additional Information: Section 4.1.1.6]

1.1.7 Disenroll Provider

5.7.1: Our solution contains robust functionality to restrict or suspend providers that do not meet AHCCCS/Med-QUEST defined eligibility rules. Each type of disenrollment is managed through a set of workflows. The actual action to deny or terminate a provider can occur through an automated process (e.g. failure to renew License or revalidate on time) or through a combination of automated and manual processes (e.g. an identified match on the OIG/LEIE sanction database that has been confirmed by the Enrollment Specialist). There are differences in how each type of disenrollment is handled and these workflows will be discussed in detail during requirements confirmation. We will configure each workflow according to AHCCCS/Med-QUEST requirements. [Additional Information: Section 4.1.4.6]

1.1.8 Inquire Provider Information

5.8.1: PDMS is packaged with robust search functionality and provides both a public facing search function (for any user) along with an internal search function that is only accessible by State authorized users. The PDMS search functions offer a variety of search parameters/filters all of which are configurable to meet any unique requirements of the State. Our intuitive search function provides search results for the entire Provider profile including Provider demographics, location(s), affiliations, networks, contracts, credentialing, and communications. Once the search results are displayed for the user, the user has the ability to sort on any field and also has the ability to export the search results into PDF or excel format. [Additional Information: Section 4.1.2]

5.8.2: PDMS records the date + time stamp in the system for every action taken by a user, every action taken by the system, and every document that is attached to the Provider's enrollment profile. The application workflow status changes based on what action has been taken and is always current. Users have multiple search methods to find the status of a Provider in real time. For example, PDMS records the date + time stamp when the provider begins an application (referred to as the Provider Data Entry step in the workflow) as well as when the provider electronically signed and submitted the application (referred to as the Generate PDF step in the workflow). If a user had the need to look up the status of the Provider in the system, the user could use the PDMS Dashboard, the PDMS Search function, or by viewing the Workflow Steps screen. Any of these search methods will inform the user as to the status of the provider along with the date and time of each workflow step in the enrollment/re-enrollment process. PDMS also records the date-time stamp (along with other Meta data) for all documents and attachments that are uploaded either by the Provider or by an internal user. Providers and internal users upload documents directly in the system, which then automatically loads the document to our OnBase document

repository. Users have the ability to search for and find documents by date + time stamp of the document, if required.

5.8.3: PDMS allows for numerous search parameters when searching for a provider, including Provider licensure. Other search filters include: Provider Name, Tax ID, Medicaid ID, NPI, PDMS Status, Email Address, DBA Name, Risk Level, Application Type, Provider Category, Provider Type, MCO, and Provider Specialty. Search filters can easily be added or removed based on AHCCCS/Med-QUEST requirements.

1.1.9 Manage Provider Information

5.9.1: Our solution contains real-time edits and validations throughout the application workflow to help confirm that Provider-submitted data meets CMS and AHCCCS/Med-QUEST requirements. The system prevents Providers from submitting applications that have missing, incomplete, or conflicting information. During the Provider Review workflow step, if additional information is required, the Provider Enrollment Specialist is able to return the application to the Provider by using the "Return to Provider" function, which generates an email that lists the additional information required. This functionality eliminates the paper correspondence trail typically associated with the enrollment review and allows for timely and accurate processing of all required Provider applications and revalidations. When a provider corrects the information and resubmits the application, it goes directly back to the enrollment specialist that originally reviewed the application.

5.9.2: The system configuration is to default the effective date for the provider to the approval date (screening completion date). In our most recent implementation in the District of Columbia, the configuration allows the provider to request a retroactive effective date, but when doing so they are required to supply an attachment that supports their claim for the retro enrollment. Enrollment Specialists review the request during provider review to determine if the retro request can be granted. In other implementations, any provider requesting a retroactive effective date is forwarded to the State Provider Services for review and approval. The system workflow automatically coordinates this transition. The system also provides an admin function where an authorized user can manually override or set the effective date to a retroactive date. In all cases, the effective date is sent to the MMIS through the MMIS interface.

5.9.3: PDMS is packaged with pre-built functions for both initial data/document conversion and for ongoing information transfer (the MMIS Interface). MAXIMUS will convert all required provider data from PMMIS and HPMMIS into each State's PDMS database. During conversion design, we will work with AHCCCS/Med-QUEST to define the conversion file layouts, method of file transfer, and the amount of historical data to be converted. For ongoing information transfer, we use the MMIS Interface. The MMIS Interface file definition includes transactions that allow for add new Provider, update Provider, terminate Provider, terminate with sanction reasons, add affiliate, and update affiliate. These transaction definitions are configurable and can be extended based on the needs of AHCCCS/Med-QUEST. Our solution also has the ability to send "emergency" transactions. These scenarios are available in cases where a Provider is found to be sanctioned and needs to be stopped from receiving payments immediately. The use of such transactions is dependent on the MMIS system and the ability to immediately process transactions that are sent. We will work closely with AHCCCS/Med-QUEST to implement a process that will work with the MMIS system. [Additional Information: Section 4.1.5]

5.9.4: PDMS contains an Update Workflow, which allows existing Providers to use the web portal to make direct updates to data within their enrollment profile. We configure our solution based on state specific processing rules for the type of data that can be updated without involvement by the operations staff or approval from state personnel. When a provider is in an active status and not due for revalidation, the provider can make updates to most data elements on the provider file. We guide the provider to a user-

friendly update selection screen where they are able to select from a list of updates to make to their enrollment profile. The provider simply selects the type of update and we navigate them directly to the screen to make the update. Providers can then submit the update or opt to make further updates before submitting. [Additional Information: Section 4.1.1.7]

5.9.5: The system is configured to create a work queue item for the State administrator anytime an adverse action is possible (e.g. a match of the Provider on the Medicare Exclusion screening check).This gives the State the ability to view the impact of changes before the action is taken. From this function, the action can be overwritten, excluded, or the application sent back to the Enrollment Specialist's review queue for further action. Workflow and Provider statuses are updated when actions are taken and all updates are stored in the Provider's audit trail. In the case where the State user takes the action to apply the exclusion policy toward a provider, the system is configured to automatically send notices to the provider with copies to other interested parties (which can include CMS). The State can opt for this notice to be electronic (via email) or in paper form (mailed). [Additional Information: Section 4.1.4]

5.9.6: PDMS uses Hyland OnBase for content management. MAXIMUS has deployed Hyland OnBase in our Nebraska and District of Columbia implementations for all paper applications, documents, and attachments uploaded by Providers during the enrollment process and all converted documents that come along with conversion of providers. Our integrated solution contains a paper entry component and system integration directly with the web-portal to receive and display electronically uploaded documents. PDMS integration with OnBase provides for images that can be uploaded in duplex mode as well as storing the full image of the document. The system also provides the ability to add annotation, notes and comments to any uploaded document and to any specific section of an uploaded document. For scanned paper documents, the system is currently configured to capture certain types of meta data for the document including Type of Request (New Enrollment, Re-enrollment, Update), Document Type (e.g., Full Enrollment form, License, CLIA), NPI (if available), and Tax ID (if available).

Documents uploaded by a Provider or internal users via the web portal are requested by PDMS based on the business rules specified by AHCCCS/Med-QUEST. When the provider uploads a document, PDMS links the document to the data in context (for example, proof of license is uploaded with the License Number of the provider) and stores it in the provider record. The system allows users to add additional information to the document such as description, file name, and additional comments.

5.9.7: All documents uploaded by a provider during the enrollment, re-enrollment, or update process are stored in our OnBase repository and indexed with several meta data fields, including the Provider's Tax ID, NPI, Medicaid ID (if assigned), and Registration ID. When the provider uploads a document, PDMS links the document to the Provider and also to the data related to the document (for example, ownership disclosure is uploaded with the provider's ownership information). The provider receives a confirmation notice each time they submit a new enrollment or an update, which references the Registration ID. When users search for and retrieve Providers in PDMS, the user is able to view all documents attached to the provider's enrollment profile. Based on this model, we find it rare that an internal user (or Provider) ever requires the need to search for a specific document in PDMS. Providers may also submit a document to the State Provider Services center via paper mail or via email. Paper documents can be scanned into the system and are also indexed in our OnBase document repository. In all cases, any document attached to the provider's file is assigned a unique internal tracking number, along with the meta data previously discussed. AHCCCS/Med-QUEST users and Providers are able to search for documents using both PDMS and native OnBase using any combination of meta data that is stored in the system.

5.9.8: Each PDMS screening source has its own matching algorithm, which is dependent on the types of identifying information available from the screening source. The system automatically detects potential matches for providers against each of the screening sources and alerts the Enrollment Specialist to

review the potential match. To confirm the match, the system guides the Enrollment Specialist to the appropriate source for verification (for example, entry of SSN to verify the provider on OIG/LEIE). If the Enrollment Specialist determines that the provider is not a match, the system records this action and future screening checks will exclude this particular record as a potential match. This sophisticated process reduces the number of false-positive matches for the subsequent screening of Providers during the Monthly Database Checks process. [Additional Information: Section 4.1.4]

5.9.9: PDMS automatically generates comments that are attached to a Provider's profile based on certain actions that may be taken on the provider by an internal user, the system, or the provider themselves. All comments are viewable by a simple menu item click using the PDMS main menu. The system also prompts (requires) providers and internal users to add comments depending on the update being performed. For example, if an internal user modifies the enrollment status of a provider (e.g. dis-enrolls the provider based on provider request) the system requires the user to add a comment that documents the update as well as to upload a document that provides an audit trail of the dis-enrollment request.

5.9.10: PDMS is designed to fully automate all of the enrollment, credentialing, screening, and review functions to the maximum extent possible. However, the workflows also accommodate the need to allow for human intervention in certain cases. An example of this would be when the system detects a potential match of the provider on the SAM/EPLS screening source based on the provider's name. Because SAM/EPLS does not always contain any identifying information for the Provider (e.g., the NPI is blank on the SAM/EPLS file), the system alerts the Enrollment Specialist during the screening process to perform a search on SAM/EPLS to confirm the match. PDMS alerts the Enrollment Specialist to these exceptions during the screening process. The workflow guides the user through the appropriate actions that need to be taken in order to confirm the screening match, with a full audit trail of each action taken regardless of the outcome of the screening event.

5.9.11: PDMS has the capability to capture multiple types of provider characteristics for any provider, including IHS/638 and non-IHS/638 providers. There are numerous ways to reflect this data. PDMS can be configured to automatically detect, based on information collected by the provider during the enrollment process, whether the Provider is an IHS/648 or non-IHS/638 facility. For example, if the provider's primary practice location is in a certain county or zip/zip-extension or by the type of license submitted by the provider. Optionally, the system can be configured to request this type of information up front during the enrollment process. The system can also be configured to allow the internal Enrollment Specialist to assign the IHS/638 designation based on the data submitted by the provider.

5.9.12: PDMS captures the relationships between MCO providers and the contracting MCO. We have configured this requirement differently based on the unique requirements in each of our PDMS implementations. In our Tennessee implementation, where the State is essentially 100% managed care, the MCO relationships are automatically assigned based on an interface with CAQH. In our DC implementation, credentialing agents enroll the MCO providers using the PDMS web portal. During the enrollment process, the credentialing agent is required to associate the provider to a pre-defined set of MCOs currently under contract. In all cases, users are able to search for and find providers based on their association with an MCO, as well as to retrieve a list of all providers contracted by a particular MCO.

1.1.10 Manage Provider Communication

5.10.1: Provider communications are auto-generated based on configurable business rules and the workflow step a provider is in. System workflows include external communication processes to allow automated reminders and notices to flow electronically to providers based on their actions in the system and the associated status of those actions. PDMS is designed to send advanced notices to providers alerting them of upcoming deadlines or expiration dates, specifically deadlines for re-enrollment or license updates. Using templates with configurable text, PDMS sends emails to providers based on trigger

events, such as when the application is received, whether additional information is needed to complete the application, or as the Welcome Letter containing the Medicaid ID after final approval. Whether these notices are sent by email or paper, the contents are always retrievable by the provider or by an internal user with access to the account. [Additional Information: Section 4.1.1.5]

5.10.2: PDMS supports both paper and electronic notification. PDMS automates the communications process to the fullest extent possible, including communication delivery by email or paper depending on provider preference or whether a confirmed email address is included in the provider's record. All Provider correspondence generated by PDMS, whether paper-based or electronic, is captured and retained in our document repository. Authorized State staff have access to all correspondence regarding Providers, including full Provider files, through viewing the provider's profile.

5.10.3: Moderate and high-risk providers require a site visit. Site visit workflows are initiated once a provider has successfully passed the automated and manual screening processes. PDMS features automated notifications that can be configured as part of every workflow. At these pre-defined trigger points, the system automatically sends notifications to designated roles based on the triggering event, such as site visit. This function is already configured in our base solution and will be implemented as part of our solution for AHCCCS/Med-QUEST. [Additional Information: Section 4.1.4.4]

5.10.4: At the time the provider submits the online application, the automated workflow assigns the appropriate risk level according to provider type and state and federal rules. When the risk level is assigned, PDMS sends an automated email based on risk level. For moderate and high-risk providers, the email contains language indicating the provider will be subject to an unannounced site visit as part of the enrollment and screening process. The language contained in the notices is configurable according to state preference and will mirror the language required by AHCCCS/Med-QUEST.

5.10.5: Our solution provides self-service functionality to allow existing providers to perform updates and submit requests through the web portal. Once logged in, Providers can navigate directly to the Submit Request screen, enter free form text in the comments section of the screen, upload a document, and submit the request for operations review/action. Each submitted request by the provider is tracked via a new workflow (which includes a tracking number) that is established for the request. Once submitted, the system forwards the request on to an Enrollment Specialist for internal review/action. We can configure the system to send a notice to the provider at any time during the workflow (e.g., once the request is assigned to an Enrollment Specialist, when completed by Enrollment Specialist, etc.).

5.10.6: PDMS contains a communications framework that allows us to create and configure the content of any system generated e-mail or notices based on business rules, workflow items and events that occur within the system. MAXIMUS is implementing an external Correspondence Management platform supported by the Quadient Inspire ™ Platform. This platform enables users to create timely, contextual, personalized, and accurate communications for all channels, including email and SMS text, from one intuitive interface. We will capture the user's communication preference during the enrollment process. As part of the specification of each workflow, we will identify the trigger points, define the required correspondence, and specify the parameter for sending the notification. This type of specification is standard to the system configuration we complete during the implementation effort.

1.1.11 Perform Provider Outreach

5.11.1: PDMS enables several different communication channels with providers. The first is by sending configurable, automated notices to providers based on the status of their enrollment, revalidation, or data change as it moves through the different workflows. Providers may also contact Enrollment Specialists by accessing the Chat feature during business hours to directly communicate with operations staff. We propose to use the MedChat product. MedChat is designed for a streamlined user experience, and

exclusively for healthcare. MedChat provides the functionality to record/store all sessions and the sessions are available to internal staff for reference. For the AHCCCS/Med-QUEST implementation, MAXIMUS is implementing the Quadient Inspire platform, which will enable additional communication channels including text and email submissions. Finally, the provider portal contains a section where messages are shown to give providers information about upcoming initiatives or policy changes that might impact them.

5.11.2: MAXIMUS is implementing the Quadient Inspire Customer Communications Management software for AHCCCS/Med-QUEST. This software will provide multi-channel communications and provide the repository of communications that will be sent to providers. The product will be implemented in a seamless fashion and integrated using a .NET API that is a part of the product set.

1.1.12 Manage Provider Grievance

5.12.1: PDMS supports the AHCCCS/Med-QUEST's Program Integrity offices with an automated appeals process compliant with 42 CFR 431.105 for providers who have been denied or terminated. Currently, all providers who are terminated or denied due to screening failure, background check failure, site visit failure etc., are automatically put into an appeals workflow which tracks the timeframes for the appeal, sends out notices related to the decision and appeals rights and enables tracking of the final appeal decision. MAXIMUS will work with AHCCCS/Med-QUEST to define the appeal workflow that conforms to the state-specific requirements and implement it in a seamless manner within our system.

1.1.13 Reporting

5.13.1: Within the production hosting configuration is a separate reporting server designed to allow near real-time reporting to occur while minimizing the impact on the production processing environments. [Additional Information: Section 4.1.3.2]

5.13.2: Our solution contains a wide variety of system dashboards, standard reports, custom reports, ad hoc reports, and analytics that provide detailed and summary information about all aspects of Provider management. PDMS is packaged with over 50 on-demand reports that provide detailed insights into application processing, staff performance and operational tasks. The reports are configured to have standard features such as totals, parameters that are used to execute the query and the date and time in which the query is executed. All the reports are point in time reports and allow for several filtering parameters. MicroStategy supports business intelligence and provides the analytics platform for state-approved staff to conduct analysis.

5.13.3: MicroStategy provides the basis for the development of reports, dashboards, and queries in the system. All of these items can be stored in a variety of libraries that enable authorized users to modify and reuse at the report, template, or query level. Our solution allows for drag and drop of query templates so that minor changes can be made. This allows for creating customizable dashboards and reports for users to modify and reuse. All queries and parameters are viewable and modifiable by authorized users and output can be sent to reports and/or exported to a variety of reporting packages including Excel, Word, PDF, and CSV.

5.13.4: The MicroStrategy business intelligence suite provides authorized users with powerful query and reporting capabilities. The basis for the reporting functions is the database structures that store all information about the enrollment and screening process. Authorized staff are able to use the MicroStrategy platform to create ad hoc queries or execute queries that have been previously created and saved. In addition, native SQL queries can be executed using SQL Server Management Studio.

5.13.5: The MicroStrategy platform enables a full suite of ad hoc reporting and query development capabilities. Our solution allows the use of wild cards and operators as part of designing and executing

queries. In addition to these, dashboard reports allows conditions to show different kinds of graphical elements and advanced functions to change colors based on a value of a variable.

5.15.6: As an enterprise reporting solution, our industry leading reporting engine provides a variety of formats to create and view data. The formats include Summary, Details, Charts, and graphs all of which can be created within the tool without the need to export data.

5.15.7: Our solution can produce reports based on different fields of a provider record including NPI, proprietary ID, or by a subset of the provider's practice or taxonomy. All data that can act as a filter can be used to query provider data.

5.15.8: The online ad hoc reporting tool allows authorized users access to provider and trading partner data (e.g., provider enrollment status, alphabetic and numeric provider listing, re-certification listing, revalidation listing, group affiliation listing, provider classification listing, and category of service listing). Reports and queries can be created using a variety of different filters to support ad hoc reporting capabilities.

5.15.9: Our library of reports has detail and summary level information pertaining to all activities a provider can undergo within the system. We are able to display data related to provider enrollment, suspension, termination, re-enrollment, revalidation, and re-certification. In addition, there are filter criterion such as provider type, provider category, etc. to allow for search on provider information based on various categories, application types and other information stored about the provider.

5.15.10: PDMS is packaged with a variety of error reports that provide real time statistics on the status of key processes in the system. This includes all interface transactions. Our report library has reports that detail transactions, the date on which they are sent, and the status of the transaction results. These can be filtered by successful, cancelled and error transactions.

5.15.11: PDMS supports the initiation of reporting and correspondence using various mechanisms. Reports can be manually initiated using on-demand functions or as batch processes and scheduled accordingly. Reports can also be generated as part of a workflow initiated from a triggering system event. Reports are distributed to specified secure locations based on criteria included with the reports. The secure locations include secure FTP, encrypted email and other secure mechanisms. All system-generated correspondence is stored with the provider file and can be accessed online from the PDMS system allowing them to be reprinted as necessary.

5.15.12: All previously stored reports, filters, and queries are published and accessible in public libraries. Authorized users can store reports, filters, and queries in this public folder to allow access to other system users. In addition, each authorized user has a personal library where reports, filters and queries can be stored for future use or as work in progress. All the reports are indexed based on names, filters, and descriptions. In addition, the data being used is also indexed so that users can search for similar reports or queries. PDMS has comprehensive search capabilities, which enable users to search the various libraries for reports, filters, and queries based on all indexed criteria.

5.3.13: As part of the initial setup of our reporting platform, a standard report template is defined based on each States' logos and requirements. All new reports inherit this template that includes the standard information including banner, header, footer, title, page number and date, as well as other fields that might be required. Users can input parameters, paging, report run date etc.

5.3.14: The PDMS solution contains a separate reporting infrastructure, which includes all of the production data as well as all audit and historical tables and data. The MicroStrategy tool will have access to this complete set of data and reports and queries can be run against all current and/or historical data.

5.3.15: MAXIMUS proposes Amazon CloudWatch and AppDynamics for tracking and managing performance, availability, utilization, and service levels. Using CloudWatch in conjunction with AppDynamics allows us to monitor and manage the entire PDMS ecosystem, from the browser client request through to network, backend databases, applications servers, and interface performance. With the help of these tools, MAXIMUS provides real-time view of the complete health of the Provider Services application by monitoring load, average response times, and error rates. A custom report will also be made available through MicroStrategy that includes the specifics regarding the issues encountered, the measures taken to resolve the anomalies, and the resources participating in the process.

5.3.16: The change control process is controlled by a formal procedure documented within the MAXIMUS Project Management Methodology. All change requests are fully documented, contain a detailed estimate of the effort and the approval process is tracked and reported weekly in the status report. Approved change requests are reflected in the project schedule. MAXIMUS utilizes project control tools to track all requirements, design, configuration, testing, and certification artifacts. MAXIMUS uses JAMA Contour to develop and maintain an RTM and requirement changes throughout the project. As software items are assigned, these will be identified in JIRA. Both tools allow online access for authorized users and include full status reporting including assignments, requirement tractability and coding assignments.

5.3.17: MAXIMUS uses JIRA for tracking issue reports and resolution, defect remediation, action items and changes. JIRA enables real-time status tracking, online access, and a wide variety of reports that can be generated. As a project management standard, reports of outstanding changes, issues, action items, and defects are created on a weekly basis and included with the status report.

5.3.18: At the core of the analytics and reporting framework is an integrated business intelligence platform supported by MicroStrategy. The business intelligence suite provides authorized users with powerful reporting capabilities within the solution to design reports, create reports against all provider data, and generate reports in variety of output formats including the ability to save the reports and other output.

5.3.19: Our solution is packaged with a library of standardized operational reports, provider reports, and CRM reports, and will have the ability to create a wide range of configurable detail level and summary level reports, dashboards and queries. This will enable authorized users to pull historical trending data for AHCCCS/Med-QUEST by looking at any aspect of the provider community, including revalidations for a period of time, enrollment status at any step in the process, providers terminated and suspended, and any other combinations of provider status.

1.1.14 Solution Help System

5.14.1: MAXIMUS publishes, implements, and maintains online searchable and printable end user manuals for both internal and external users. We also develop comprehensive training modules that can be broken up by topic and linked to specific areas within the system using hyperlinks. *Section 1.1.19: Training* of our proposal details our training approach and the materials that will be developed and made available within the system. As part of our base solution, we provide a configurable Learning page where all training materials and user guides are be posted to the website. This page is accessed from any area of the application using a direct link. Electronic training guides are beneficial for ease of use and the ability to search for keywords. Training documentation is maintained as the system evolves to confirm the latest information is made available to users.

5.14.2: In addition to training manuals, PDMS features page-level and field-level help for Providers as they complete the application through direct information links on a page. The text of the online help is customizable. Similar functionality is available for internal users.

1.1.15 System Availability

[Additional Information: Section 4.1.3.2]

5.15.1: The MAXIMUS performance monitoring dashboard will be available 99% of the time, 24 hours a day, seven days a week, excluding AHCCCS/Med-QUEST approved down time. The dashboard is integrated with our real-time performance monitoring reporting tools. Using CloudWatch in conjunction with AppDynamics allows us to monitor and manage the entire PDMS ecosystem, from the browser client request through to network, backend databases, applications servers, and interface performance. With the help of these tools, MAXIMUS provides real-time view of complete health of Provider Services application by monitoring load, average response times, and error rates. There are several out-of-the-box reports and dashboards available.

5.15.2: MAXIMUS proposes a set of environments that will be in place for the life of the project. Our solution includes development, integration/system testing, user acceptance testing (UAT), Training, and production environments, each with its own hardware requirements. To support the specific RFP requirements, MAXIMUS has configured the production environment to provide redundancy and meet the system availability 24x7 with 99.5 percent availability excluding AHCCCS/Med-QUEST approved planned Downtime.

5.15.3: Our cloud-based hosting environment, disaster recovery process, infrastructure toolkits and database management system all contain robust functions that support archive and retrieval functions. As part of the implementation effort, we will implement a configurable archival process that meets the RFP requirements and can be tested along with the other system components. It will enable data that meets a pre-determined set of criteria to be archived from the production database into a repository that is indexed by key data characteristics. The archival process is run as a batch process during non-peak hours and does not require system downtime to execute.

5.15.4: PDMS is capable of purging all State data from our solution and backups based on a configurable timeframe or at the end of the contract. The purge process does not require the system to be unavailable, using a parameterized set of filters to first identify the data and then a cleanup function that eliminates the identified files. Given the retention period of ten (10) years, MAXIMUS will work with the States to determine how the purge functions will be implemented during the contract period.

5.15.5: The archiving process included with PDMS includes indexed data and a restoration process that allows the States to identify the criteria for data to be restored. The restoration process will use the archive data store to retrieve the data and restore it into the production database. The retrieval process can run without requiring system downtime.

5.15.6: MAXIMUS proposes Amazon CloudWatch and AppDynamics for tracking and managing performance, availability, utilization, and service levels. Using CloudWatch in conjunction with AppDynamics allows us to monitor and manage the entire infrastructure including browser client request through to network, backend databases, applications servers, and interface performance. With the help of these tools, MAXIMUS is able to monitor load, average response times, and error rates and make updates to our cloud environments or system configurations to address any performance problems.

5.15.7: MAXIMUS implements real-time interfaces according to the specifications and methods allowed by each source. The processes used to call real-time interfaces verify the service is available before a request for data is sent. If the data is required by a process and the service is not available, the process will display an error message and queue the request for a later time. MAXIMUS designs all real-time interfaces to provide data received immediately for use by the PDMS. Our will real-time interfaces will make the data accessible in PDMS within three seconds at least 99 percent of the time, excluding batch interface updates.

5.15.8: As part of our integration methodology, MAXIMUS has optimized the production database and access processes for performance and reliability. We draw on actual experience from our production implementations to maximize the performance of the application especially in areas where queries are returning high-volume result sets. PDMS response time for user-initiated functionality related to the Data store including simple queries will not exceed three seconds and for complex queries whose output is greater than 10,000 rows will not exceed 30 seconds.

5.15.9: PDMS is designed with a simple straight-forward user interface focused on speed, accuracy and ease of use. User interface processes are based specifically on the work being done and the business rules being executed. This design approach enables us to accommodate a user interface response time of two seconds or less per discrete transaction.

5.15.10: MAXIMUS designed our system to immediately execute procedure calls based on the user interface, process logic, or other trigger mechanisms. PDMS response time for adding, updating, or deleting data from operational components will not exceed three seconds per action.

5.15.11: Through our implementation with other states, MAXIMUS understands that accurate interface processing is one of the most important aspects of the system. During System Design, we will identify each interface required and develop or update the interface control document and specifications for processing. The ICD will include documentation of the data layout, inbound/outbound capability, and error handling. We will analyze our existing data layout and processing approach and verify that all of the required interfaces for the PDMS will operate in accordance with the specifications, without degradation in performance.

5.15.12: We designed our technical solution to prevent system outages and be available on 24x7 basis to Providers, the State, and operations staff. It also contains high-availability production environments with built-in redundancy to eliminate most unscheduled downtime and a full-time replicated environment for disaster recovery that will enable MAXIMUS to meet the required recovery point and recovery time objectives. In instances when a critical issue is encountered that requires downtime, MAXIMUS will restore availability using procedures in the Business Continuity and Disaster Recovery Plan within four hours from the start of the unscheduled downtime.

5.15.13: MAXIMUS staff assigned to the AHCCCS/Med-QUEST project are primarily mobile-workers who have the ability to work from a variety of locations as necessary. From an infrastructure perspective, the PDMS production environment will be hosted in US West Oregon data center of AWS. The DR will be setup in US East (N. Virginia) data center. Each AWS region is completely isolated from the other AWS regions, which achieves the greatest possible fault tolerance and stability. Within a given region, there are multiple availability zones (AZ) and our servers are deployed in different AZs for highly availability, fault tolerance, and scalability. AZs consist of one or more discrete data centers, each with redundant power, networking, and connectivity, housed in separate facilities. In the event any aspect of the primary site becomes unavailable, other data centers in the AZ automatically pick up the processing load, which is done dynamically with no impact to the user community. In the event the primary business site becomes unsafe or inoperable we will failover to the DR environment well within (2) business days.

5.15.14: MAXIMUS completes the Disaster Recovery (DR) Plan as part of the system implementation effort. This plan documents the strategies and capabilities to safeguard and resume business functions within pre-determined timeframes established in the RFP. The DR plan will include all the steps necessary to complete the recovery of affected systems from a disaster. We will perform a DR exercise prior to go-live and again annually. Our experience during the annual tests will confirm we are able to recover the entire system within the timeframes specified in our DR Plan. The DR Test Report includes the outcome, corrective action plan and any revisions to the Department and will be provided to the State within thirty (30) days of test completion.

5.15.15: The MAXIMUS recovery approach includes archiving of files as updates are made. We also replicate data from the production environment to the DR site and complete daily backups of all data and files. In the event a file is found to be corrupt of has some type of error, MAXIMUS will complete file restoration within six (6) hours of the issue being detected.

5.15.16: We plan well in advance for any system downtime to allow all system users to prepare. We will notify the State at least five business days prior to the installation or implementation of hardware, software, network, and data center environmental changes that require downtime. We also understand that sometimes unknown issues occur that may require system downtime to correct. In these cases, we will notify and obtain approval from the State at least five business days prior to scheduling non-emergency system downtime or maintenance for during normal hours of operation. We will follow the documented processes and understand AHCCCS/Med-QUEST must approve the planned downtime.

5.15.17: A part of our Maintenance Support methodology deals with reporting errors and issues in the Production system. We have well-defined processes that describe how system defects and other issues are reported to MAXIMUS and how we will go about completing the required tasks to correct the defect. As defects are reported, they are entered into our JIRA tracking system where the MAXIMUS system maintenance team immediately assesses the issue and assigns a priority. The steps and timeframes we use to resolve the Provider Management System error resolution SLAs are outlined in our responses to Requirements 5.15.17.1 through 5.15.17.18 below.

5.15.17.1: Priority 0 errors occur when the system is unavailable. These issues are immediately assigned and worked on in conjunction with our corporate IT teams. MAXIMUS will notify the impacted state within thirty (30) minutes and provide the state a status every thirty (30) minutes until a corrective action plan is approved. We will provide a corrective plan to the State within 2 hours of the issue.

5.15.17.2: Priority 1 errors involve serious production issues. These issues are immediately assigned and worked on in conjunction with our corporate IT teams. MAXIMUS will notify the impacted state within thirty (30) minutes and provide the state a status every one (1) hour until a corrective action plan is approved. We will provide a corrective plan to the State within 2 hours of the issue.

5.15.17.3: Priority 2 errors involve a significant production issue where work around is available. These issues are assessed immediately upon report and assigned to the appropriate team for resolution. MAXIMUS will notify the impacted state within thirty (30) minutes and provide the state a status twice a day until a corrective action plan is approved. We will provide a corrective plan to the State within 24 hours of the issue.

5.15.17.4: Priority 3 errors include all errors that do not fall into the category above. These are reported and tracked within our JIRA tool and assigned to the appropriate team for resolution. MAXIMUS will notify the impacted state within thirty (30) minutes if the error occurs during the business day or at the beginning of the next business day if the error occurs after business hours. MAXIMUS will provide the state a status every twenty-four (24) hours until a corrective action plan is approved. We will provide a corrective plan to the State as agreed to in the contract.

5.15.17.5: MAXIMUS agrees that all priority levels shall be subject to AHCCCS/Med-QUEST review and approval. We anticipate formalizing the procedures used to report and correct errors as part of our Operations Plan, which will be delivered during the Implementation phase of the project.

5.15.17.6: MAXIMUS understands and agrees that upon contract award or shortly thereafter, AHCCCS/Med-QUEST shall supply contact information to the Contractor for reporting incidences in 5.15.17.

5.15.17.7: In the event a high or critical risk is identified by either MAXIMUS or by AHCCCS/Med-QUEST, MAXIMUS will submit an acceptable risk mitigation plan to AHCCCS/Med-QUEST within 5 business days

of risk identification for 100% of the identified risks. MAXIMUS acknowledges that AHCCCS/Med-QUEST will determine the level of criticality for each risk.

5.15.18: MAXIMUS will ensure 100% of the data interfaces identified for the ESB integration are managed and orchestrated by the ESB. We will work closely with our system partners to define the message structure and subscription types that will be used to manage interfaces through the ESB.

1.1.16 Security

[Additional Information: Section 4.1.3.3]

5.16.1: As part of our proposal, MAXIMUS has completed the State of Arizona Baseline Infrastructure Security Controls 2017 and included it as *Attachment A* of our proposal.

5.16.2: Our system logs all user accesses including unsuccessful login attempts. A user account is locked after 3 unsuccessful attempts. Our system maintains a detailed audit trail of all operations including date and time of operation, type of operation (Insert, Update, and Delete), and user ID along with the affected data elements. Our configurable reporting solution will generate reports and alerts based upon the criteria defined by AHCCCS/Med-QUEST to identify usage anomalies.

5.16.3: The system logs contain information about system access and are stored in database tables which include current and historical information. The audit capability is built into the system and automatically stores the information which is available to the reporting platform. PDMS is packaged with the Application Audit Trail report, which includes before and after values of data element(s) that were changed, along with ID of the user that made the change, including changes that were made via interfaces or batch processes.

5.16.4: The underlying application data is encrypted at rest using Transparent Data Encryption (TDE). We use SQL Server 2016 Enterprise edition to support this function.

5.16.5: Because the application includes an externally facing Internet component, we engaged our Office of Information Services (OIS) Security and Audit Team to help define the specific security requirements. We also continually conduct internal vulnerability assessments of the application. We conduct full third-party vulnerability and penetration tests of the application on a yearly basis, correct identified defects, and add them to lessons learned. We also provide Test Report results to our clients and work with them on a plan to address the vulnerabilities. MAXIMUS will perform a penetration test six months prior to go live and annually or when major system changes have occurred. We will utilize an industry standard third party to conduct the testing.

5.16.6: The state data is transmitted through https secured protocol; thereby avoiding any packet sniffing. SSL certificate with the highest level of encryption is used. We have developed policies and procedures that our solution will meet. To control security across the multiple application tiers and numerous data interface components, our solution contains a variety of security layers to protect the application and its data. We encrypt data in motion and at rest and all system access is based on user role.

5.16.7: All access to the system is through the web portal. A security banner is shown prior to entering the system. The security banners, headers, and footers are configurable. We will work with AHCCCS/Med-QUEST on what needs to be displayed and verify that they adhere to Federal, state, and other applicable standards.

5.16.8: As a regular component of our infrastructure security processes, source code and executable objects are scanned for vulnerabilities anytime a new release is introduced into testing or production environments. In addition, the complete server and hosting infrastructures go through detailed security scans on a regular basis to verify no vulnerabilities are found and that all server software is up to date.

Upon identification of a security vulnerability, MAXIMUS will apply patching and corrections to resolve the vulnerability within three days for critical issues and within ten days for major issues. MAXIMUS acknowledges that AHCCCS/Med-QUEST will determine the level of criticality in consultation with MAXIMUS.

5.16.9 MAXIMUS privacy and security policy prohibits use of shared accounts for any system. MAXIMUS staff undergo annual refresher training on privacy and security topics and Project Management personnel emphasize project standards with all project staff. No MAXIMUS user or system administrator will utilize a shared account.

5.16.10: MAXIMUS privacy and security policy requires that any security incident be reported immediately to the MAXIMUS Security Team for assessment and reporting. All project staff are required to meet this requirement under strict guidelines. The MAXIMUS Security Team will provide a written report and assessment to the AHCCCS/Med-QUEST within 12 hours following the identification of any security incidents. The report will detail actions taken, type of incident, status, and potential impact(s).

5.16.11: Our solution is packaged with a built-in and robust security mechanism that complies with federal architecture guidelines and standards (including NIST) and incorporates the appropriate evolving national standards including HIPAA privacy and security requirements. As a major state and federal vendor, MAXIMUS is required to comply with HIPAA across the majority of our health and human services projects.

5.16.11.1: HIPAA security and privacy compliance is a core component of our approach. MAXIMUS designed all aspects of our solution to meet Medicaid requirements for interoperability, data exchange, security, and confidentiality. Our solution addresses federal architecture guidelines and standards and incorporates the appropriate national standards including HIPAA privacy and security requirements and technological guidelines as defined by the Health Information for Economic and Clinical Health (HITECH) Act.

5.16.11.2: PDMS complies with federal architecture guidelines and standards (including NIST) and incorporates the appropriate evolving national standards including HIPAA privacy and security requirements. We create a System Security Plan (SSP) that details each of the security controls we use. During finalization of the SSP, we will validate that our solution is compliant with all AHCCCS/Med-QUEST security standards.

5.16.11.3: MAXIMUS creates a system security plan (SSP) that adhere to recognized best practices including the latest version of the National Institute of Standards and Technology (NIST) Special Publication (SP) 800 series related to cyber security. We also include the performance of risk assessments that meet the NIST 800-30 requirements. We complete external penetration testing and, as a regular procedure, scan our software before any UAT or production release. As a regular component of our application development approach, MAXIMUS engages our corporate OIS Security and Audit Team to secure our systems, infrastructure, and operational sites that conform to federal standards.

5.16.11.4: Our solution follows the guiding principles of MITA 3.0 and is compliant with the CMS Seven Standards and Conditions for Enhanced Funding. We have proven our system can be implemented outside of traditional MMIS in a modular fashion while acting as a functional conduit to support data integration and interoperability between legacy systems and Medicaid data partners. Our SOA and web services design allows for flexibility in interface technology and interoperability with any other Medicaid systems.

5.16.11.5: PDMS includes all of the data and business processes required by ACA. We collect all data needed to enroll and screen providers of all types included in the Medicaid Program. Our system contains a proven set of workflows and edits that ensure data is accurately reported and that providers are run

through the appropriate screening sources during initial enrollment, reenrollment and on a monthly basis. We have also focused on implementing a solution that contains the appropriate security and privacy controls. A full IV&V and CMS review was completed on our system during the Nebraska federal certification process and we have completed the full range of MECT checklists and provided backup information.

5.16.11.6: The MAXIMUS OIS Security and Audit Team is responsible for data security. This group's role includes not only system security administration, but also security assessments and reviews to verify and validate the safeguarding of corporate data assets. The team continuously evaluates and assesses our capabilities and requirements to safeguard the security of client data entrusted to MAXIMUS and works directly with project teams to identify, report and investigate security incidents. On an annual basis, MAXIMUS will use a third party that is certified to perform a SSAE-16 or equivalent assessment. As part of the scope of work, MAXIMUS will receive reports will the full results of the audit and provide them to the State within 24 hours of finalizing the report. MAXIMUS will develop mitigation plans for areas of non-compliance and correct any deficiencies.

5.16.11.7: We conduct full third-party vulnerability and penetration tests of the application on a yearly basis, correct identified defects, and add them to lessons learned. MAXIMUS will apply patching and corrections to resolve high and medium vulnerabilities identified unless otherwise approved by AHCCCS/Med-QUEST.

5.16.11.8: The MAXIMUS OIS Security and Audit Team will provides a written report and assessment to AHCCCS/Med-QUEST within 24 hours following the identification of any security incidents, per the policy set forth in the Business Associate Addendum. The report will detail actions taken, type of incident, status, and potential impact(s). MAXIMUS will take corrective action to mitigate the potential or actual incident within two hours following the identification of the incident. The MAXIMUS Security Team will assist with the identification, corrective action plan and implementation of the security fixes.

5.16.11.9: MAXIMUS conducts infrastructure wide vulnerability assessments using industry standard products with results that are assessed by our OIS Security and Audit Team. We also scan source code and executable objects with every new release to identify potential security issues. When issues are identified they are immediately reported to the applications team who must implement corrections within an agreed upon timeframe.

5.16.11.10: MAXIMUS develops system and user documentation during the onset of the project. This documentation is then updated and revised as necessary throughout the life of the project based on specific configuration and policies set by the State. MAXIMUS documentation is written in a procedural step-by-step format that helps users understand the purpose and operation of specific application components for each business process and major program/functional area. Onsite training is used to solidify understanding of both the system and the procedures for handling data and security items. All documentation is available to users on-line, with key word search capability and context-sensitive help.

5.16.11.11: The Web/Application servers control access to the web portal using the SSL protocol to achieve confidentiality, message integrity, and authentication. Our solution uses 2048 bit SSL with a 256-bit encryption level. We have developed an Authentication web service hosted in our solution. The solution has the necessary infrastructure and capabilities to be a consumer of Kerberos, LDAP 3.0 authentication, SAML and other SSO technologies. We will work with AHCCCS/Med-QUEST to determine the configuration necessary for this service.

5.16.11.12: PDMS uses role based access control to secure the application. The primary rules for our security model are based on the user role and the permission to take an action. The permissions are based on the context of various enrollment application states (workflow steps), such as Provider Data

Entry, Ready for Approval, and so on. The application has role-based security with rules to make sure users can access only the minimum information required for their role. Access and use of data is limited by role and is traced to the user ID which is stored in the system audit trail.

5.16.11.13: To access the PDMS a user must have a valid user account with a unique ID. Each log in ID is tied to a specific role and that governs what data can be accessed or updated. To begin any sessions, the user ID and permissions for the role must be validated. Functions that are not available to a role cannot be executed and data set access can be controlled based on authentication.

5.16.11.14: Access to MAXIMUS applications, data, and computer resources is managed through user account IDs and passwords that are unique to each user, as well as user privilege restriction mechanisms. The user account passwords are stored as hash values in the database to prevent compromise. User passwords have a configurable expiration time which is set to 90 day per CMS requirements. Password strength is configured to force the users to select strong passwords that are more complex to include at least 8 characters in length, upper and lower case letters, a number and a special character. Password requirements will be configured to conform to AHCCCS/Med-QUEST policy.

5.16.11.15: the PDMS includes a configurable session timeout function which is implemented to protect idle user session data. The timeout period is a configurable feature and will be set based on AHCCCS/Med-QUEST requirements.

5.16.11.16: Our system maintains a detailed audit trail of all users who pass through or view a record. The audit data includes the date and time, the user ID, and the data elements being viewed. We also use system logs to identify system level access. This auditing model tracks all user activity and stores all of the details in the audit tables. Our configurable reporting solution can generate reports and alerts based upon the criteria defined by AHCCCS/Med-QUEST and we will consolidate all sources into a single report.

5.16.11.17: Our solution provides various mechanisms to redact information to comply with state and federal requirements. PII and PHI data is either redacted or de-identified for entities not authorized to receive the information, for example public searches, etc. We also have the ability to control access to information for internal records based on configurable criteria.

5.16.11.18: We perform all development functions using Visual Studio as our Integrated Development Environment. In addition, SQL Server Enterprise has an integrated toolset to support data model development and maintenance. All source code is kept within our configuration management tools and together we maintain interfaces code and data models. Project deliverables and other artifacts are stored online in the Project SharePoint site. MAXIMUS will work with AHCCCS/Med-Quest to identify authorized users who need access.

5.16.11.19: MAXIMUS OIS Security Team and our Privacy Officer are responsible for data security and privacy as well as conducting security assessments and reviews to verify and validate the safeguarding of corporate and client data assets. MAXIMUS has implemented mandatory procedures for reporting issues or possible breaches in security of privacy and we will tailor each process to align with the specific service level agreements in the RFP. Our security and privacy teams continuously evaluate and assess our capabilities and requirements to safeguard the security of client data entrusted to MAXIMUS. In the event of a security incident, we will immediately report incidents upon discovery, including breaches, to State-designated personnel. Our team will conduct a full investigation and submit a root cause analysis and Corrective Action Plan to the State to ensure the same issues does not occur again.

5.16.11.20: As a corporate standard, MAXIMUS does not allow remote control or file sharing software to be installed on any corporate assets except as needed for corporate security patching and updates. No

remote control or file sharing software will be allowed within the AHCCCS/Med-QUEST environments unless specifically approved by AHCCCS/Med-QUEST.

5.16.11.21: MAXIMUS has a strong understanding of information security requirements and associated privacy and confidentiality laws and regulations. We have a comprehensive approach to security for each of our contracts and a long history of implementing security policies covering physical, system, and personnel security protocols. Through the many contracts we operate for both federal and state government agencies, we have deep experience complying with applicable standards, policies, laws, and regulations. Our best practices incorporate adequate security in the information systems we provide for our clients. If at any time we are found to be out of compliance, we will provide a root cause analysis and a mitigation plan to the State within ten (10) business days with mitigation and testing to be completed in the timeframe defined in the mitigation plan.

5.16.12: MAXIMUS has a comprehensive corporate training program that focuses on security and privacy and the potential for data breach. Every MAXIMUS employee is required to attend this HIPAA training at the time of hiring and annually thereafter. This training incorporates the MAXIMUS policy governing access to, duplication and dissemination of individual or entity information. In addition to Code of Conduct and Ethics Training, MAXIMUS includes a section on responsibilities and the need to maintain confidentiality of all data entrusted to MAXIMUS. Employees are required to pass a test that demonstrates their understanding of their responsibilities. Training dates and test scores are maintained in each employee's MAXIMUS University transcript which will be provided to AHCCCS/Med-QUEST on an annual basis.

1.1.17 Project Governance

[Additional Information: Section 4.1.6]

5.17.1.1: Having been through two state provider management modular certifications, MAXIMUS understands the importance the IV&V contractor brings to the project and supports AHCCCS/Med-QUEST with any IV&V activities associated with CMS Certification. The system capabilities, along with our team's exceptional experience and commitment, facilitates and expedites CMS certification. MAXIMUS provides a combination of business and technical support staff to support AHCCCS/Med-QUEST in achieving CMS certification of PDMS. This support occurs before, during and after system implementation. MAXIMUS maintains continuity in staffing during the entire certification effort, including any follow-up necessary to resolve compliance issues.

5.17.1.2: We will coordinate to support any program level change management process. From the beginning of contract award, MAXIMUS plans for the steps necessary to achieve federal certification, relative to the most current strategy laid out by the MECT. The Certification Plan provides the roadmap for achieving federal certification within AHCCCS/Med-QUEST timeframes. Not only do we develop a thorough and detailed Certification Plan, we also incorporate certification steps into other plans, such as the Test Management Plan, Implementation Plan and Change Management Plan. Any changes as a result of the Certification Plan are implemented according to the Change Management Plan.

5.17.1.3: Certification is not just a task in the schedule, it is an effort that is interwoven into all aspects of the project. As such, certification activities must be accounted for during the planning phase to ensure adequate preparation for the CMS review. Document preparation and review can be very time-consuming and an adequate period must be built into the Integrated Master Schedule. In collaboration with AHCCCS/Med-QUEST, we will provide begin and end dates of the certification phases. This includes the key project milestones, integration points, cross module dependencies, and support for the AHCCCS/Med-QUEST reporting requirements.

5.17.1.4: Because of our experience with the MECL, and because we embed certification staff in every step of system design, we confirm that all project activities, plans and deliverables comply with the requirements of the MECL. MAXIMUS is committed to achieving the State's goal of obtaining federal certification. The system capabilities, along with our team's exceptional experience and commitment, facilitates and expedites CMS certification.

5.17.2: As a result of our certification responsibilities in both Nebraska and the District of Columbia, our team has deep and current experience with modular implementation procedures. MAXIMUS will integrate certification activities into our DDI approach and provide appropriate documentation and support during the various reviews that must occur as part of the DDI effort. We will also draft certification plans and checklist responses, and prepare the evidence and artifacts required for the CMS Certification Final Review (R3). MAXIMUS supports the State in any additional program governance activities as necessary.

1.1.18 Project Management

5.18.1: The MAXIMUS Project Management Methodology (PMM) is the approach we follow for project management and the System Development Methodology (SDM) is our methodology for delivering system solutions. We have taken steps to make sure that the PMM and SDM work together, do not conflict, and each maintain focus on their respective project areas. All aspects of Project Management are governed by the PMM. All aspects of systems and software development, particularly design, configuration, coding and testing are governed by the SDM. The MAXIMUS project methodology is based on a comprehensive implementation approach that starts with implementation of the system and the support infrastructure required to execute the plan. We use a repeatable, proven approach to deliver a compliant solution for the State. Our methodology addresses each element of the RFP specified scope of work and includes additional activities we believe are critical to project success. Our Project Management Plan template is tailored to the requirements, deliverables and timelines specified in the RFP to address each major project phase. We adapted our approach specifically to balance the needs of supporting routine maintenance and operations while at the same time supporting major product upgrades and implementation projects. Our approach confirms that the MAXIMUS deliverables, tracking, and monitoring functions are in line with those contained in the RFP.

5.18.2: Upon contract award, MAXIMUS schedules a kick-off meeting with key stakeholders and the AHCCCS/Med-QUEST project team to review our project approach, gain commitment to a common objective, and gauge expectations of various stakeholder participants. We find the kick-off meeting to be essential in developing a common understanding of the methodology, schedule, and responsibilities of all parties. We use this opportunity to answer participant's questions, and discover and address any concerns, rumors, or confusion that project stakeholders have before proceeding with scheduled project activities. MAXIMUS provides an agenda prior to the meeting to confirm that we address all meeting objectives. During the kick-off meeting, we provide a demonstration of the PDMS. This demonstration is an important part of the agenda as it allows the State stakeholders and subject matter experts to visualize the system's ability to meet the functional requirements from the RFP. We transition from the kick-off meeting demonstration to then conducting the Requirements Confirmation and gap analysis sessions.

5.18.3: MAXIMUS uses an industry standard suite of tools and methods to facilitate Project Management, track project artifacts, capturing decisions, mange issues and risk and document defects. In addition to the Microsoft Office suite of tools, below are additional tools that we will use on the project.

- **SharePoint** – We understand AHCCCS/Med-QUEST will provide an electronic document repository for project documents and deliverables. However, MAXIMUS is also capable of setting up the repository.

- **Adobe Acrobat** – MAXIMUS uses Adobe Acrobat to convert deliverables into PDF format for final delivery
- **JIRA** – This tool is used for tracking issue reports and resolution, defect remediation, action items and changes. This tool is flexible enough to be used for recording and tracking many of the critical project management artifacts.
- **JAMA Contour** – This tool is used to manage the Requirements Traceability Matrix and confirmation of testing for each requirement.

If any of these tools are not approved by AHCCS/Med-QUEST, MAXIMUS will explore the use of a different tool that is State approved.

5.18.4: During Project Initiation, MAXIMUS will meet with the State to review our project management processes and procedures and determine roles and responsibilities for the various team members. The results of this review will be a Responsible Accountable Signatory Informed Consulted matrix. MAXIMUS project status monitoring incorporates a consistent and proven process that provides our clients with the progress data and documents they need to accurately assess the status of the project, understand project issues, address issues and risks, and resolve time critical action items. An agenda and copy of both the weekly and monthly status reports, presentation materials, and documents will be delivered to the AHCCCS/Med-QUEST team at least 24 hours prior to every meeting in accordance with the responsibility assignment matrix.

5.18.5: The detailed project work plan (PWP) contains all activities, deliverables and milestones required for successful project completion, including the appropriate dependencies between activities as well as the expected activity duration. By including all activities and their related dependencies, project leaders are assured that completion of the activities on the schedule will lead to a successful project implementation. The PWP contains the critical path marking the set of activities and durations that, if changed, will change the project schedule. We update the project schedule each week so that our management team can assess progress and make updates to staffing or delivery to eliminate possible delays. We plan to submit all deliverables to AHCCCS/Med-QUEST according to the PWP. Depending on the size and complexity of the deliverables, we will include additional time for detailed walkthroughs and, when agreed to, a revision period so that we can incorporate updates from the walkthrough into the deliverable before it is submitted. MAXIMUS will provide to the AHCCCS/Med-QUEST team an updated PWP at each status meeting.

5.18.6: Weekly status meetings are targeted to the project team members from MAXIMUS and AHCCCS/Med-QUEST and address the status of day-to-day tasks, assignments, and any potential risks or issues. We also review the overall project schedule and discuss change requests that are pending or have been approved. MAXIMUS will lead and participate in status meetings and ensure all required staff are available to discuss the specific aspects of the project. We use ReadyTalk™ for web conferencing allowing geographically dispersed teams to interact and we also record the meetings so that the discussions can be references as needed. These recordings are also used to create the minutes, which are submitted within 48 hours after the meeting for AHCCCS/Med-QUEST team review, editing, and approval.

5.18.7: During Project Initiation, MAXIMUS will develop a list of project stakeholders and other contractors that we will interact with. From a project management perspective, the stakeholder list will shape our Communications Plan and help us define when we need to meet with the various stakeholders to complete project activities. MAXIMUS will define the meetings necessary and work with the State to schedule the meetings. Our staff will also be available to participate in meetings initiated by other contractors.

5.18.8: We understand the importance of regular project communications directly between the teams. In addition to the formal status meetings, project staff will be empowered to participate in or initiate all necessary meetings with the stakeholders and/or other Contractors in person, by phone or by web conference as necessary. This includes the ability to schedule meetings related to issues, risks, progress of current projects, system changes, resource changes, and other areas specific to the scope of work.

5.18.9: MAXIMUS will establish an electronic document repository to house all project documentation including deliverables, action items, issues, risks and decision registers, agendas, meeting minutes, presentations, design documents, and other project artifacts. MAXIMUS uses Microsoft SharePoint as our standard tool and will gain AHCCCS/Med-QUEST approval before implementing the toolset. The MAXIMUS repository will consist of subfolders for each project phase for project team members to locate easily and update the most current version of each document. SharePoint provides document versioning, backup, and recovery in the event a document becomes corrupted or accidentally overwritten. The document repository has the capability to grant access AHCCCS/Med-QUEST staff and other Contractors with the appropriate security level to upload/attach new or revised versions of documents.

5.18.10 – 5.18.10.4: The on-time and on-budget delivery of the Provider Services Solution is largely based on the quality of the deliverables we submit. We plan to submit all deliverables according to the project schedule. Depending on the size and complexity of the deliverables, we will include additional time for detailed walkthroughs and, when agreed to, a revision period so that we can incorporate updates from the walkthrough into the deliverable before it is submitted. We will develop specific processes for obtaining and incorporating comments and verify that all deliverable updates follow the agreed upon change control procedures.

The time constraints of the project necessitate that both deliverables and the subsequent reviews are completed on time to meet the project schedule. Our Project Management staff perform a review to validate quality and content of each deliverable before submission. It is critical that during the AHCCCS/Med-QUEST review, all comments and concerns are captured and consolidated during the initial review. Subsequent reviews will only check that MAXIMUS adequately handled the initial review points and new items will be handled through the change control process. This approach keeps the teams focused on what is needed for a specific deliverable, aligns with the timeframes included in the project schedule, and closes the loop on the service level agreement that we are required to meet related to no more than two submissions of any deliverable. [Additional Information: Section 4.1.7]

5.18.11 – 5.18.11.6: We take quality very seriously and have constructed a deliverable production process to support the quality of our deliverables. Deliverable quality includes verifying the content meets the intent of the deliverable, meets the needs of the intended audience, and includes correct grammar and spelling. Following industry-related standards, our deliverables contain clear and meaningful diagrams and include appropriately defined and referenced information. MAXIMUS conducts reviews throughout the development of the deliverables to verify conformance with the DED and that each deliverable meets minimum quality standards.

5.18.12: MAXIMUS uses the Project Management Plan (PMP) to describe in detail how the project is managed from start to finish. In addition to our adherence to PMBOK® principles, we established our own set of best practices through our years of project transitions and implementations, and compiled them into PMP that supplement PMBOK® in guiding our projects to success. The PMP is the overarching plan that defines the methodology, processes and procedures used to manage the Provider Management System project. The PMP includes several component plans that define the detailed workings of the management of the Provider Management System project. To implement the Provider Services module, MAXIMUS will tailor our project management methodology based on the specific RFP requirements to deliver a PMP that includes:

- Communication Plan
- Change Management Plan
- Work Breakdown Structure
- Staff Management Plan & Organizational Structure
- Quality Management Plan
- Risk Management Plan
- Issue Management Plan
- Deliverable Submission Process

The PMP provides a comprehensive baseline of what needs to be achieved by the project, how it is to be achieved, who will be involved, how it will be reported and measured, and how information will be communicated with the project.

5.18.13: MAXIMUS creates a comprehensive, integrated PWP that includes all work required by all parties to successfully implement the Provider Management module and capture sufficient information to support the AHCCCS/Med-QUEST reporting requirements. The PWP includes a Gantt chart that aligns with the scope of work and is built with realistic person hours with start and completion dates for all deliverables and milestones. All project tasks are linked to successor tasks so that in the event the start date is moved forward or back, only one change is required to reschedule the plan. Also, successor and predecessor relationships provides for the quick assessment of the downstream impact of any task completion delays and for the creation of mitigation actions to offset the impact and maintain the original schedule. The project schedule is progressively updated at quarterly intervals so that all necessary activities are planned at a level of detail that is appropriate for monitoring progress against the plan without making the project schedule unmanageable.

The MAXIMUS PWP also includes configuration and implementation of our hosting solution along with external dependencies for partner systems. By identifying components that are not directly controllable by the project we are able to keep integration points visible and identify potential schedule risk based on how our partners are proceeding with their tasks. Placing emphasis on the execution of an integrated plan for the entire solution allows MAXIMUS to implement the full solution into production within our proposed ten-month timeframe. MAXIMUS will continually refined and update the PWP as the project progresses and shall retain the baseline for comparative reporting. As described in *Section 1.3: Timeline*, MAXIMUS is proposing an integrated schedule to implement both Arizona and Hawaii's solutions concurrently. We believe this approach allows us to maximize our resources, reduce risk, and lower the overall costs of the implementation. However, we will work with the State to determine the best available implementation schedule based on the all factors impacting the decisions. [Additional Information: Section 4.3]

5.18.14: MAXIMUS anticipates scheduling walkthroughs for all large deliverables and as components of the system move from configuration into testing. We also plan to participate in module walkthroughs for other components of the Medicaid Enterprise that we may interface or impact is some way.

5.18.15: System enhancements will be managed using the approved change management process approved during Project Initiation. When enhancements are approved, MAXIMUS will track the hours expended on the effort and submit a monthly System Enhancement Pool report that includes the hours used and the remaining hours. MAXIMUS and AHCCCS/Med-QUEST will negotiate the details of the pool hours and rates and agree upon the format of the report.

5.18.16: One of the most important project management principles we bring to the AHCCCS/Med-QUEST project is an emphasis on communication and collaboration with the State and other key stakeholders. We strive to keep easy, open channels of communication between our projects and clients. MAXIMUS will fully cooperate with the IV&V contractor to give an accurate and honest status of the project.

5.18.17: Based on direction from AHCCCS/Med-QUEST, MAXIMUS will contribute to the AHCCCS/Med-QUEST and/or the Systems Integration Services collaboration site. This may include any of the project's technical and non-technical artifacts.

5.18.18: Upon request from AHCCCS/Med-QUEST, MAXIMUS will follow the contract to transfer all federal or State-funded computer applications, data, reference tables, scripts, documentation, and records required by the State.

5.18.19: MAXIMUS understands the numerous activities that must occur to support a smooth transition. Our proposed approach to turnover includes tasks, subtasks and a proposed schedule for turnover, including supplying the Monthly Turnover Reports during the turnover phase and the Turnover Results Report required at completion of turnover activities. We will update the operational tasks and procedures, and provide a list of incomplete tasks, such as system defects, modifications or enhancements, mass adjustments, reference updates, and configuration requests. The MAXIMUS Turnover Plan describes the vendor and state coordination activities that will occur during the turnover task and implementation of the activities with the end goal of continued system and services as deemed necessary by AHCCCS/Med-QUEST. Coordination with the successor vendor or AHCCCS/Med-QUEST is key to a smooth transition. We will organize the data and documentation in a format required by AHCCCS/Med-QUEST.

5.18.20: MAXIMUS is committed to meeting our contractual requirements and implementing our solution within ten (10) months. We understand we are responsible for meeting the contractual requirements and for meeting the overall project schedule.

5.18.20.1: The PWP guides all work the project team undertakes for the project. We will meet the due date for acceptance of each deliverable as defined within our PWP.

5.18.20.2: MAXIMUS will develop and distribute meeting agendas as described in response to 5.18.6

5.18.20.3: MAXIMUS acknowledges that Key Personnel positions may not be vacant for more than 10 business days without a qualified, temporary substitute. MAXIMUS has 18,000 employees worldwide and deep program expertise in Medicaid, which allows us to quickly identify qualified substitutes if a Key Personnel position becomes vacant.

5.18.20.4: MAXIMUS uses Jira software for issue management. MAXIMUS will use reports and or a customized JIRA dashboard to monitor where in the process the critical tickets are. Each ticket can be given a due date and/or a planned release date. This process ensures that 100% of all critical priority tickets are completed and implemented by the required implementation date.

5.18.20.5: The MAXIMUS virtualized hosting environment provides our team with the flexibility to establish any number of test environments based on the specific needs of the project. We will establish and maintain all mutually agreed upon environments required to perform system validation, integration testing, and data migration to determine production readiness. Each environment will include all system components required to support the specific types of testing that are planned for the environment. MAXIMUS configures test environments in the same manner as production to ensure tests are valid; however, any component not replicated in a designated environment will be disclosed to AHCCCS/Med-QUEST with a written explanation of why this will not negatively affect the use of the environment for its intended purpose.

5.18.20.6 MAXIMUS will document all business rules applicable to the functioning of the Provider Management module and document any new or changed business rules within 10 business days of the implementation of a change. Business rules are initially captured and documented in narrative format in the detailed design specification for the specific component within the application. Once the rules are documented and approved in the detailed design specification, we enter (or update) these rules in the Corticon Business Rules engine. To create rules that are easily understandable and human readable, MAXIMUS has put extensive effort into creating a vocabulary set. This vocabulary contains the building blocks with which business rules are implemented. Provider Services vocabulary consists of various entities, their attributes, and their relationships to other entities.

5.18.20.7 MAXIMUS will document 100% of the configuration items applicable to the system and update the documentation within 10 business days of the implementation of a change.

1.1.19 Training

5.19.1: Our Training Plan for the State will be built on the foundation we already have in place for our other Provider Management projects. Training will be primarily instructor-led and will be comprehensive in content to ensure all users are fully prepared to operate the MAXIMUS Provider Management solution. We will deliver and maintain the Training Plan according to the schedule in the approved PWP. The Training Plan guides the tasks and activities involved in our training approach. This required deliverable will be submitted to AHCCCS/Med-QUEST well in advance of the Operational Readiness phase and will outline all the tasks, planning activities, and schedule required to implement the Provider Services solution. The final format and times will be determined by AHCCCS/Med-QUEST.

5.19.2 MAXIMUS will provide instructor-led training to AHCCCS/Med-QUEST operations staff during the implementation phase. In addition to providing training on the use of the system, this training includes instructing designated Administrators to manage user accounts and passwords, and training site visit specialists on the use of the system for site visits. We will also provide instructor-led Train-The-Trainer (T3) training sessions to designated agency team members, instructors and other staff who are responsible for user and provider training to achieve an understanding of the new system, services, releases, and future enhancements. We will use classroom materials, including but not limited to, courses, job aids, computer-based training modules, videos, user guides, publications and other materials according to AHCCCS/Med-QUEST-approved content, format and schedules. The number of sessions is dependent upon the number of participants requiring training; with typically no more than 10 participants per session. MAXIMUS will work with AHCCCS/Med-QUEST to identify the training participants and the number of required sessions.

5.19.3 The MAXIMUS Provider Management solution contains robust tools and dashboards for agency project resources and designated contractors to monitor the system. Our training curriculum includes technical training in understanding how to monitor the system through the accurate and complete use of these online tools. In addition, technical and functional documentation serve as additional resources to ensure maximum use of all system monitoring features.

5.19.4 A significant step in ensuring system implementation readiness is developing the training schedule so that training does not occur too soon before system rollout. We collaborate with the agency to develop and maintain a training schedule for all users.

5.19.5 Hands-on training is key to system use readiness. We will maintain and update the training environment with training data to use during user training. This environment is online and accessible from any authorized computer.

5.19.6 MAXIMUS is experienced in delivering train-the-trainer sessions and we look forward to providing these sessions for agency resources or other staff responsible for training.

5.19.7 As the system evolves, so does the training necessary for the users to fully take advantage of all system features. In the event of a major software release that materially changes the user interaction, we will provide the necessary training to the trainers.

5.19.8 MAXIMUS will be on-site in Arizona and Hawaii to support the requirements definition, training and implementation phases.

1.1.20 Testing

5:20.1: The MAXIMUS virtualized cloud hosting infrastructure enables our team to implement any number of test environments based on project requirements. To support our solution for AHCCCS/Med-QUEST, MAXIMUS will validate that at a minimum separate testing environments will be implemented for integration, system and regression testing. We will work with the State to define the user access to these environments.

5:20.2: A plan and schedule for interface testing is developed in conjunction with the Trading Partners and interface file exchanges occur throughout the System Integration Testing Phase. We understand that the interface with the MMIS is the most critical interface to be implemented. We place particular emphasis on testing the MMIS interface, as well as the initial data conversion load of provider data from the MMIS. MAXIMUS will work with AHCCCS/Med-QUEST, trading partners and external entities to determine the preferred method of data exchange for each interface. Using the PDMS Open Interface Framework, we are able to support multiple exchange methods including ESB, Secure Web Service, and SFTP. Regardless of the method, the interface testing will verify the data exchange is accurate and secure. MAXIMUS commits that all crucial and high defects will be resolved prior to releasing code to UAT or production.

5:20.3: MAXIMUS utilizes a process-based approach for undertaking projects. During design we will have created a set of ICDs which clearly define all data integration activity, responsibilities and constraints. We build a comprehensive, integrated Project Work Plan that includes all work required by all parties to craft an integrated project schedule that fully identifies tasks, estimated timelines, responsibilities and interdependencies of every organization. Creation of this integrated plan helps each partner understand the tasks and schedule that has to be met for the project. However, we also know from experience that not all interdependencies can be planned for as issues may arise that might impede the required testing. MAXIMUS identifies and resolves interdependencies that restrict or impede required testing of the solution, other enterprise modules, or module components from other required testing.

5:20.4: To confirm that the system is adequately tested and ready for implementation, test scenarios will be developed to cover all aspects of the screening and enrollment process. MAXIMUS will perform a variety of tests and provide results for the following types of testing: Performance Test, System Test, Parallel Test, Regression Test and Integration Test. At each testing level, test scripts will be used to guide testing. JAMA Contour is used to trace the testing use case back to the design document and requirement being tested. MAXIMUS will thoroughly test the entire Provider Services solution along with the specific modifications and enhancements. MAXIMUS will create a Requirements Traceability Matrix (RTM) to indicate what types of tests are required, whether tests can be automated or manual, and the extent of the regression testing required. The RTM will be used to assess test coverage and test all specifications. Our Test Plan will document all items to be tested and will cross-reference the RTM for each release. The Test Plan will also indicate features and services that are excluded from testing.

5:20.5: MAXIMUS encourages extensive User Acceptance Testing (UAT) by AHCCS/Med-QUEST. We ensure the UAT environments mirror the production configurations and are contained in environments setup specifically to support UAT completely separate from all other environments. MAXIMUS will support and coordinate UAT with State staff throughout the project.

5:20.6 – 5.20.9: UAT is the final system focused test before we proceed to implementation. We address the UAT stage within our project plan, and coordinate with the State to identify the users who will participate in the scheduled testing. In addition, we will clearly define the desired outcomes with AHCCCS/Med-QUEST input and approval to confirm that we are meeting expectations for Provider Management System functionality. MAXIMUS brings extensive experience to AHCCCS/Med-QUEST to facilitate a successful UAT. During our three modular provider system implementations our clients

validated the system functionality during each project's UAT phase. MAXIMUS business and test analysts are available to answer questions, provide suggestions, and assist when problems are encountered. Our UAT support for the project will include:

- Providing test cases and scripts from previous testing – leverage inventory of existing test scripts from the project as well as other implementation efforts
- Assisting the State in developing UAT test cases – assist with test activities including developing test cases and detailed schedules, scheduling interfaces, reviewing potential defects during a daily meeting and providing ongoing subject matter expertise throughout the process
- Providing a dedicated UAT environment to the State for continuous testing – implement a production configured UAT test environment as a separate environment that mirrors production and includes interface integration and external web-based access
- Refreshing data, executing processes, and migrating code fixes as requested – develop a schedule for data refresh based on the testing schedule, provide on-call resources to perform data refreshes if necessary and coordinate new releases in UAT including determination of data refresh requirements
- Providing test data – convert production data for use in UAT along with other test scenarios and data entered test cases used in system testing
- Providing a defect and enhancement tracking system – provide training and access to JIRA for appropriate AHCCS/Med-QUEST testers to enter defects discovered during the UAT process
- Providing a test repository – MAXIMUS carefully prepares and maintains test documentation, including test scenarios and results, using a combination of the JIRA, Contour and SharePoint online tools.

MAXIMUS does not simply turn the system over to our client with the expectation that UAT goes well unassisted. We work closely with the State Test Leads to develop a plan that supports the available State staffing and timeline for UAT. We will work with AHCCCS/Med-QUEST to review test results and create verification procedures using the necessary system and functional specifications.

5:20.10: MAXIMUS works with the State and their subsystem owners to conduct integration testing of the PDMS and all external systems. The need for this collaboration will be particularly important for coordinating the testing of the MMIS interface. MAXIMUS testers are available to support the State and external vendors to facilitate a thorough and complete integration test.

5:20.11: MAXIMUS writes and delivers test criteria and algorithms for expected outcomes prior to producing reports. Our technical and business staff write queries that are independent of the reporting tool to provide raw lists of data which is used to validate the contents of the report. The resulting analysis provides expected results for details and totals on each report that can be verified by the tester. We provide this information to the State prior to testing so the State can similarly verify the reports.

5:20.12: MAXIMUS builds a project work plan that includes sufficient time for the AHCCCS/Med-QUEST to complete a thorough user acceptance test of the system. Budgeting the right amount of time allows for additional testing cycles to be conducted which reduces risk, improves quality, and benefits the overall implementation effort.

1.1.21 Maintenance/Operations

5.21.1: Our build process includes scripts for database table modifications and also data manipulation scripts, when required. These scripts are run in the lower level test environments and verified through test cases prior to being approved as part of the software upgrade. Our release management procedures package all aspects of the release, including table changes, so they are automatically deployed as the release is moved through the implementation path.

5.21.2: PDMS has a well-defined data structure and data dictionary for reference data, including acronyms and codes. Our base system includes all national code sets used within the Provider subsystem and additional reference tables based on our experience with other State implementations. Our reference data structure is designed to be simple and easy to understand with metadata for each table and what it is used for. To the extent possible we use code tables to display actual values in windows and drop downs. When necessary we validate acronyms are consistent across the different aspects of the system.

5.21.3: Each PDMS reference data table contains components for effective date and end date. We have defined a data model that includes both the required data as well as date spans on enrollment data where necessary. The use of effective dating enables system processes to use specific dates in edits by type and transaction. As part of the design process, we will work closely with the State to identify Provider enrollment data that must contain effective date spans and change dates. We typically find that much of this analysis occurs as part of the Data Conversion and MMIS interface design effort because we capture the specific business rules that must be supported during these activities.

5.21.4: The majority of the processes contained in the PDMS are online real-time functions. However, there are a number of batch processes that are run. MAXIMUS provides read-only access to system job and maintenance schedules, submissions, and processing statistics, and system performance tools for designated staff. The system job and maintenance schedule is published on the project SharePoint document repository and available in read-only access to AHCCCS/Med-QUEST staff. As jobs are run, reports are created with processing statistics which will be made available for review.

MAXIMUS will be using Amazon CloudWatch and AppDynamics for tracking and managing performance, availability, utilization, and service levels. We will work with AHCCCS/Med-QUEST to identify what information will be made available. Refer to our responses to Requirements 5.3.15 and 5.15.6 for more details on our proposed use of these monitoring tools.

5.21.5: As part of our standard deployment process, MAXIMUS takes full back-ups of the database and the software code branch prior to each software release. MAXIMUS technical and business resources then conduct a smoke test of the new environment once the deployment is complete. In the case where there may be an issue with the build, we have the capability to reverse the software update (and any data updates) using the system backups. At the server level, snapshots are taken of the configurations before patching occurs. Patching is only approved after it has been run and reviewed by our corporate IT staff.

5.21.6: Batch jobs are scheduled by populating the job information into the job service. The information includes items such as job name, schedule, type, description, needed parameters, and job dependency. The job service allows the following job types: SQL, Stored Procedures, Views, Send, or Receiving files via SFTP/FTP, .NET interfaces, and Web Services. This flexible design allows us to provide a wide variety of outputs for the State on configurable schedules to meet internal and external needs. The job service also allows authorized users to sequence jobs, triggering subsequent jobs to run based on the outcomes of predecessor jobs. Our solution reports on the pre-defined transactions to make sure the processing dates and the number of successful and failed transactions are accounted for in each run. Automated alerts are generated on each interface run to bring attention to issues; including processed and failed transactions.

5.21.7: MAXIMUS is using AWS storage solutions to have full backup and archiving capabilities. The two storage mechanisms we use in AWS are Amazon EBS and Amazon S3. All of the Amazon EBS storage is stored as snapshots in Amazon S3 and can be retrieved based on need. Amazon S3 has different storage classes for that allows for archiving data with different options for access to archive, from a few minutes to several hours. These will be used on as-need basis. MAXIMUS will retain all data (including PII) as directed by AHCCCS/Med-QUEST, understanding the data retention requirements might be

longer for some data. We are able to support a variety of retention requirements including those cited in 45 CFR 164.316. We understand the State may require a longer retention period on an exception basis to support ongoing business needs. We will work closely with AHCCS/Med-QUEST on defining and implementing these requirements.

5.21.8: Our data integration approach exposes APIs and web services for easy integration. We also support legacy interfaces through secure FTP file exchanges and/or other methods that trading partners support. MAXIMUS understands that flexibility is key to success and we focus on new technology but also understand the limitations of legacy systems. In both Nebraska and the District of Columbia, we interface with the legacy MMIS using a two-way SFTP flat file interface structure based on the legacy MMIS requirements.

5.21.9: The PDMS Open Interface Framework provides AHCCCS/ Med-QUEST with existing interface functionality "out-of-the-box," with the ability to easily configure any unique interfaces required for the Project. Our experience with connecting our solution to legacy MMIS applications allows us to cross-reference the data in our system to the key values needed by our trading partners. Our data integration approach exposes APIs and web services for easy integration. We also support legacy interfaces through secure FTP file exchanges and/or other methods that trading partners support. [Additional Information: Section 4.1.5]

5.21.10: PDMS has an error-handling module that provides a mechanism for exceptions, which occur during processing of interfaces transactions. These exception processes are directly integrated with each interface process so that we are able to either restart an extract process or process another inbound transaction completely while identifying any issues with inbound data. Error codes and descriptions along with their categories are available as reference data. This allows for reporting and notifications when rules have been violated. The system also has error ‘override’ capabilities available to certain user roles that can be used in specific situations. Each interface process is designed to complete processing while ensuring all errors are accounted for and missing data can be resent or reloaded. All interface job monitoring reports include record counts and totals.

5.21.11: PDMS uses MS SQL Server as the database management system. If needed, we can integrate with different databases, such as ORACLE. Our solution is capable of sharing and federating data in the format needed by other vendors. We have provided flat file based, SOAP, and XML based formats to MCOs and other trading partners in our previous implementations. Based on specific trading partner needs we will clearly define APIs and other endpoints as well as cataloging all web service interactions. PDMS is packaged with several adapters including ODBC and is working with different protocols such as FTP, SFTP, FTPS, HTTPS, SSH, POP3, SMTP and TCP. Our solution is capable of working with asynchronous communication protocols and message queuing technologies like MSMQ, ActiveMQ, etc. These adapters are primarily configurations in our solution that can be easily pluggable. PDMS has accommodated different transformations using our transformation engine from one format to another as part of performing interface data exchange.

5.21.12: PDMS supports integration with the emailing and calendar functions of MS Outlook 2010 and 2013. All system generated email messages to Providers are also sent (bcc) to the designated staff within the State’s Provider Services operations group. The system also allows internal users to resend emails from the web portal – these emails are also sent (bcc) to the operations group. MAXIMUS will work with AHCCCS/Med-QUEST during Requirements Confirmation to understand the full scope of this requirement and to define user stories where this integration will be applicable.

5.21.13: All search results screens in PDMS, as well as all reports in the system can be exported into several formats, including Excel, Word, PDF, and CSV. Using the PDMS Open Interface Framework we also have the capability to import data in multiple formats, including MS Excel and Word.

5.21.14: MAXIMUS will employ a Service Level Management (SLM) process to capture the SLAs and provide ongoing monitoring and reporting of each SLA. This process begins with definition of the SLM Framework that contains the underlying service contract along with the contractual and performance standards. The next step is to develop documentation of the service requirements. Documentation for each requirement includes definition of the methods for measurement, acceptance criteria, the reporting method, and the process for corrective action. Once the SLAs are clearly defined, the next SLM process is to “perform” the services required. The monitoring step captures the metrics throughout the performance period and provides the data that will be analyzed and reported at the end of the reporting period. In the reporting step, the performance metrics are compared to the contract SLA targets and the pass/fail results are then circulated to all parties responsible for SLA oversight. In the event one or more SLA targets are missed or at risk of missing future targets, corrective actions are defined, tested and implemented as soon as possible. MAXIMUS will use this process to track and meet the required SLAs from the RFP and will work with AHCCCS/Med-QUEST to confirm all SLAs during Requirements Confirmation.

5.21.15: In accordance with our project management approach and using data from the JIRA defect tracking tool, MAXIMUS is able to track and report on remediation and rebuild to satisfy issues identified and resolved. In the event that rework jeopardized on-time release delivery, MAXIMUS will prepare a written mitigation plan that includes the provision for additional resources at no additional cost to AHCCS/Med-QUEST.

5.21.16: During Operations and Maintenance, MAXIMUS uses industry standard COTS tools that automatically track and report system response time and system availability. MAXIMUS relies on a product named Pingdom for capturing the data and providing accurate performance reporting of the system availability statistics. Pingdom is a service that tracks the uptime, downtime, and performance of websites. Pingdom monitors websites from multiple locations so that it can distinguish genuine downtime from routing and access problems. Pingdom alerts are configurable and multiple communication methods can be used, based on user preference.

1.2 Technical Approach Areas

While our proposed system is a critical aspect of the overall project, we understand that in order to be successful we must configure this system to take into account how the Medicaid programs in Arizona and Hawaii interact with their providers. We focus on ensuring the system aligns with the policy requirements for each program and that we implement a project approach that engages State staff in defining the workflow configurations. We also understand that gaining AHCCCS/Med-Quest staff buy-in is pivotal for a successful project so we integrate staff involvement in every aspects of our delivery approach. The end results is a common sense, incremental delivery approach that results in the PDMS system being implemented using a 10-month schedule.

While we focus on a variety of tasks included in our Software Development Methodology (SDM), including helping states understand how the new system will impact their existing business processes. A key aspect of our technical approach is communication with and inclusion of all project stakeholders so the new system is not implemented as a surprise and when it is moved into production it is fully adopted and simplifies the overall provider enrollment and screening processes.

1.2.1 Business Process Redesign

We focus on business process redesign at the beginning of the project. During requirements review, we not only take the time to understand each requirement, we use our system to show how we plan to implement the requirements using existing functions. In situations where we identify differences in how business will have to be conducted, we spend extra effort to understand how new processes will impact

existing staff and the provider community. We involve our training staff from the beginning of the project so they gain the knowledge about these differences in business processes and focus training materials on explaining how the new processes will be implemented and impact the existing operation staff and providers. In addition, we use lessons learned from our other modular implementations to provide insight to issues and successes that other states have had, to help decide on the best business process outcome. We also bring expertise to this process by verifying that decisions made are in alignment with CMS requirements and meet certification standards. The result of this approach during requirements is not only understanding what configuration changes must occur, but also identifying specifically how business processes will be affected by both new regulations as well as the use of the new system.

As we move into system design, we help the state visualize business process changes by defining workflows using Business Process Management (BPM) diagrams that clearly show each interaction with and decision point in the system. Because the workflows represent how each business process will occur in the system, we incorporate all business processes into our design documentation. We walkthrough each workflow with the state and take extra effort to note where changes in current processes will occur and how they will be handled once the system is implemented. We continue to involve our training staff throughout this effort so that training materials are designed understanding impacts that will occur once the system is moved to production. This design step and walkthrough process helps the teams stay aligned and help identify communications points with internal staff and providers for outreach events.

As the system is configured to meet AHCCCS/Med-QUEST requirements, our business team focuses on the development of training materials and user documentation for the system. We use all of the information gathered from the requirements and design sessions to create documentation that not only explains how the system works but also focuses on where differences exist between existing and new business processes. This important step sets the basis for how new business processes will be documented and communicated to project stakeholders. We use this documentation to train project users on both the system and business processes and communicate new CMS requirements to explain how and why the system works in the manner it's designed.

The testing and operational readiness efforts set the stage for a final review of the system and updated business processes. This final step in the implementation effort allows project stakeholders to not only see the changes in the system but to tie the entire system together. MAXIMUS works closely with AHCCCS/Med-QUEST staff to fully understand system functions and to determine if the system meets the specifications defined in the RFP. We use post implementation support to further reinforce how business processes will function and verify that we meet all certification requirements. These final steps place the providers and internal users as the owners of the system and allow our team to make adjustments based on production use.

1.2.2 Requirements Confirmation

Conducting the Requirements Gap Analysis (RGA) sessions are a core component of the MAXIMUS software development methodology. MAXIMUS uses the RGA approach to validate project requirements against existing application components to quickly and easily determine functionality gaps. Our RGA approach relies on facilitated work sessions where our Business Analysts present the functionality of the base system and describe how we meet each requirement as presented in our proposal. AHCCCS/Med-QUEST subject matter experts communicate whether they believe the system meets the RFP requirements or if modifications may be necessary. We also identify the business process changes impacted by the new system as described in *Section 1.2.1: Business Process Redesign*.

The series of RGA sessions include participation by each State's business and technical staff and the MAXIMUS project team. We organize these sessions around specific system functions required to administer the program and organize the requirements in the same manner. We further analyze these

requirements and prepare a complete session schedule that we submit to the AHCCCS/Med-QUEST. For functional requirements confirmation, MAXIMUS will schedule separate RGA sessions for Arizona and Hawaii. This allows us to identify where a requirement is interpreted or met differently between the two States, which in turn will direct us to focus attention on how we may configure the system differently to meet the requirement for each state. During each RGA session, MAXIMUS provides a walkthrough of each system function in conjunction with a demonstration of the system that illustrates the capabilities. The demonstration enables users to understand how the Provider, Operations, and other state users interact with the system. We also review infrastructure, processing, performance, security, and non-functional requirements to confirm how our solution will meet each requirement with the appropriate teams.

The walkthroughs result in the identification of functionality matches and gaps. MAXIMUS Business Analysts capture high-level descriptions of the modifications necessary by functional and/or technical areas. We identify requirement gaps in the JAMA Contour requirements management tool and create placeholders to record the need for additional application components until the designs for the new components are complete. This is where we map the decomposed requirements to high-level test scenarios or use cases that will eventually become test scripts.

The gap analysis documents are the basis for System Design documents that we create during the Design Phase. The RTM provides for traceability of all specified system changes and forms the basis for the development of test cases to be used during system, integration, and user acceptance testing. We finalize and submit the RTM to the States for review and approval at the end of the Requirements Confirmation phase. However, our technical team swiftly transitions into conducting further analysis and preparing for the System Design phase as/when major functional sections of the RTM are completed. We conduct this analysis in parallel with completing the RTM to be sure we are well prepared to begin the System Design phase.

1.2.3 Software Configuration

[Additional Information: Section 4.2]

MAXIMUS uses a system design and software configuration process that aligns with Agile/SCRUM practices but is much more focused on completion of functional packages than on four-week sprints. We use an incremental build methodology based upon “iterative configuration.” By iterative configuration, we mean that requirements and software evolve through collaboration between AHCCCS/Med-QUEST Subject Matter Experts (SMEs), MAXIMUS Business Analysts, and the development team. We present results of the development effort to the user community as soon as they are complete, rather than at the end of the entire phase. Our approach follows a structured, repeatable cycle, with each development stream producing independent functional components we promote through configuration and testing.

We propose six incremental deliveries (referred to as Packages in our PWP) of application components for the AHCCCS/Med-QUEST Provider Management System project. Four of the packages focus on the system configurations necessary to support the enrollment and screening functionality while the remaining two are focused on interface and conversion development. Based on our expertise in implementing modular Provider Management systems, we organize the functionality and the workload into these tracks that we have defined to be very similar in size and complexity. This approach allows us to break the system up into manageable pieces, allows testing to occur sooner, and provides users with early opportunity to view and work with the application.

Using the results of the Gap Analysis, we organize and conduct Design Sessions with AHCCCS/Med-QUEST to identify the components of the application that require configuration changes to our base solution. MAXIMUS Business Analysts use the existing AHCCCS/Med-QUEST legacy application

documentation to make an initial assessment of the changes necessary to screen/data flow, code tables, notices, and business rules. This collaborative analysis leads to the creation of three primary design artifacts that we use to identify the configurations necessary for the PDMS:

- Screen Flow by Provider and Application Type – this artifact lists all valid Provider Types and the required and optional data for each type and application.
- Document Uploads by Provider Type – this artifact lists all of the supporting documents that a provider is required to submit with their enrollment or revalidation.
- Workflow Diagrams – these diagrams show the steps, users and system actions involved in each step of the PDMS workflows.

The configuration of the system is a set of tasks with a number of activities occurring simultaneously. We review and confirm these changes in Design Sessions with AHCCCS/Med-QUEST SMEs. For configuration items that may be new to the State, such as a new system workflow, our Business Analysts provide structured walkthroughs of the workflows with the State's SMEs. We explain how workflows are changed through configuration modifications in our system and then identify where changes are required. We use the base system flows as a starting point, which allows AHCCCS/Med-QUEST to leverage best practices from previous implementations as a basis for defining the solution. These specifications cover the full range of changes from code tables to the modification of workflow actions that trigger notifications and interface transactions.

Once the design artifacts for a package are reviewed and approved by AHCCCS/Med-QUEST, our Business Analysts coordinate with the development team to make the configuration changes to the system. These changes are then incorporated into our next build increment and visible to our test team. PDMS has several administrative functions available through the user interface that allow our Business Analysts and technical staff to make reference data and configuration changes to the system. During configuration, we also fully leverage the adaptable features within our COTS platform system architecture. We incorporate business rule changes into the Progress Corticon Business Rules engine. We use our MicroStrategy reporting toolset to configure and produce reports. For notice configuration, we take full advantage of the Quadient Inspire correspondence management suite. Workflow modifications are made using our custom-built Business Process (workflow) engine built on the .NET framework.

1.2.4 Software Development

In conjunction with the configuration work, MAXIMUS also builds any new application components to address functionality gaps that cannot be made strictly through system configurations. New customizations are typically limited to specific changes needed for the MMIS interface for a State, Data Conversion, and any State-specific screening/verification sources that may be required. Software components that require customization follow the same incremental build methodology we discussed in *Section 1.2.3: Software Configuration*. Our development team uses the System Design documentation to update the base solution to meet the requirements of AHCCCS/Med-QUEST and the needs of the Provider community. We make sure that we have executed all unit tests on each software component and that they function according to the approved specifications. We group the components together to conduct system and integration testing to confirm proper operation of the system. It is also during this timeframe that our business team begins documenting test scripts and test cases.

1.2.4.1 Interface Development

MAXIMUS works closely with the AHCCCS/Med-QUEST and required Trading Partners to design and construct efficient data exchanges. Interface approaches include application programming interfaces (APIs), web services under a service-oriented architecture (SOA), shared standards-based data stores,

and other means as proposed during analysis. Once all parties agree to the best solution for the PDMS and the Trading Partner, the formatting, editing, and validation rules, data exchange frequency, error reporting, and data correction procedures are defined in the Interface Control Document. From our previous modular implementations, we have accumulated a large library of application components that validate incoming data and format outbound provider data. These pre-built routines will aid design and development for all required interfaces.

Our flexible interface design and expert staff are capable of supporting all interface data transfer integration and associated business rules for Provider data updates. The existing interfaces incorporate checks and balances to make sure data transfers between the Provider Services Module and various Trading Partners are successful. In addition, the interface designs include exception handling to allow MAXIMUS and State authorized users to process any errors encountered in the interface.

By using our Open Interface Framework, we configure the MMIS and other required interfaces to the unique requirements of AHCCCS/Med-QUEST. This provides a quick and effective integration with the MMIS and other external partners while limiting the impact of changes in the PDMS base system. We place heavy emphasis on the MMIS Interface and data conversion and devote a separate track for each in our PWP.

1.2.4.2 Data Conversion Development

Our approach to conversion is based on a proven methodology. We take the test data files from the source systems, stage them, and load them into our secure conversion data test environment. We conduct an initial data analysis in the staging tables to determine where potential data cleansing activities may need to occur. We also test the user interface against the converted data to make sure the user interface is capable of displaying and updating the converted data. We follow a basic process of Extract, Transform, and Load (ETL), with measures taken to safeguard data quality and validation throughout the design, development, and implementation cycle. Our data conversion approach is comprised of four primary steps:

- **Step 1** – Extraction and Analysis
- **Step 2** – Cleansing
- **Step 3** – Transformation
- **Step 4** – Data Loading

We repeat Steps 1 through 3 until all data issues are resolved. We then load and test the data in business test scenarios, such as re-enrollment and provider data updates. We repeat the conversion load process as many times as needed prior to implementation. Each iteration represents a trial conversion pass, with a final, full production conversion load at go-live. From a software development perspective, we leverage reusable components and load procedures from previous implementations to the maximum extent possible but customize where necessary to meet any unique needs for AHCCCS/Med-QUEST. We also integrate the MMIS interface testing with the data conversion process so we are sure we can transfer the converted data back to the MMIS.

MAXIMUS conducts data conversion meetings to review the existing system and begins the mapping exercise between the provider data sources and our solution early in the project. Once data mapping has occurred, we document data gaps, data purification, and data transformation needs in the Conversion Design Document. We identify the source of each data element and any special editing that must occur. We provide the development team with the documentation so they can account for any missing data or data anomalies that require special handling in the web-based components of the system. Regularly scheduled and frequent meetings are critical to keep conversion analysis, design, and development from

delaying System Testing. We also propose that a dedicated team of MAXIMUS, AHCCCS, and Med-QUEST staff should be assigned to four weeks of conversion data analysis work sessions to resolve all conversion issues in a timely manner. Our team will hold follow-up work sessions as necessary to resolve any issues that arise during testing.

1.2.5 Security Configuration

[Additional Information: Section 4.1.3.3]

Security configuration is driven by the System Security Plan (SSP) and by the types of user roles that are defined in support of the system workflows. MAXIMUS OIS is actively engaged beginning with proposal development and continue throughout the implementation and operations. Our security configuration approach takes into account security for each solution component. Our Corporate OIS group helps define the specific security requirements and provides enterprise level tools to scan for vulnerabilities. We conduct internal vulnerability assessments of the application at each build. We also conduct full third-party vulnerability and penetration tests of the application on a yearly basis, correct identified defects, and add them to lessons learned. We provide Test Report results to our clients and work with them on a plan to address the vulnerabilities if required. For the Provider Management System project, MAXIMUS will perform a penetration test six months prior to go live and annually; or when major system changes have occurred. We will utilize an industry standard third party to conduct the testing.

PDMS is packaged with pre-defined roles. Internal users are assigned an account with an associated role. Our flexible role-based security model accommodates different types of configuration for teams and partner access to the system. For example, the Operator role can review and screen the application while the Site Visit Operator role can only perform system functions relating to site visits. In addition to that, our solution provides the ability to grant authorization through role-based security (create, delete, modify and view) access to user interfaces, reports, data elements/field level, menu items, etc. PDMS allows authorized users to create groups and roles and provide access to the groups. Tasks in the workflow can be associated to a group or role and they are automatically assigned to the respective group as the application moves through the workflow. An administrator role is also available with broader access across multiple functional areas, including security administration. MAXIMUS will verify the roles needed for AHCCCS/Med-QUEST authorized staff and Providers during System Design, configure the roles, and validate them during testing.

MAXIMUS provides different environments for system, integration, training, and user acceptance testing (UAT). We will work with AHCCCS/Med-QUEST to define the user access to these environments. PDMS has a user administration module that allows administrators to search for users based on name, NPI, Medicaid ID and user role. PDMS allows the administrator to activate, de-activate, add, reset user password, and to verify security questions to reset a user's password. PDMS can provide state authorized users the functionality to perform such activities in various environments as needed.

1.2.6 Documentation

[Additional Information: Section 4.1.7]

MAXIMUS will submit all project deliverables, including system and user documentation, as required by AHCCCS/Med-QUEST in the timeframe as specified in the approved PWP. Our PDMS base solution is already bundled with extensive project and product documentation. For the PDMS implementation for AHCCCS/Med-QUEST, we will be able to leverage this documentation largely as is, including our screen designs and logical/physical data model documentation. The investment we have made in our product documentation during our previous implementations will save us time throughout all phases of the project while at the same time providing AHCCCS/Med-QUEST with high-quality documentation. MAXIMUS will revise our deliverables to meet the needs for AHCCCS/Med-QUEST.

MAXIMUS will establish an internal Microsoft SharePoint repository to house all project documentation to include deliverables, action items, issues, risks and decision registers, meeting minutes, presentations, design documents, and other project artifacts. The MAXIMUS repository will consist of subfolders for each project phase for project team members to locate easily and update the most current version of each document. SharePoint provides document versioning, backup, and recovery in the event a document becomes corrupted or accidentally overwritten. Based on direction from AHCCCS/Med-QUEST, MAXIMUS will contribute to the AHCCCS/Med-QUEST and/or the Systems Integration Services collaboration site. This may include any of the project's technical and non-technical artifacts.

MAXIMUS will submit a Deliverable Expectations Document (DED) that contains a draft outline and annotated table of contents (ATOC) for all deliverables. Shortly after submission of the ATOC and before work on a deliverable begins, we will meet with AHCCCS/Med-QUEST to discuss and agree upon the content to verify everyone has a common expectation of each deliverable. Our goal is to make the deliverable review process less rigorous by submitting a deliverable format and content that is familiar to AHCCCS/Med-QUEST. This approach eliminates the need for rework and potential schedule delays. We believe that the deliverable expectations of MAXIMUS and AHCCCS/Med-QUEST need to be in full agreement well in advance of the deliverable development and submission.

Each deliverable is submitted with a deliverable review form. This allows AHCCCS/Med-QUEST reviewers to provide specific feedback on the document and allows MAXIMUS to use this same form to make changes and to respond to comments from AHCCCS/Med-QUEST. MAXIMUS also supports feedback, comments, and questions provided in the deliverable document as revisions (MS Word / Track Changes).

1.2.7 Knowledge Transfer

Because of the user-engaged approach we take for implementing our solution, training and knowledge transfer activities essentially begin during the Project Startup phase and continue through Post-Implementation. During the kickoff meeting, the MAXIMUS Business Lead will give a full demonstration of the base PDMS solution. AHCCCS/Med-QUEST users and technical staff will immediately gain a solid understanding of the automation offered by the solution and begin to visualize how the system can assist in optimizing existing business processes in place within each organization. This user-engaged approach continues throughout all of the phases of the project.

For formal training and knowledge transfer, MAXIMUS will provide instructor-led training to AHCCCS/Med-QUEST operations staff during the implementation phase. In addition to providing training on the use of the system, this training includes instructing designated Administrators to manage user accounts and passwords, and training site visit specialists on the use of the system for site visits. We will provide instructor-led Train-The-Trainer (T3) training sessions to designated agency team members, instructors and other staff who are responsible for user and provider training to achieve an understanding of the new system, services, releases, and future enhancements. We will use classroom materials, including but not limited to, courses, job aids, computer-based training modules, videos, user guides, publications and other materials according to AHCCCS/Med-QUEST-approved content, format, and schedules. The number of sessions is dependent upon the number of participants requiring training, with typically no more than 10 participants per session. MAXIMUS will work with AHCCCS/Med-QUEST to identify the training participants and the number of required sessions.

Our training curriculum also includes technical training and knowledge transfer in understanding how to monitor the system through the accurate and complete use of the PDMS online monitoring tools. Our solution contains robust tools and dashboards for AHCCCS/Med-QUEST project resources and designated contractors to monitor the system. In addition, technical and functional documentation serve as additional resources to ensure maximum use of all system monitoring features. For additional

information on our approach for training and knowledge transfer on the project, refer to our responses to requirements in *Section: 1.1.19: Training.*

1.2.8 Cultural Change Management and Communication

The primary focus of our cultural change management approach is creating and implementing organizational change management plans that minimize resistance and maximize user adoption. We develop and apply a structured change management approach and methodology for the people-side of change based on the providers and Medicaid staff affected by the PDMS implementation. Cultural change management and communication will follow a structured path that aligns with the phases outlined for the project, from requirements confirmation through design, development, training, and implementation. Moving from a paper to electronic approach changes many of the functions undertaken by providers and operations staff. However, these features could be met with resistance, and therefore not implemented fully or correctly, if system users are not brought along at the appropriate points in the process.

In practice, our approach includes identifying early in the process key users who will assist in the design configurations of PDMS. Heavy emphasis is placed on the user participation in the definition of the enrollment, revalidation, re-enrollment, and update workflows. We integrate these steps into the requirement review process where users get a demonstration of the PDMS base system. We follow the requirement sessions with a listening session to identify concerns from State staff to gauge their level of support in the project. This step includes identifying a champion of the project who is responsible for encouraging adoption and monitoring staff reaction. Early communication with providers is important as well. Preparing the provider community, especially large provider groups, for the electronic tools coming their way, generates excitement and supports early adoption. Some states even choose to include key provider groups in the user acceptance testing (UAT) process to provide input and support among their peers.

As part of our training approach, our trainers conduct frequent formal and informal assessments to determine whether participants have gained the requisite knowledge of the system and feel comfortable training the end users in a way that promotes system adoption and use. Comprehensive training to users is fundamental to managing change. Users are less likely to be enthusiastic about a system they are not comfortable with its use or, more importantly, the reason it functions as it does.

1.2.9 Deployment and Roll Out Support

During the Implementation Phase, MAXIMUS performs all required tasks to ready the system for implementation and transition to production. These tasks include execution of the Disaster Recovery Testing, System Performance Assessment, the Security Scan and Deployment preparation. As part of our Implementation methodology, MAXIMUS incorporates an Operational Readiness task as a formal method to review the results of testing along with the results of other tasks such as training and infrastructure implementation to determine if the system and business operations as a whole are ready to move to production. The review is a composite of all preparation tasks and serves as a final check to ensure that the application, system configurations, user setups, and operational readiness are complete.

The tasks and activities involved in our Implementation approach will guide the project's Implementation Checklist. This deliverable will be submitted to the State in advance of the Operational Readiness phase and will outline the tasks and activities required to deploy the Provider Services solution. The planning documentation that we produce leading up to production roll out (Go-Live) will be detailed and well scripted, and will clearly define the individual persons responsible for each of the Go-Live tasks. From a system perspective, we plan for a specific set of tasks related to both the Provider Services system deployment to the production environment as well as coordinating the deployment of the MMIS system changes that will need to be in place once the system is in production.

The Implementation Checklist identifies all the activities that must be done prior to when a go live decision can be rendered. Testing must be completed, defects must be remediated, and security protection and disaster recovery capability must be confirmed. Users must be trained, providers must be notified, and the production data center, database, and applications must be deployed. The Implementation Checklist defines these tasks, establishes target completion dates, and defines responsibility for each of the categories of implementation tasks.

Other Implementation Checklist tasks include verification of dashboard reporting for SLAs, production report readiness assessment, interface transaction error reporting, Provider communications, and a confirmation of SLA agreements. In preparation for the Go/No Go decision, MAXIMUS works collaboratively with AHCCCS/Med-QUEST through daily implementation meetings to monitor progress on the Implementation Checklist tasks and make course corrections if necessary. All of these activities lead to submission of the Operational Readiness Document, which provides AHCCCS/Med-QUEST with a detailed view of the readiness of the system and operations for production. Once AHCCCS/Med-QUEST gives the approval to implement PDMS, we transition into executing the actual tasks required to deploy the production application, as discussed in *Section 1.2.10: Production Transfer*.

We have created an implementation plan that allows for the option of AHCCCS and Med-Quest to be implemented on different release schedules. We are able to support this scenario; however, to best leverage project resources we are assuming that both systems will be implemented on the same date as shown in our proposed project schedule. Refer to *Section 1.3: Timeline* for a summary view of the PWP we created for the proposal. To build in flexibility for two different implementation schedules, our plan reflects separate tasks and activities for both State implementations, where required during the DDI phase of the project. We will work with AHCCCS/Med-QUEST to determine the best implementation schedule for each state. [Additional Information: Section 4.3]

1.2.10 Production Transfer

After the acceptance criteria have been met and the States indicate the system is ready to “Go-Live,” a flurry of Implementation Checklist tasks need to occur leading up to production implementation. Notifications are issued to providers to announce the new system. State web sites that contain instructions to Medicaid providers are updated with new instructional materials and links to the new Provider Services web portal are activated.

Leading up to the implementation, weekly release planning meetings will be conducted. The tasks required for the system implementation must be carefully coordinated between AHCCCS, Med-QUEST, and MAXIMUS. Using these procedures, and through careful planning, we were able to successfully implement our initial Production releases in Nebraska and the District of Columbia over a single weekend. This resulted in minimal impact to the Provider community, to each State’s MMIS, and to State Provider Services staff. The conversion data extracts are taken from the source systems as close as possible to the go live date. This is to verify the data in the new PDMS is current with the source systems. We then run the production conversion load process to load each production database with the MMIS data. In both implementations, the web portal was available on Monday morning and the first transactions sent to the MMIS that same night.

During implementation, MAXIMUS deploys a production release of the application that includes all COTS products to the production platform. We also confirm that the disaster recovery site is operational. We schedule and confirm all batch production jobs. This includes interface file exchanges if they cannot be performed via web services. Procedures for reporting system problems are defined and tested. A security scan of the application software is performed prior to the production build. Once the scan is complete, the build is deployed to the production environment. The final activity before loading the users’ security profiles is a smoke test conducted by MAXIMUS, which verifies that the production build is complete,

functioning, and ready for operations. Links to the new application are enabled and Providers and the AHCCCS/Med-QUEST staff can begin using the system.

1.2.11 Post-Implementation Support

Once the system is implemented, we provide two (2) months of post-implementation support. This support includes stabilization of the newly implemented production system along with all required post-implementation deliverables. During this support period, we will work in partnership with the AHCCCS/Med-QUEST to identify areas of the newly installed system that may not be performing to the specifications set forth in the implementation plan or where questions may exist about how a function is operating. MAXIMUS business and technical resources will immediately begin work to resolve the non-compliant system functions and will track and address all reported issues and defects.

MAXIMUS uses a well-defined and proven approach to application support of the PDMS after implementation. Post-Implementation support is not simply a break-fix and enhancement effort. Our support team performs a variety of tasks to keep the system operating at the best possible level of performance with no disruptions in service. These activities include:

- Resolving issue reports
- Monitoring system performance
- Monitoring and updating system security
- Verifying the execution of batch procedures
- Distribution of regularly scheduled reports
- Answering questions for business users
- Prioritizing, planning, scheduling, testing and implementing system enhancements
- Implementing third party software upgrades
- Implementing hardware and network upgrades

MAXIMUS uses JIRA as the central repository for defects and enhancement tickets. States can enter tickets directly into JIRA, but for the support period, we utilize a Customer Service Request (CSR) form to facilitate the exchange and formalize the communication process. Based on past projects, CSRs helping staff verify the request is not duplicated and contains supporting documentation to help the system staff understand the issue. The State emails completed forms to an inbox monitored by MAXIMUS technical and business support staff. Upon receipt of the CSR, the MAXIMUS business analyst logs the request in the JIRA tracking tool. If the request indicates an error has occurred, our business analyst researches, documents, and assigns a priority. If the issue can be resolved without a software change, we propose a resolution and close the issue. If the business analyst cannot resolve the issue, the analyst passes the JIRA ticket to the development lead for further triage and assignment based on the request's priority.

MAXIMUS staff logs enhancement requests in JIRA. MAXIMUS works these items similar to system defects, except AHCCCS/Med-QUEST management will set the priority for enhancements, determine when they are needed, and provide approval to proceed using the enhancement hour bucket. MAXIMUS will work with AHCCCS/Med-QUEST to develop the schedule for software releases in advance. We typically schedule software releases every three to four weeks during the support period, which may include defect fixes and enhancements. All software changes go through three testing cycles: unit, system/integration, and user acceptance. After the production deployment, MAXIMUS staff smoke test the software release to verify it is ready for production.

In additional to the production support of the implemented systems, MAXIMUS also creates and submits all required post-implementation deliverables. These include the Post-Implementation Plan, Revised System Documentation, and Operations & Maintenance Plan. The planning documents are submitted very early in the Post-Implementation phase. Revisions to system documentation occur ongoing as needed based on potential changes to system functions. Post-implementation, MAXIMUS also continues to issue weekly status reports and hold status meetings. Much of the discussion at the weekly meetings relates to service requests initiated by our clients.

1.3 Timeline

Based on lessons learned from our past implementations and anticipated risks for this project, we determined that a 10-month implementation effort provides adequate time to successfully complete the project and comply with all RFP system requirements. The 10-month period will be followed by a 2-month post-implementation support period to allow for system stabilization and to create post-implementation deliverables. Following post-implementation, our implementation plan extends an additional 4 months to include the support required to assist the IV&V and AHCCCS/Med-QUEST in preparing to request CMS certification that can only occur after six months of production operations. In this section of our proposal, we provide an overview of each of the major project phases, tasks, deliverables, and milestones required to implement the PDMS solution for AHCCCS and Med-Quest. [Additional Information: Section 4.3]

1.3.1 Project Management

MAXIMUS provides the required project management support throughout all phases of the project. Within the first 10 days of the project, MAXIMUS submits the Project Management Plan and the Project Work Plan (PWP) to each State for review and approval. *Exhibit 1.3-1* shows a summary view of the PWP as it relates to our project management support on the project.

WBS	Task Name	Duration	Start	Finish
1	**AZ/HI Provider Management System Implementation Phase**	**350 days**	**Mon 8/27/18**	**Tue 12/31/19**
1.1	**Milestone: Contract Start Date**	0 days	Mon 8/27/18	Mon 8/27/18
1.2	**Project Management**	**350 days**	**Mon 8/27/18**	**Tue 12/31/19**
1.2.1	**Planning Deliverables**	**12 days**	**Mon 8/27/18**	**Tue 9/11/18**
1.2.1.2	**Deliverable: Submit Project Management Plan**	0 days	Tue 9/4/18	Tue 9/4/18
1.2.1.5	**Deliverable: Submit Project Work Plan**	0 days	Tue 9/4/18	Tue 9/4/18
1.2.2	**Ongoing Project Management Support**	**350 days**	**Mon 8/27/18**	**Tue 12/31/19**

Exhibit 1.3-1: Project Management Tasks and Milestones. *By providing project management expertise to the PDMS implementation system, AHCCCS/Med-QUEST can rely on support throughout the implementation period.*

1.3.2 Project Startup

During project startup, MAXIMUS prepares for and conducts a project kickoff meeting for the project. The kickoff meeting brings all the stakeholders together and presents the project team with a clear picture of the short-term and long-term goals and timelines required for the project. We review the processes and procedures included in our Project Management Plan (PMP) and make adjustments based on stakeholder input. Environments are established and preparation gets underway for Requirements Confirmation. *Exhibit 1.3-2* shows the key activities necessary to initiate the project.

WBS	Task Name	Duration	Start	Finish
1.3	**Phase: Project Startup**	**7 days**	**Mon 8/27/18**	**Tue 9/4/18**
1.3.1	Prepare and Conduct Project Kick-off Presentation	3 days	Mon 8/27/18	Wed 8/29/18
1.3.2	**Milestone: Project Kickoff Complete**	0 days	Wed 8/29/18	Wed 8/29/18
1.3.3	Implement SharePoint Project Repository	3 days	Thu 8/30/18	Mon 9/3/18
1.3.4	Prepare for Requirements Confirmation/Gap Analysis (RGA) Sessions	3 days	Thu 8/30/18	Mon 9/3/18
1.3.5	Establish PDMS Demo Environment	4 days	Thu 8/30/18	Tue 9/4/18

Exhibit 1.3-2: Project Startup Tasks & Milestones. *We use a highly collaborative approach when beginning an implementation and support our approach with thorough project schedules and documentation.*

1.3.3 Requirements Confirmation & Gap Analysis

To accommodate the potential differences in workflows and business processes between AHCCCS and Med-QUEST, we have staffed the project with a Business Track Lead for AHCCCS and a Business Track Lead for Med-QUEST, each reporting to the project's Business Lead. For functional requirements

confirmation, MAXIMUS will schedule separate Requirement and Gap Analysis (RGA) sessions for Arizona and Hawaii. We will also hold joint RGA sessions to review infrastructure, security, privacy, data conversion and interface requirements. Structuring our business team in this fashion benefits AHCCCS/Med-QUEST by providing expertise at the project level as well as building program expertise at the individual track level throughout all downstream phases of the project. We leverage the project staff for items that are can be jointly defined. The resulting deliverables for Requirements Confirmation are submitted to the States within 30 days of contract start, as shown in *Exhibit 1.3-3.*

WBS	Task Name	Duration	Start	Finish
1.4	**Phase: Requirements Confirmation & Gap Analysis**	**25 days**	**Tue 9/4/18**	**Mon 10/8/18**
1.4.1	**Functional Requirements Confirmation**	**25 days**	**Tue 9/4/18**	**Mon 10/8/18**
1.4.1.1	Conduct RGA Functional Sessions - Arizona	10 days	Tue 9/4/18	Mon 9/17/18
1.4.1.2	Conduct Business Process/Workflow Analysis - Arizona	3 days	Tue 9/18/18	Thu 9/20/18
1.4.1.3	Conduct RGA Functional Sessions - Hawaii	10 days	Thu 9/6/18	Wed 9/19/18
1.4.1.4	Conduct Business Process/Workflow Analysis - Hawaii	3 days	Thu 9/20/18	Mon 9/24/18
1.4.1.5	**Deliverable: Submit RTM & Gap Analysis Document**	0 days	Mon 9/24/18	Mon 9/24/18
1.4.2	**Technical & Non-Functional Requirements Confirmation**	**13 days**	**Tue 9/11/18**	**Thu 9/27/18**
1.4.2.4	**Deliverable: System Security Plan (SSP)**	0 days	Tue 9/18/18	Tue 9/18/18
1.4.2.6	**Deliverable: Risk Assessment Plan**	0 days	Thu 9/20/18	Thu 9/20/18
1.4.3	**Milestone: Requirements Confirmation Complete**	0 days	Mon 10/8/18	Mon 10/8/18

Exhibit 1.3-3: Requirements Confirmation Tasks & Milestones. *Requirements confirmation and gap analysis are other strategies we use to thoroughly define the project and keep it on track.*

1.3.4 System Design

MAXIMUS takes the inputs gathered from Requirements Confirmation, conducts Design Sessions with AHCCCS/Med-QUEST subject matter experts, and incrementally creates the System Design Documentation (SDD) packages that the States use to confirm the PDMS configuration. The SDD packages are used to guide our technical team in configuring the system to align with specific AHCCCS/Med-QUEST workflows and business rules, defining data requirements, and for developing new or modifying existing interfaces and any other custom functionality changes. *Exhibit 1.3-4* shows the key activities and deliverables we complete during the System Design Phase of the project. As shown, all design documentation is submitted within 60-90 days from the contract start date.

WBS	Task Name	Duration	Start	Finish
1.5	**Phase - System Design**	**55 days**	**Tue 9/18/18**	**Mon 12/3/18**
1.5.1	**Design - PDMS Web Portal Enrollment Components**	**51 days**	**Tue 9/18/18**	**Tue 11/27/18**
1.5.1.1.5	**Deliverable: Submit Design Package 1**	0 days	Thu 10/18/18	Thu 10/18/18
1.5.1.2.5	**Deliverable: Submit Design Package 2**	0 days	Mon 10/29/18	Mon 10/29/18
1.5.1.3.3	**Deliverable: Submit Design Package 3**	0 days	Mon 11/5/18	Mon 11/5/18
1.5.1.4.5	**Deliverable: Submit Design Package 4**	0 days	Tue 11/20/18	Tue 11/20/18
1.5.2	**Interface Design**	**45 days**	**Tue 9/25/18**	**Mon 11/26/18**
1.5.2.6	**Deliverable: Submit Interface Control Documents**	0 days	Mon 11/12/18	Mon 11/12/18
1.5.3	**Conversion Design**	**45 days**	**Tue 10/2/18**	**Mon 12/3/18**
1.5.3.4	**Deliverable: Submit Conversion Design Document**	0 days	Mon 11/19/18	Mon 11/19/18
1.5.4	**System Architecture Design Confirmation**	**29 days**	**Wed 10/3/18**	**Mon 11/12/18**
1.5.4.10	**Deliverable: Submit System Architecture Document**	0 days	Mon 10/29/18	Mon 10/29/18

Exhibit 1.3-4: System Design Tasks & Milestones. *We work towards milestones that show our progress.*

1.3.5 Software Development & Configuration

Our incremental development and configuration approach enables the States to quickly see the results of our configuration efforts in meeting requirement gaps. This approach facilitates enabling both MAXIMUS

and the State teams to spend more time on testing. We successfully used this approach in Tennessee, Nebraska, and the District of Columbia. *Exhibit 1.3-5* shows the key tasks and milestones that need to be completed during this phase. As shown in the Exhibit, we begin this phase within 60 days of the contract start date, well within the 120 window required in the RFP.

WBS	Task Name	Duration	Start	Finish
1.6	**Phase - Development/Configuration**	**97 days**	**Mon 10/15/18**	**Wed 2/27/19**
1.6.3.3	Milestone: Functional Package 1 Development/Configuration Complete	0 days	Thu 1/17/19	Thu 1/17/19
1.6.4.3	Milestone: Functional Package 2 Development/Configuration Complete	0 days	Mon 1/28/19	Mon 1/28/19
1.6.5.3	Milestone: Functional Package 3 Development/Configuration Complete	0 days	Tue 2/26/19	Tue 2/26/19
1.6.6.3	Milestone: Functional Package 4 Development/Configuration Complete	0 days	Tue 2/26/19	Tue 2/26/19
1.6.7.6	Milestone: Interface Development/Configuration Complete	0 days	Wed 2/27/19	Wed 2/27/19
1.6.8.4	Milestone: Conversion Development/Configuration Complete	0 days	Tue 2/19/19	Tue 2/19/19
1.6.9	**Disaster Recovery Plan**	**16 days**	**Tue 2/5/19**	**Tue 2/26/19**
1.6.9.4	Deliverable: Submit Disaster Recovery Plan	0 days	Tue 2/12/19	Tue 2/12/19

Exhibit 1.3-5: Software Development & Configuration Tasks & Milestones. *Our configuration approach allows AHCCCS/Med-QUEST to see the results of our configuration efforts.*

1.3.6 System, Integration, and Regression Testing

System Testing begins when we have assembled incrementally tested functionality for a design package. Our plan calls for multiple System Test cycles for both AHCCCS and Med-QUEST. At the completion of the last System Test cycle, we conduct a full Regression Test and resolve any regression issues prior to beginning Integration Testing. Integration Testing includes a full data conversion load and exchanges of interface test files with external partners. *Exhibit 1.3-6* illustrates the activities that need to be completed during testing. As shown, testing activities begin well within the 160-day window required in the RFP.

WBS	Task Name	Duration	Start	Finish
1.7	**Phase - System, Integration, & Regression Testing**	**180 days**	**Mon 8/27/18**	**Fri 5/3/19**
1.7.1.5	Deliverable: Submit Test Management Plan	0 days	Thu 1/17/19	Thu 1/17/19
1.7.2.3	**Conduct System Test - AZ**	**43 days**	**Fri 1/18/19**	**Tue 3/19/19**
1.7.2.4	**Conduct System Test - HI**	**43 days**	**Fri 1/18/19**	**Tue 3/19/19**
1.7.3.1	**Conduct Regression Test - AZ**	**5 days**	**Wed 3/20/19**	**Tue 3/26/19**
1.7.3.1.4	Milestone: System Test Complete AZ-PDMS	0 days	Tue 3/26/19	Tue 3/26/19
1.7.3.2	**Conduct Regression Test - HI**	**152 days**	**Wed 3/20/19**	**Tue 3/26/19**
1.7.3.2.4	Milestone: System Test Complete HI-PDMS	0 days	Mon 8/27/18	Mon 8/27/18
1.7.4.1	**Conduct Integration Testing - AZ**	**31 days**	**Fri 3/22/19**	**Fri 5/3/19**
1.7.4.2	**Conduct Integration Testing - HI**	**31 days**	**Fri 3/22/19**	**Fri 5/3/19**
1.7.5	**Conversion Testing**	**26 days**	**Wed 2/20/19**	**Wed 3/27/19**

Exhibit 1.3-6: System, Integration, & Regression Testing Tasks & Milestones. *System, integration, and regression testing help to resolve any issues as we build functionality for the project.*

1.3.7 Training

In our proposed plan, we prepare and submit the Training Plan within six months of the contract start date, well in advance of the User Acceptance Test phase. Once the Training Plan is approved, we begin tailoring our training materials to meet the unique requirements for AHCCCS/Med-Quest and reflect the system configuration efforts. We conduct Train-the-Trainer sessions immediately prior to the start of UAT. Separate training sessions are planned for AHCCCS and Med-Quest, as well as a technical training session for State technical staff. *Exhibit 1.3-7* shows the key tasks and milestones for Training.

WBS	Task Name	Duration	Start	Finish
1.8	**Phase - Training**	**66 days**	**Fri 2/1/19**	**Mon 5/6/19**
1.8.1.2	Deliverable: Submit Training Plan	0 days	Thu 2/28/19	Thu 2/28/19
1.8.2	**Training Materials**	**36 days**	**Fri 3/1/19**	**Fri 4/19/19**
1.8.3	**Train-the-Trainer Training**	**10 days**	**Mon 4/22/19**	**Fri 5/3/19**
1.8.3.1	Conduct Train-the-Trainer Training - AHCCCS	4 days	Mon 4/22/19	Thu 4/25/19
1.8.3.2	Conduct Train-the-Trainer Training - Med-QUEST	4 days	Mon 4/29/19	Thu 5/2/19
1.8.3.3	Conduct Technical Training - AHCCCS/Med-Quest	1 day	Fri 5/3/19	Fri 5/3/19
1.8.4	Milestone: Training Complete	0 days	Mon 5/6/19	Mon 5/6/19

Exhibit 1.3-7: Training Tasks & Milestones. *We prepare a training plan and materials prior to the UAT.*

1.3.8 User Acceptance Testing (UAT)

UAT commences immediately following the successful completion of Integration Testing. UAT is the final system-focused test before we proceed to the Operational Readiness assessments. Our plan calls for the support of six weeks of UAT for both States, which has proven sufficient in our previous three implementations. During UAT, AHCCCS/Med-QUEST will focus on validating compliance with approved requirements and validation of converted data. *Exhibit 1.3-8* shows the activities that need to be completed for UAT.

WBS	Task Name	Duration	Start	Finish
1.9	**Phase - User Acceptance Testing**	**39 days**	**Tue 4/23/19**	**Fri 6/14/19**
1.9.3	**Conduct UAT - AZ**	**30 days**	**Mon 5/6/19**	**Fri 6/14/19**
1.9.4	**Conduct UAT - HI**	**30 days**	**Mon 5/6/19**	**Fri 6/14/19**
1.9.5	Milestone: UAT Complete	0 days	Fri 6/14/19	Fri 6/14/19

Exhibit 1.3-8: User Acceptance Testing Tasks & Milestones. *A closely monitored UAT demonstrates our preparedness for an Operational Readiness assessment.*

1.3.9 Implementation

Our Implementation approach includes Operational Readiness Assessment and Implementation, which will lead to a successful implementation of each State's Provider Management System. During Operational Readiness, we perform all required tasks to ready the system for implementation and transition to production. Once these tasks are completed, we seek approvals to go forward with the production implementation for each State. *Exhibit 1.3-9* shows the tasks for Implementation, which occurs within 10 days of acceptance of the Integrated Test Results, as required by the RFP.

WBS	Task Name	Duration	Start	Finish
1.1	**Phase - Implementation**	**31 days**	**Mon 5/20/19**	**Mon 7/1/19**
1.10.1.5	Milestone: Performance Tuning Complete	0 days	Thu 6/13/19	Thu 6/13/19
1.10.2.4	Milestone: Disaster Recovery Test Complete	0 days	Wed 6/12/19	Wed 6/12/19
1.10.3.3	Milestone: Security Scan Complete	0 days	Mon 6/17/19	Mon 6/17/19
1.10.4	**Operational Readiness Assessment**	**25 days**	**Mon 5/20/19**	**Fri 6/21/19**
1.10.4.1.6	Deliverable: Integrated Test Results - AZ	0 days	Fri 6/14/19	Fri 6/14/19
1.10.4.2.6	Deliverable: Operational Readiness Documentation - AZ	0 days	Fri 6/14/19	Fri 6/14/19
1.10.4.3	Obtain Go-No-Go Decision from AHCCCS	0 days	Fri 6/21/19	Fri 6/21/19
1.10.6.1.6	Deliverable: Integrated Test Results - HI	0 days	Fri 6/14/19	Fri 6/14/19
1.10.6.2.6	Deliverable: Operational Readiness Documentation - HI	0 days	Fri 6/14/19	Fri 6/14/19
1.10.6.3	Obtain Go-No-Go Decision from Med-QUEST	0 days	Fri 6/21/19	Fri 6/21/19
1.10.5	**Implementation**	**6 days**	**Mon 6/24/19**	**Mon 7/1/19**
1.10.5.5	Milestone: Operational Start - AZ-PDMS	0 days	Mon 7/1/19	Mon 7/1/19
1.10.6.4.5	Milestone: Operational Start - HI-PDMS	0 days	Mon 7/1/19	Mon 7/1/19

Exhibit 1.3-9: Implementation Tasks & Milestones. *Thorough operational readiness assessments are a standard component of our progress towards production implementation.*

1.3.10 Post-Implementation Support

Once each system is implemented, we provide two months of post-implementation support. This support includes stabilization of each newly implemented production system along with all required post-implementation deliverables. All post-implementation deliverables are submitted within 60 days of Integrated Testing Acceptance, as required by the RFP. *Exhibit 1.3-10* shows the tasks and timelines required for Post-Implementation.

WBS	Task Name	Duration	Start	Finish
1.11	**Phase - Post Implementation**	**45 days**	**Mon 7/1/19**	**Fri 8/30/19**
1.11.1	**Post-Implementation Production Support**	**45 days**	**Mon 7/1/19**	**Fri 8/30/19**
1.11.2.2	Deliverable: Submit Post Implementation Plan (AHCCCS/Med-Quest)	0 days	Wed 7/3/19	Wed 7/3/19
1.11.3.6	Milestone: Implementation Documentation Delivery	0 days	Fri 8/16/19	Fri 8/16/19
1.11.4.3	Deliverable: Submit Operations & Maintenance Plan	0 days	Mon 8/19/19	Mon 8/19/19
1.12	Milestone: AZ/HI Post-Implementation Support Complete	0 days	Fri 8/30/19	Fri 8/30/19

Exhibit 1.3-10: Post-Implementation Tasks & Milestones. *To make sure systems are stabilized and deliverables are approved, we provide two months of post-implementation support.*

1.3.11 IV&V Coordination & Reporting

Our approach to CMS certification calls for activities to occur throughout the implementation phases of the project. Under current requirements, certification cannot be requested until the system has been in operation for six months. We use the six-month post-implementation period to prepare all of the required documentation leading up to the certification request. MAXIMUS provides a combination of business and technical support staff to support the States in achieving CMS certification. Given the timeframes for the project, we anticipate that actual certification will occur during the first year of Maintenance and Operations. We have included specific support during that period to support the final certification activities. *Exhibit 1.3-11* shows the timelines required for IV&V coordination and requesting CMS certification.

WBS	Task Name	Duration	Start	Finish
1.13	**Phase - IV&V Coordination & Reporting**	**352 days**	**Mon 8/27/18**	**Tue 12/31/19**
1.13.1	**Ongoing IV&V Coordination**	**350 days**	**Mon 8/27/18**	**Tue 12/31/19**
1.13.2	**Certification Planning**	**60 days**	**Mon 5/6/19**	**Fri 7/26/19**
1.13.3	**Certification Documentation**	**60 days**	**Mon 7/29/19**	**Fri 10/18/19**
1.13.3.4	Deliverable: Submit Certification Package	0 days	Fri 9/20/19	Fri 9/20/19
1.13.4	**CMS Certification Review Preparation**	**40 days**	**Mon 10/21/19**	**Fri 12/13/19**
1.13.5	Milestone: Request CMS Certification Review	0 days	Tue 12/31/19	Tue 12/31/19

Exhibit 1.3-11: IV&V Coordination & Reporting Tasks & Milestones. *Having support from an experienced team during the Certification Planning and Request period leads to improved outcomes for certification requests.*

MAXIMUS®

2: Experience and Expertise

2. Experience and Expertise

RFP Section Special Instructions 3.2, Page 31

Our success in implementing modular provider enrollment and management systems in three states is unsurpassed in the Medicaid market. These projects provide a solid foundation for meeting the requirements of the Provider Management System. Partnering with a well-known Medicaid market leader, with diverse Medicaid Provider experience and a strong client focus minimizes risk and allows Arizona and Hawaii to achieve each State's goals and objectives for this project.

2.1 Past Performance

RFP Section Special Instructions 3.2.1, Page 31

In this subsection, we describe our company's qualifications and experience to provide the services specified in this Provider Management System RFP.

About MAXIMUS

MAXIMUS, Inc. was founded in 1975 with a mission of "*Helping Government Serve the People*®." We partner with governments at all levels to provide critical health and human services programs. We deliver innovative business process management and technology solutions that contribute to improve outcomes for citizens and deliver higher levels of productivity, accuracy, accountability, and efficiency for government-sponsored programs. With more than 18,000 employees worldwide, MAXIMUS is a proud partner to government agencies in the United States, Australia, Canada, Saudi Arabia, Singapore, and the United Kingdom.

In 2006, MAXIMUS established the subsidiary, MAXIMUS Human Services, Inc., to focus on providing government human services agencies with a variety of business process services and related consulting services.

In 2007, MAXIMUS established the subsidiary, MAXIMUS Health Services, Inc., to focus on providing government health services agencies with health care operational and systems services. These encompass support for Medicaid, CHIP, health insurance exchanges, eligibility and enrollment modernization, long-term care programs, and MMIS and health information technology consulting.

Exhibit 2-1 shows our corporate organizational structure.

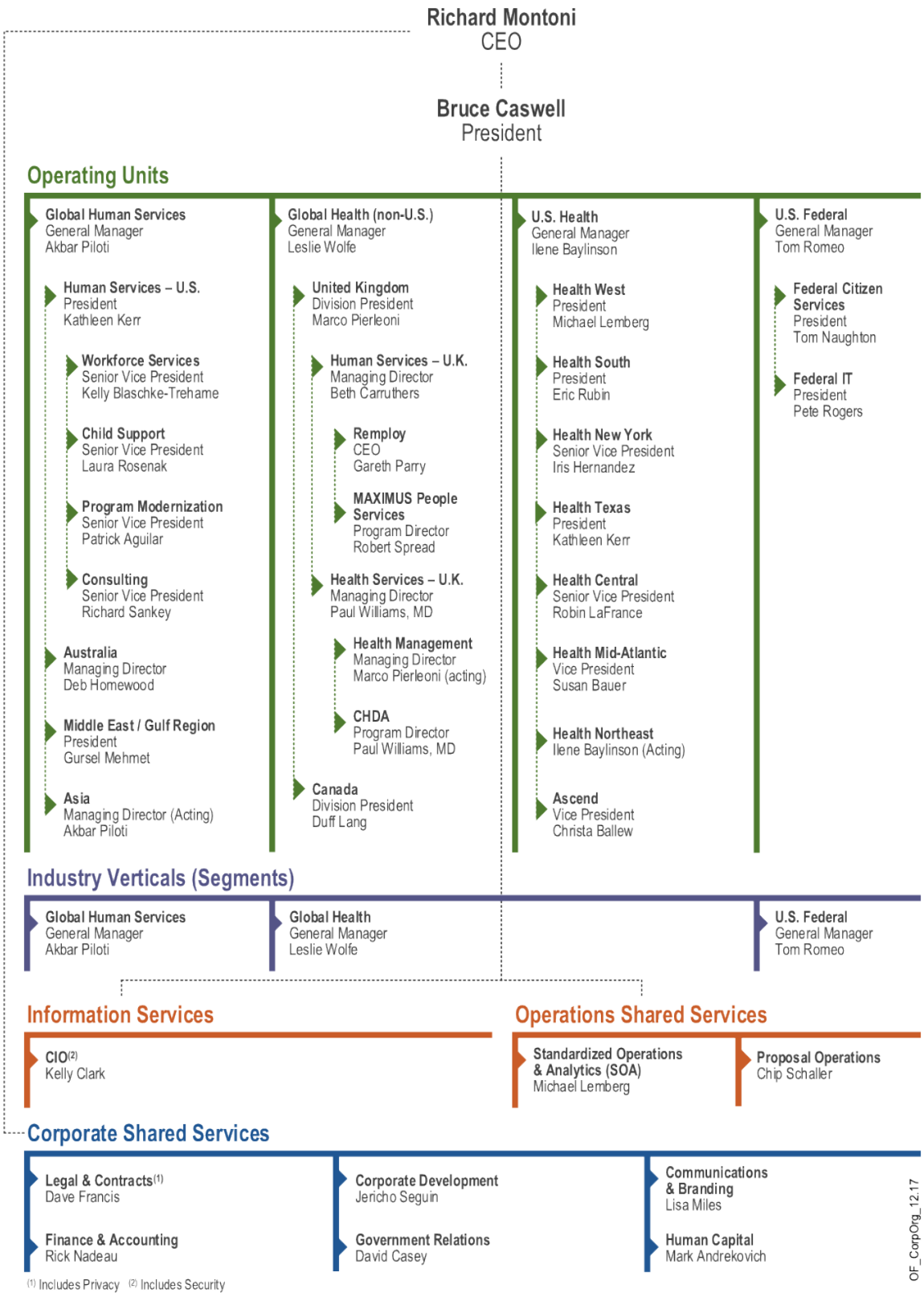

Exhibit 2-1: Corporate Organization Chart. *Our corporate organization provides a solid, reliable structure that supports our Human Services division and provides shared operational resources.*

Our strength is founded in our deliberate focus on health and human services solutions.

Medicaid Experience

Serving more than three quarters of the Medicaid managed care market, MAXIMUS has grown to be the leading contractor in the nation in providing Medicaid enrollment broker and CHIP administrative operations. We have continued to expand into other services areas, including Provider Enrollment and Screening systems and operations. As shown in *Exhibit 2-2: Medicaid and Provider Services Experience*, we operate health operations projects across 35 states and the District of Columbia for our government partners, including 30 State Medicaid programs.

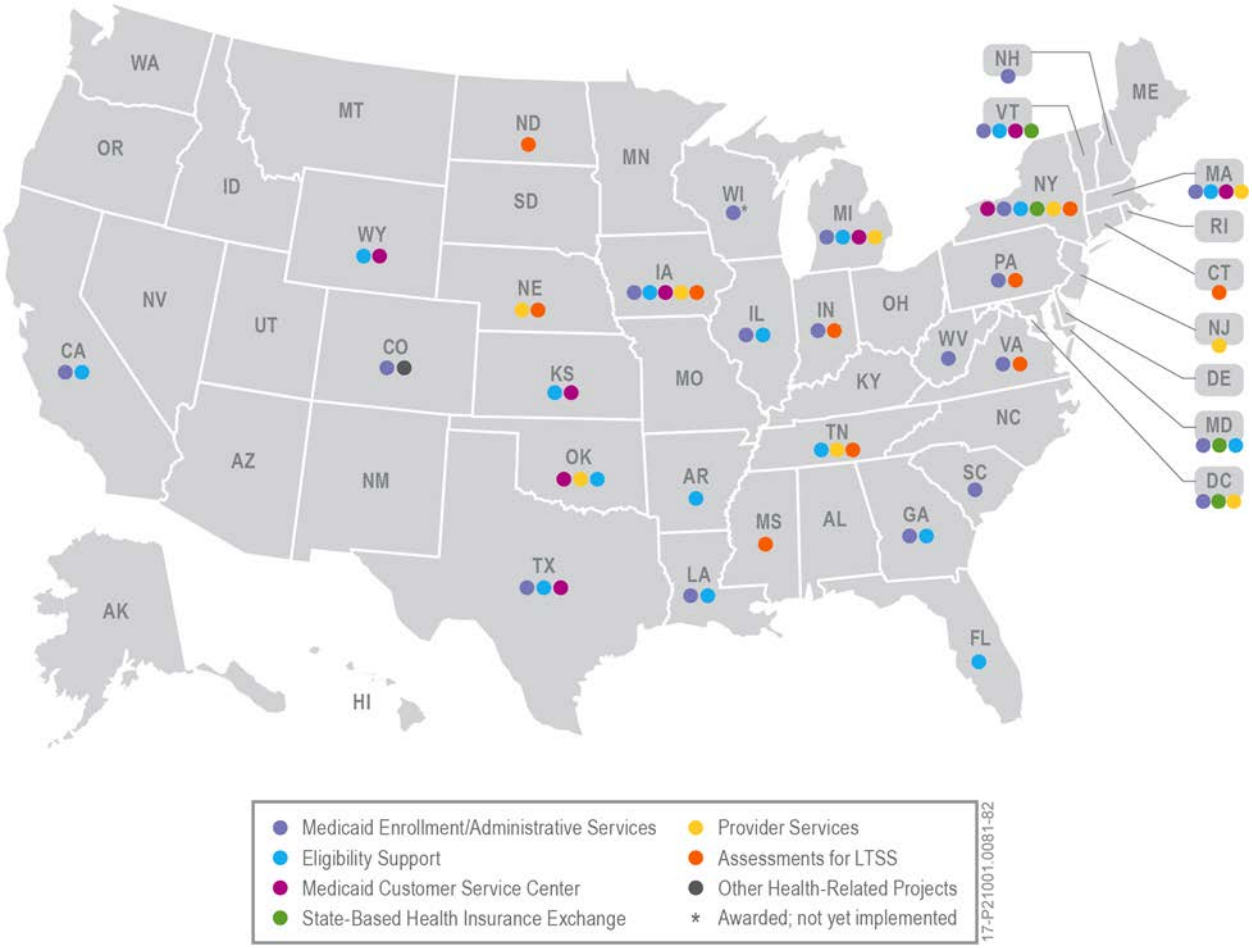

Exhibit 2-2: Medicaid and Provider Services Experience. *We operate 29 Medicaid-related projects, along with other health and human services projects in 35 states.*

Our large footprint of Medicaid projects allows us to appreciate how the various Medicaid components work together. We understand that Provider management is not isolated from other services within Medicaid, but is highly integrated with the larger Medicaid and health care environments. MAXIMUS leverages best practices and lessons learned from our Medicaid Provider experience and from our wide array of health services projects (including Enrollment Broker, Health Insurance Exchange, and eligibility support) to craft solutions that meet the requirements for the entire Program, understanding the role providers take in providing health care services to Medicaid Members.

Provider Services Experience

Since the passing of the Patient Protection and Affordable Care Act (ACA) in 2010, MAXIMUS has been involved in the implementation of this monumental policy. We focused on helping our clients achieve compliance with the Provider enrollment and screening requirements included in the ACA. When CMS began promoting modularity as a key building block for new Medicaid support systems, we were at the forefront with a modular Provider Management solution we developed and implemented in Tennessee. From this start, we now have a proven provider module that we have implemented in three states and that has undergone a full CMS certification review. In addition, we also deliver Medicaid Provider Management services to a variety of customers, using both our modular solution and, in some instances, the legacy MMIS. This combination of system and services expertise is unsurpassed in the Medicaid market. Our clients in Tennessee, Iowa, Massachusetts, Nebraska, and the District of Columbia are some of the first agencies to achieve compliance with these new requirements, and this experience provides the background and experience for our AHCCCS/Med-QUEST Provider Management System proposal.

MAXIMUS is the first company to develop and implement an independent Provider Management IT solution outside of the traditional MMIS. We accomplished this project in 2011 in partnership with the State of Tennessee as they moved away from a traditional MMIS model to one that more fully supported their managed care Medicaid Program. As modularity ideas have advanced, MAXIMUS has extended our solution into a model to transition fiscal agent operations into standalone business services components governed by service level agreements and technology requirements. This approach benefits our clients by allowing the incremental modernization of systems and services to improve the quality of services delivered. It also enables clients to control how and when new services and supporting technology are delivered. The Provider community specifically benefits from having a customer-centric, intuitive, web-based solution that eliminates mounds of paper and encompasses a variety of communication methods that support the modern technology currently used by the larger Medicaid Provider population.

And we have not stopped there. We have combined our system and services expertise into an integrated offering that includes all of the services required to meet CMS Medicaid Provider Management certification requirements. We are currently pursuing modular certification for our integrated solutions in Nebraska and the District of Columbia. Nebraska has completed the full certification review and is waiting for notice from CMS. DC is currently working through the IV&V reviews. We expect both modular solutions to be federally certified well before the Arizona Provider Management System project begins.

MAXIMUS continues to work with multiple states, forming new ideas for how Provider data should be structured and made available outside of the traditional MMIS to avoid built-in constraints that impact data sharing and advanced business processes. Our extensive modular solution expertise brings the skills, experience, and qualifications to implement our solution for AHCCCS and Med-QUEST.

Broad Experience Benefits AHCCCS/Med-QUEST

Success in delivering the Provider Management System requires an intricate mix of Medicaid Provider management expertise, understanding of the requirements, ability to provide experienced project management to implement systems and operations simultaneously, and an experienced, customer-focused technology team able to quickly understand and implement the AHCCCS's priorities. Modular implementations add complexity because of the need to integrate with the other components of the Medicaid Enterprise. Our ability to deliver the services that the AHCCCS/Med-QUEST seeks for this solution is reflected in several of our key corporate attributes:

- **Experience Providing Modular ACA-Compliant Solutions.** MAXIMUS was the first vendor to implement a modular provider management system. We now have three modular provider solutions

in production for State Medicaid clients — more than any other vendor. The MAXIMUS Provider Management System was developed and customized specifically for Medicaid Provider Management and offers the ability to operate Provider functions outside of the traditional MMIS model. Our fully ACA-compliant Provider Management System automates all Provider management functions and facilitates the process of properly screening and re-validating Providers to ensure that they meet all Medicaid eligibility guidelines. It is a web-based solution designed for Provider self-service and screening automation, supported by a flexible data integration platform that addresses all ACA requirements and is able to integrate with existing legacy systems.

- **Experience Supporting Provider Self-Service Access.** The Provider registration portals built by MAXIMUS are designed to optimize and encourage self-service through easy-to-use functions and time saving capabilities. We focus on those areas that are problematic, such as electronic submission, including document upload functionality, front-end profile editing, and web-based access. We have built functionality that Providers understand will save them time and resources when they need to update or maintain their data. Our self-service registration portal is currently driving 100 percent online submission of Provider applications in Tennessee, and has been instrumental in vastly reducing paper applications in our other Provider operations projects.
- **Provider Management System and Provider Operations Experience.** From a Provider system and services perspective, MAXIMUS is working with multiple states with different scopes of work. In Tennessee, we are responsible for the design, development, and implementation of technology systems while the State provides the operational support for their providers. We provide maintenance, enhancements, and hosting support of the systems that we have built for the program. In Nebraska and the District of Columbia, we were awarded contracts to bring the state into compliance with the new ACA requirements for Provider enrollment and screening, including implementing our provider management system and providing operational services for enrollment and screening, conducting site visits, and providing enhanced screening for high-risk providers. MAXIMUS is also well versed in the nuances of Provider Services system administration through our extensive experience performing Provider operations projects nationwide using legacy or state-provided systems.
- **Experience Ensuring Provider Network Adequacy.** In New York and New Jersey, we maintain statewide directories of health care Providers to help these states make sure they have adequate coverage, help with Managed Care Organization (MCO) compliance checking, and help to enable states to make accurate data available to members. We work with the Provider data to normalize the provider network for accuracy and reporting. Our operations and system work also enable us to work with the Provider data so that unique providers are identified and can be used for compliance reporting and to facilitate member inquiry.
- **Knowledge of Industry Best Practices.** MAXIMUS has extensive experience implementing modular provider systems. We understand the complexities and the specific issues that are encountered converting data from the legacy MMIS, and then enabling processes to move our data back to the MMIS. Because of our flexible and well-tuned implementation model, we are able to stand-up complex projects successfully within aggressive timeframes. We are not limited to legacy ideas about how business processes and technology should be used or implemented, and we continually look for innovative methods to use technology to improve performance. Due to our experience in implementing modular provider solutions within Medicaid, we are able to bring the right staff to our projects, using proven implementation processes based on industry best practices and lessons learned.

We also leverage best practices and lessons learned from our wide array of health services projects. We work alongside health and human services agencies to ensure that their programs perform well, that

states meet program goals and expectations, and that in the end, the most important clients are being served — the customers. This perspective, and our specific experience, is important because we are able to approach projects from multiple perspectives and not be constrained by worrying about "how it was always done."

Detailed Description of Similar Past Projects

MAXIMUS has been continually supporting provider enrollment and screening activities specifically for Medicaid for the past 19 years. Throughout this time, we have continued to add new projects and currently have seven projects specifically related to Medicaid Provider data and systems. *Exhibit 2-3: Significant Relevant Experience* presents our experience with similar Medicaid Provider-focused projects nationwide. The number of years in operation displayed in the exhibit is a testament to our strong past performance and overall customer satisfaction.

Relevant MAXIMUS Experience	Number of Years in Operation	Provider Screening and Enrollment	Provider Data Management System	Web Portal Development and / or Operation	Data Collection and Validation	Data Integration
Tennessee Provider Portals, Systems and Databases	6.5	✓	✓	✓	✓	✓
Nebraska Provider Enrollment and Screening	3	✓	✓	✓	✓	✓
District of Columbia Provider Data Management System and Services	2	✓	✓	✓	✓	✓
Iowa Medicaid Enterprise Provider Services	12	✓			✓	
Massachusetts MassHealth Customer Services	19	✓			✓	✓
New York State Physician Profile	15		✓	✓	✓	✓
New Jersey Health Care Provider Profile	13		✓	✓	✓	✓

Exhibit 2-3: Significant Relevant Experience. *MAXIMUS has 19 years of successful experience with numerous contracts similar to the Arizona Provider Management System requirements.*

Tennessee Provider Portals, Systems, and Databases

The Tennessee Provider Portals, Systems, and Databases contract is the evolution of a multi-year effort to externalize Provider management functions outside of the traditional MMIS model. Tennessee's ultimate goal is for all Provider functions to be accessible from the online portal, including HIPAA transaction request response, electronic remittance advice, and all Provider-related functions. Our contract has included the development of several systems, including the Electronic Health Records (EHR) Provider Incentive Payment Program (PIPP) system, a financial payment workflow approval system for payments made to Providers outside of the regular processes, and multiple phases of the development of the Provider Data Management System (PDMS).

Through these successful projects, the State has benefitted from our ability to design and maintain a base infrastructure that contains a multitude of Provider management functions and provides a technology basis that enables integration with partner systems and the ability to create new functions. Our web-based, Provider-facing system automates and improves data validation by integrating with a variety of external data sources, including the State's Council for Affordable Quality Healthcare (CAHQ) Credentials Verification Organization (CVO) and EDIFECS to integrate HIPAA X12 transactions. This modern technology platform enables us to quickly adapt to new program initiatives. MAXIMUS currently performs

maintenance, enhancements, and support of the easily accessible, yet dynamic web-based portal we have built to support all Provider management functions, including Provider registration.

Our basis for achieving excellence in operating and maintaining the Provider portals, systems, and databases lies in our understanding of the Provider service business process and requirements. Using this understanding, we have designed, built, and implemented innovative solutions to support Medicaid Providers and improve program performance. The Tennessee Project includes Provider data management functions that are very similar to the Arizona requirements, as they demonstrate our experience with design, development, and implementation of systems, as well as our ability to support these systems.

The modern technology infrastructure of our solution has allowed the State to benefit from the ability to quickly and cost effectively develop new systems and functional components, web-based services, data integration among numerous platforms, and automation of what were previously manual and paper processes. Our Tennessee Provider solutions, which are directly relevant to the Arizona Provider Management System requirements, facilitate the modernization of all Provider management functions, including the ability to:

- Register and screen Providers electronically
- Enhance and standardize data collection and eliminate all paper applications
- Provide web-based self-service to Providers for all Medicaid functions
- Integrate with a variety of system platforms to exchange data, including CVO and web services integration with the MMIS
- Automate communication with Providers
- Implement improved functionality to manage Providers and support the Provider network
- Align with MITA 3.0 for enhanced federal funding participation

District of Columbia Provider Data Management System and Services

MAXIMUS has implemented a Provider screening and enrollment solution for the District of Columbia that assists the District in its efforts to meet the enhanced Medicaid Provider enrollment and screening requirements included in the ACA, and reduce the need for paper applications and processing. We provide enrollment and screening operations supported by our ACA-compliant Provider Data Management System (PDMS) solution for this project. We brought together the best in self-service features, existing connections to key data sources, in-depth knowledge of the District of Columbia area health systems and Providers, and a flexible, modular approach to delivering a purpose-built solution to the District. This helps the District Medicaid program to better connect with the Provider community, using methods that help facilitate transparency, understanding, and participation. It has also vastly improved the efficiency of the Provider enrollment process and reduced the timeframes for enrollment.

Our solution for the District includes the following services:

- Implementation of our PDMS solution, including configuration of D.C.-specific business processes and full compliance with modular federal certification requirements
- Data integration components to interface with automated screening sources and the legacy MMIS operated by Conduent
- Data conversion and data cleansing to enable our solution to become the system of record for the Provider data

- Federal certification support, including working with the IV&V vendor and leading the certification effort
- A full operations center, which includes enrollment, screening, and site visit operations, as well as a fully operational call center
- Hosting of the PDMS solution in a Software as a Service (SaaS) model
- Full infrastructure and technical support, including maintenance, operations, and enhancement staff

MAXIMUS is using the District of Columbia as reference for the Arizona project.

Nebraska Provider Enrollment and Screening

MAXIMUS was the first vendor to offer a modular Provider enrollment and screening solution that included both system and the operational components provided in a single Service as a Service (SaaS) model. Our solution for Nebraska assists the Department in its efforts to meet the enhanced Medicaid Provider enrollment and screening requirements included in the ACA, allowing them to move away from the traditional MMIS as they increase the amount of managed care services they provide. As a part of this solution, MAXIMUS was responsible for implementing an ACA-complaint system, operating a full-service contact center, and developing processes for enrolling and screening Nebraska Providers within our solution. We have also led the certification activities, completed the IV&V process, and supported the CMS certification review of the system. We are waiting for final notification from CMS and anticipate that our Nebraska solution will be the first modular Provider enrollment and screening solution certified under the new modular requirements for a State Medicaid Agency.

Our solution for Nebraska includes the following services:

- Implementation of our PDMS solution, including configuration of Nebraska-specific business processes and full compliance with modular federal certification requirements
- Data integration components to interface with automated screening sources and the legacy MMIS operated by the State
- Data conversion and data cleansing to enable our solution to become the system of record for the Provider data
- Federal certification support including working with the IV&V vendor and leading the certification effort
- A full operations center, which includes enrollment, screening, and site visit operations, as well as a fully operational call center
- Hosting of the PDMS solution in a Software as a Service (SaaS) model
- Full infrastructure and technical support, including maintenance, operations, and enhancement staff

Our solution embodies a technical system and platform for managing workflows that support assigning, routing, and monitoring tasks, and gives supervisors the ability to prioritize, delegate, or reroute tasks as needed. It automates all Provider management functions, including the ability to enroll Providers and conduct periodic reactivation / revalidation activities electronically via a web portal, standardize and improve the data collection process through automated business edits and task-based workflows, screen Providers against verification databases, track the status of required Provider site visits and other outreach activities, and monitor the payment of application fees as applicable.

MAXIMUS is using Nebraska as a reference for the Arizona project.

Iowa Medicaid Enterprise Provider Services

In early 2004, the Iowa Department of Human Services took a new approach to operating its Medicaid program, creating the Iowa Medicaid Enterprise (IME). The IME divided a large, multi-faceted Medicaid contract into nine smaller contracts awarded to multiple vendors with special expertise in each Medicaid area. MAXIMUS brought customer service expertise within Medicaid to IME, enabling Iowa to become one of the first states to include screening and site visits as part of their enrollment process. Within the IME, MAXIMUS is responsible for managing the Provider Services Unit, and provides the following services to support Medicaid Providers:

- Enrolling Providers and maintaining Provider data, including meeting the ACA requirements for enrollment and screening
- Re-validating Providers
- Operating a full-service contact center
- Performing site visits for moderate and high risk Providers
- Training and assisting Providers participating in Medicaid
- Responding to Provider inquiries
- Maintaining the repository of Provider information
- Conducting outreach and providing education to Medicaid Providers

Our solution reflects the Arizona Provider Management System requirements, because in performing the screening and enrollment functions using a legacy platform, we understand where improvements in processes can be supported by a new platform. We also understand the limitations of legacy data and how a lack of data integration impacts the operational staff. MAXIMUS is unique in its structure because we use our experience from our operations to inform our system builds. Similar to the role required to in Arizona, our Provider Services project interacts directly with current and potential Medicaid Providers on a daily basis, answering their questions and concerns, assisting them in updating their information, and enrolling them in the State's system through a dedicated contact center. The MAXIMUS operation in Iowa also performs the ACA-mandated functions for Provider enrollment and screening, including making site visits.

MAXIMUS is currently providing contact center customer service for Providers participating in Iowa's medical assistance programs, enrollment and registration, maintaining and updating a comprehensive Provider database, as well as providing outreach and education services. MAXIMUS delivers full Provider management services, helping ensure that Providers meet ACA enrollment and screening requirements.

Massachusetts MassHealth Customer Services

MAXIMUS serves approximately 65,000 active Providers through our MassHealth project in Massachusetts, conducting Provider enrollment and credentialing for 62 unique Provider types. We currently support ACA-required enrollment and screening services, perform site visits for moderate and high risk providers, perform ongoing re-validation of all active MassHealth Providers based on risk level, and offer project management, subject matter expertise, and operational support for Ordering / Referring and Section 1202 enhanced payments. This is an interesting project for MAXIMUS because the existing MMIS does not fully support the ACA-mandated requirements for enrollment and screening. To maximize performance, MAXIMUS created technical solutions to fill in these gaps. We have used our PDMS product as an example of how to structure our support systems in Massachusetts.

It is our responsibility to maintain the information that Providers need to enroll as a MassHealth Provider and to be aware of all regulations, policies, and procedures that must be followed to allow claims to be

processed. MAXIMUS is responsible for developing and maintaining a cohesive and comprehensive approach to working with Providers, beginning at the point at which a prospective Provider applicant first contacts MAXIMUS for information on the MassHealth Program, and continuing through the services of Provider-related activities performed under the contract, such as re-validation. MAXIMUS understands how data is stored in the MMIS and we have developed several interfaces that enable our support systems to update the MMIS with data we collect outside of the traditional application processes.

New Jersey Health Care Profile

MAXIMUS is proud to have served the New Jersey Division of Consumer Affairs in implementing and operating the New Jersey Health Care Profile (NJHCP) project since its inception in 2004. This repository of Provider information, mandated by the New Jersey Health Care Consumer Information Act, has proved to be an important resource for the health care consumers in New Jersey. Each Provider profile in the NJHCP Project includes a wealth of information about the Provider's education and specialty training, disciplinary actions, malpractice history, and hospital privileges. Additional information may include office practice locations, insurance plan participation, professional and community service activities, and other details that consumers may wish to consider in making their choice of health care provider. Our experience building this online Provider directory is important because we have a similar requirement in Arizona.

Our efforts to establish and operate this service have included compiling a database of more than 52,000 health care providers; implementing and operating a Helpline and Help Desk to field consumer and Provider inquiries; and designing and operating a self-reporting site for Providers, as well as a paper survey for those who prefer not to use the site. We have sought to create a user environment – whether via the Internet, phone, or mail – that facilitates both compliance with the law for Providers and retrieval of information for consumers. Our efforts in this highly successful Provider profile initiative have included:

- Designing and operating user-friendly websites to serve Providers and the public
- Implementing Provider data collection tools that allow Providers an easy and convenient method for completing their self-reporting information online
- Designing a hard copy survey for Providers to report their information via mail
- Conducting follow-up calls to encourage and facilitate Provider participation
- Building a Provider database for use in analysis, reporting, storage, and retrieval
- Establishing a robust and effective protocol for data verification
- Maintaining licensing agreements for obtaining profile data from outside sources such as the AMA, the AOA, the NPDB, and the Healthcare Integrity and Protection Data Bank (HIPDB)
- Researching conflicting or discrepant Provider information
- Designing and operating the Helpline to serve consumers, and the Help Desk to serve health care professionals
- Providing ad hoc reports to the client as requested

This site receives approximately 400,000 visits per year.

New York State Physician Profile Project

The New York State Physician Profile Project provides health care consumers in the State of New York with information about all licensed and registered physicians in the State, with the objective of helping consumers locate and determine the appropriate physician to meet their health care needs. MAXIMUS works closely with the New York Department of Health to achieve its vision for a comprehensive and

easy-to-access physician profile that provides updated and unduplicated information through a public-facing website.

The project demonstrates our experience understanding the multitude of Provider data, our ability to cleanse and analyze this data to create the state physician profiles, and our call center operations capabilities to support the Provider community. This project also demonstrates our experience with large-scale Provider operations projects.

MAXIMUS collaborated with the State to design and implement the New York State Physician Profile and provided relevant support to include the following:

- Compiling and maintaining a complex database of roughly 115,000 physicians
- Offering profile information to the public via the New York State Physician Profile website
- Verifying the accuracy of randomly selected profiles and confirming the accuracy and completeness of physician self-reported information
- Establishing and operating a toll-free call center for consumers and health care professionals
- Building an application to accommodate data analysis, management reporting, storage, and retrieval
- Conducting ongoing refresher trainings for call center customer service representatives
- Designing and conducting online and paper-based physician surveys to gather physician self-reported information

MAXIMUS collaborates with the New York Department of Health and the New York Office of Professional Medical Conduct to validate and verify that all information is 100 percent correct and reported in a timely fashion, and that duplicated information does not exist. The website provides the public with detailed information about practitioners' education, training, and practice locations. The website also provides medical malpractice information and other legal action information including, but not limited to, licensee actions, criminal convictions, hospital restrictions, and out-of-state actions. We also forged constructive relationships with Provider and consumer advocacy groups, and integrated their feedback as a measure of continuous process improvement.

2.2 Organizational Chart

RFP Section Special Instructions 3.2.2, Page 31

MAXIMUS approaches the Provider Management System project from both a system and business perspective. While we appreciate that technology is the key aspect of the requirements, we also understand that a system must meet the business process requirements and overall project goals in order to be successful. After a careful review of the RFP requirements, we have assembled an excellent team that brings the complementary skills necessary to meet the diverse program management, business, and technical skills required in the RFP. Our team possesses the following skill sets:

- Project oversight staff with extensive senior management leadership qualifications, significant Medicaid provider management qualifications, and Project Management Professional (PMP) certifications to provider senior project leadership and oversight
- Project management staff with a diverse mix of project management experience across Health and Human Services (our staff possesses the Medicaid and technical qualifications to ensure required designs are implemented appropriately and timely, as well as providing overall project leadership to the business and technical teams)
- System development staff, including functional and technical experts in Provider Services, Medicaid, and system development and implementation to maintain, operate, and enhance the various releases throughout the life of the program

- Supplemental expertise in system infrastructure and hosting, training program development and execution, and a wide variety of technology expertise in reporting platform implementation
- Specific expertise in modular federal certification to complete the requirement documentation and support the CMS review and approval of the system

We augment the main project team with data center and enterprise network experts to ensure a reliable infrastructure that supports system development and testing, along with connectivity with the Arizona technical infrastructure.

Our project team brings broad skills in project management, requirements definition, business process analysis, and operations, giving us a strong foundation that will help this project to be successful. *Exhibit 2-4* shows the Arizona Provider Management System Organizational Chart.

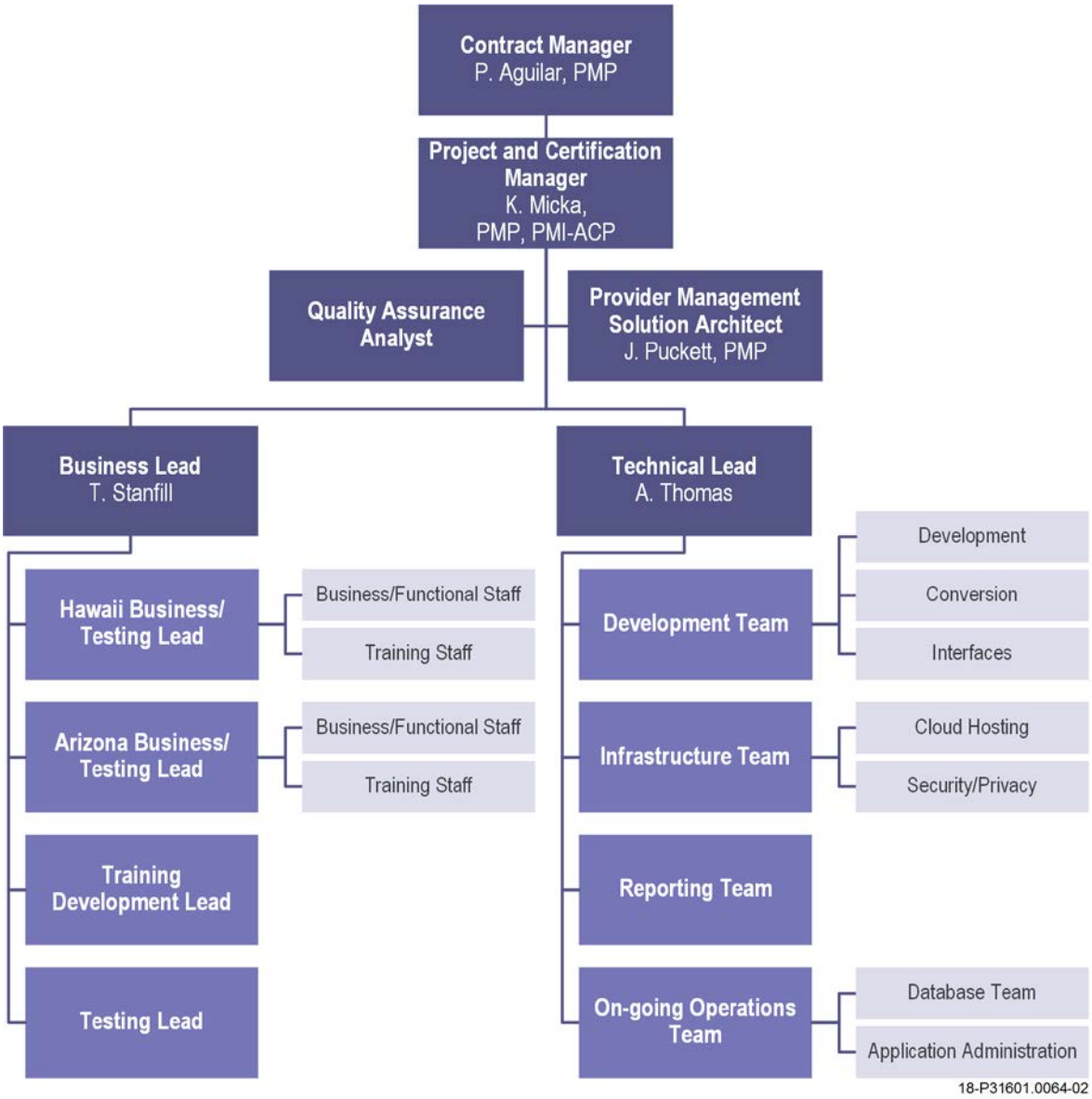

Exhibit 2-4: Arizona Provider Management System Project Organization Chart. *The MAXIMUS Project Team offers AHCCCS/Med-QUEST project management, Medicaid, and Provider management experts to meet your goals and expectations for this project.*

A critical aspect of our staffing solution is continuity of the team across the different stages of implementation and, ultimately, maintenance and operations. We do this by assigning team members throughout the project to support business and technical aspects of our development methodology. The MAXIMUS approach for AHCCCS/Med-QUEST is to use the same proven technology platform, but to ensure the end solution is configured specifically to meet both Arizona and Hawaii business requirements. To that end, we have allocated staff across Arizona and Hawaii business teams to work with each state to understand the specific business requirements, explain how our system meets each requirement and to document configuration updates that are necessary to align with each state's business model. As requirements are reviewed and system design finalized, these teams transition into the testing staff who will build test cases and actually test the system. While both teams work closely together and are overseen by a single Business Lead, they ensure that the specific configuration made for each state is correctly implemented and meets the overall objectives. As we move into testing, the individual business teams again work closely with their respective states to test functionality, train user staff, and, ultimately, prepare for and execute implementation tasks. We have found this continuity of staff across the implementation project leads to fewer issues, greater knowledge transfer, and a smooth implementation.

On the technical side of the team, we pool resources to support system configuration, data conversion, interfaces, reporting, and infrastructure needs. While it is likely that each state will have a technical lead to coordinate and validate system updates, we anticipate much of the technical work will support both states, especially in terms of data conversion, interfaces, and reporting needs. Our technical team members will be focused on configurations and updates, and we will manage version control through our configuration management processes.

Our staffing approach is based on lessons learned from our three modular provider management system implementations. The staff we assign to lead the projects are instrumental to the project's success because they have firsthand knowledge of what works, what issues are likely to be encountered, and how we can best react to keep the project moving forward. MAXIMUS selected the project team for this engagement specifically for the skills and abilities they possess. We are veterans of working with government agencies in highly dynamic and political environments. We offer Arizona and Hawaii a valuable real-world understanding of the need for new advanced provider solutions and for understanding how the resulting processes improve healthcare availability and outcomes. We also bring an important understanding of the provider community, the functionality of the Medicaid support systems (including the MMIS), and federal policy regarding the Medicaid program.

Resumes for key staff members are included at the end of this section.

2.3 Key Personnel Qualifications

RFP Section Special Instructions 3.2.3, Page 31

For the Arizona Provider Management System project, we are naming the following individuals as key personnel, and describe their experience, technical expertise, and qualifications for their proposed positions.

Pat Aguilar, PMP, Contract Manager

Mr. Aguilar is Senior Vice President and Practice Lead of the MAXIMUS Program Modernization Consulting group. He has more than 29 years of experience consulting for health and human service programs. As a certified Project Management Professional (PMP), he has led large system development and technical infrastructure projects in a dozen states, and is well versed in system development efforts for Medicaid, child

support enforcement, child welfare, SNAP and TANF projects. Mr. Aguilar is a nationally recognized expert in Medicaid systems and is responsible for the MAXIMUS Medicaid and Human Services system and solution practice. He is the chief architect of the MAXIMUS Provider-facing applications for Provider Enrollment, Provider Management, and administration of the Electronic Health Records (EHR) Incentive Payment program.

As our proposed Contract Manager, Mr. Aguilar will be the single point of contact for matters concerning MAXIMUS performance under the Contract. As a Senior Vice President within MAXIMUS, Mr. Aguilar has the authority to make decisions that are binding to the Contract. He will be responsible for timely completion of the project, as well as for meeting all contractual obligations.

Kelly Micka, J.D., PMP, Project and Certification Manager

Ms. Micka has 13 years of experience in Provider Services and Provider Management, and an additional ten years of child support experience. She has served as the Certification Manager for both the District of Columbia and Nebraska certification projects. As HIPAA informs many of the MECL items, she is highly familiar with how HIPAA compliance influences CMS certification. She has extensive experience in interpreting and applying federal regulations to systems implementations related to health and human services, specifically Medicaid, the Affordable Care Act, and Child Support Enforcement. With a comprehensive background in Medicaid and child support systems design and development, she worked frequently with CMS in the last six years while implementing ARRA and ACA requirements. She has worked on technology-related health and human services projects for both state governments and private contractors for 20 years

Ms. Micka has served as the Affordable Care Act Integration Manager for the State of Iowa, the Iowa Medicaid Health Information Technology Coordinator, the Iowa Electronic Health Records Incentive Payment Coordinator, and the Project Manager and Implementation Manager for the Provider Services Unit at the Iowa Medicaid Enterprise. All of these projects involved information protected under HIPAA requirements, a subject about which Ms. Micka is highly knowledgeable. She is also a Child support attorney, having represented the State of Tennessee in state and federal court, and has held various roles in numerous state and federal consulting projects. In this engagement, Ms. Micka will serve as Project Manager as well as the Certification Manager. She is focused on ensuring the Provider Management System is delivered according to the requirements and schedule. In addition, Ms. Micka will oversee the effort to certify the system; including working with AHCCCS/Med-QUEST, IV&V and CMS.

Teresa Stanfill, Business Lead

Ms. Stanfill has over 15 years of experience in the healthcare industry, working with healthcare information systems, Medicaid, Electronic Health Records Incentive Programs, Provider Services, and Managed Care. She has been primarily focused on system development projects and has worked on teams responsible for design, testing, conversion, gap analysis, training, operational support, and general implementation tasks. During her tenure at MAXIMUS, Ms. Stanfill has been an integral part of the business teams for the Iowa and Tennessee EHR incentive management web portals and the Tennessee and Nebraska Provider Management Systems. Ms. Stanfill leads a business team focused on the provider services market and is currently the Business Lead for the Tennessee Provider Data Management web application. Her role in this project has included designing User Interface pages for external Providers and internal Provider management review processes, and analyzing existing Provider records to aid in conversion of the Provider data. Ms. Stanfill brings specific AHCCCS/Med-QUEST program expertise to this project through her role as an Operations Manager for the Maricopa County

Health Plan and her specific business analyst role with AHCCCS. This unique experience will allow Ms. Stanfill to lead the Arizona and Hawaii teams as requirements are reviewed and configuration changes designed, tested and implemented. Ms. Stanfill is local to the Phoenix area and will be available to work closely with the AHCCCS/Med-QUEST's project team.

Jon Puckett, PMP, Solution Architect

Mr. Puckett is the product architect for the MAXIMUS Provider Management System we have implemented in Tennessee, Nebraska, and the District of Columbia. He works closely with our project teams and our clients during all aspects of the project. He has a unique blend of expertise in both legacy MMIS systems and modern day MITA-aligned Provider management systems. Mr. Puckett was the Implementation Manager on all three of the MAXIMUS PMES implementations, most recently for our implementation in DC. He is a Certified PMP with 29 years of experience in the systems and management areas of the information technology industry, utilizing skills in analysis, planning, and quality management. Mr. Puckett has 24 years of experience in Program and Project Management, 7 years in Provider enrollment and Medicaid program integrity activities, and 25 years in testing. As the Implementation Manager on all three of the MAXIMUS modular Provider Management implementations, one of Mr. Puckett's responsibilities was to conduct oversight and data quality reviews related to the MMIS data conversion and MMIS interface. Jon will help align this project with our other installations and bring fresh new ideas to the project.

Aneesa Thomas, Development Team Lead

Ms. Thomas is a technical leader for the MAXIMUS Provider Management Solution team. She has been instrumental in implementing new modern technologies within our platform, including the Corticon rules engine, ESB integration, and a wide variety of user interface updates. Ms. Thomas has 17 years of experience developing and using object-oriented, client-server, and multi-tier frameworks to support projects in multiple industries, including healthcare and pharmaceutical companies. She is experienced in working with the complete Software Development Life Cycle, and a variety of databases. Ms. Thomas is skilled at providing technical leadership to development teams and ensures successful delivery of projects on time. She has practical, hands-on experience as a Team Lead and Lead Programmer, and is actively involved in business requirements and proposal development, hiring processes, product evaluations, project feasibility studies, and mentoring. Since 2016, she has served as Senior Software Engineer for the District of Columbia Provider Management System at MAXIMUS. Ms. Thomas is responsible for ensuring translation of the functional requirements to the technical specifications, overseeing the software configuration and development effort, and ensuring adherence to the MAXIMUS quality standards.

2.4 Resumes

Resumes are on the following pages.

MAXIMUS®

4: Additional Information

4.4 Financial Stability

RFP Special Instructions 8, Page 32

We are a financially stable corporation and can substantiate this through our annual financial statements and independent financial rating services. The importance of financial strength and strategic liquidity in today's market cannot be overstated.

MAXIMUS, Inc. is a publicly traded corporation on the New York Stock Exchange (NYSE: MMS). MAXIMUS Human Services, Inc. is the Offeror of this opportunity and a wholly owned subsidiary of MAXIMUS, Inc., with which we share resources and expertise.

With revenues of nearly $2.5 billion in fiscal year 2017, MAXIMUS has experienced steady growth and workforce expansion as shown in *Exhibit 4.4-1: MAXIMUS Revenue — 2011-2017*. Our financial strength provides our government clients with the confidence that we can fulfill contractual responsibilities and provide high-quality, uninterrupted services.

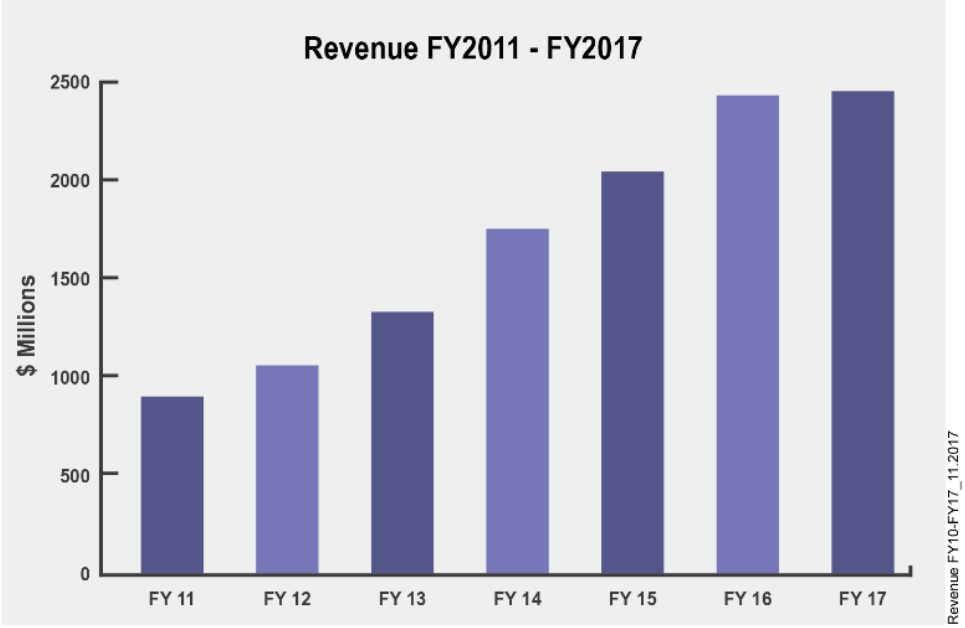

Exhibit 4.4-1: MAXIMUS Revenue FY2011 – FY2017. *MAXIMUS, Inc. is a stable and growing company with strong balance sheets.*

As a publicly traded company, our financial stability is independently verifiable. An essential component of contract management is maintaining strict financial controls. Our financial structure and practices meet Committee on Sponsoring Organizations (COSO) and Generally Accepted Accounting Principles (GAAP) requirements. We have never filed (or had filed against us) any bankruptcy or insolvency proceeding or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. Presently, MAXIMUS commands a high financial rating from Dun & Bradstreet, reflecting its assessment of both our financial statements and our credit worthiness. Our Dun & Bradstreet number is 08-234-7477. Our bank of record is SunTrust Bank.

MAXIMUS Human Services, Inc. relies upon MAXIMUS, Inc. and other MAXIMUS, Inc. subsidiaries to supplement its workforce and to provide corporate resources such as technology and support, finance, accounting, auditing, real estate and facility management, human resources, and legal services.

Financial Integrity and Transparency

As a publicly traded company and a government contractor that serves the public, MAXIMUS regularly submits to transparent reviews and audits. Achieving the highest level of integrity in all our staff, departments, projects, and company is only accomplished if it is a guiding principle that is demanded and enforced from the top down by all MAXIMUS employees. As such, we have been recognized by the financial industry:

Fortune Magazine named MAXIMUS to its 2017 "World's Most Admired Companies," ranking us eighth among industry technology services.

Institutional Investor Magazine recognized MAXIMUS Senior Vice President of Investor Relations Lisa Miles as one of the nation's top investor relations professionals in 2016, ranking Ms. Miles third for Best Midcap Investor Relations Professionals in the business, education, and professional services sector.

Barron's 400 Index selected MAXIMUS for two consecutive years (2013 and 2014) as one of the top six percent of all North American publicly traded companies based on their fundamental soundness and overall attractiveness to investors. Only 1.5 percent of North America companies remain on the list for two consecutive years.

Forbes / GMI Ratings named MAXIMUS to Forbes 2014 list of 100 of "America's Most Trustworthy Companies" based on the accounting and governance behaviors of United States publicly traded companies.

4.5 Responsibility, Responsiveness, and Susceptibility

RFP Special Instructions 13, Page 33

For convenience, we address the following criteria from RFP Special Instructions to Offerors Section 4. MAXIMUS Human Services, Inc.:

1. Has not had a contract within the last five years that was terminated for cause due to breach or similar failure to comply with the terms of the contract
2. Has not failed to satisfy the terms of our agreements with any party to a contract
3. Is legally qualified to contract with AHCCCS/Med-QUEST
   - Has not, nor have our key personnel, been debarred, suspended, or otherwise lawfully prohibited from participating in any public procurement activity, including but not limited to being disapproved as a subcontractor of any public procurement unit or other governmental body
4. Has promptly supplied (and will supply) all requested information concerning our responsibility
5. Strives to permit evaluation by AHCCCS/Med-QUEST, in accordance with the evaluation criteria identified in this Solicitation or other necessary offer components, including attachments, documents or forms, an indication of the intent to be bound, reasonable or acceptable approach to perform Scope of Work, acknowledge Solicitation Amendments, references to include experience verification, adequacy of financial/business/personal or other resources to include a performance bond and stability including subcontracts and any other data specifically requested in the Solicitations
6. Strives to be in conformance with the requirements contained in the Scope of Work, Terms and Conditions, and Instructions for the Solicitation including its Amendments and all documents incorporated by reference
7. Does not limit the rights of AHCCCS/Med-QUEST
8. Does not include with our Offer unreasonable conditions upon AHCCCS/Med-QUEST necessary for successful Contract performance
9. Did not materially change the contents set forth in the Solicitation, which includes the Scope of Work, Terms and Conditions, or Instructions
10. Did not knowingly provide misleading or inaccurate information