

# Independent Review

## Medicaid Management Information System (MMIS) Care Management Solution

For the

State of Vermont

Agency of Human Services (AHS) and Department of Information and Innovation

Submitted to the

State of Vermont, Office of the CIO

By

Strategic Technology Services

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**Attachments:**

1. FINAL-REVIEW-SOV-AHS-MMIS-CARE\_STS\_Risk\_Register.pdf
2. FINAL-REVIEW-SOV-AHS-MMIS-CARE\_STS\_Project\_Cost\_Detail.xlsx
3. FINAL-REVIEW-SOV-AHS-MMIS-CARE\_STS\_Project\_Plan.pdf

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# 1. Executive Summary

*Provide an introduction that includes a brief overview of the technology project and selected vendor(s).*

## Project Summary

1. This is a 5 year project with 2 optional 1 year extensions totaling **\$32M** over that 7 year time period, and will involve Design, Development and Implementation Services (DDI) and Maintenance and Operations (M&O) services provided by prime contractor **eQHealth**, whose eQSuite® software solution is being implemented, with subcontractor services provided by **Cognizant**. These two vendors have yet to collaborate on any project to date.
  - a. IV&V Services provides by **CSG Government Solutions** over a 3 year period at a total cost of **\$4.95M, \$817K of which is allocated to this project**. This total is included in the \$32M noted above.
2. The incumbent solution and service provided by APS is expected to be extended 6 months through 12/31/2015.
3. Senior Business Leadership, Technical Leadership, and Subject Matter Leadership are aligned to complete solution implementation.
4. Risks identified in the Risk Register should be mitigated before proceeding.

## Vendor Profile

### 1. EQHealth

- a. \$40M annual revenue, \$2M income, 501(c)3 Not for profit privately owned, 340 employees, <http://www.eqhs.org/>, HQ: Baton Rouge, LA), founded in 1986, has been working in the medical management and care management arena for over a decade in various capacities. Not only develop the systems but as an organization perform medical management services for Medicaid and commercial clients. eQHealth has over 16 years of experience successfully managing large scale medical management contracts for state Medicaid programs, with a history of 68 successful implementations that included 34 major contract start-up efforts. 38 of these implementations were in the Medicaid environment.
  - i. State of Mississippi Division of Medicaid: 1997 - present
  - ii. State of Illinois Healthcare and Family Services: 2002 - present
  - iii. State of Florida Agency for Healthcare Administration: 2010 - present
  - iv. State of Louisiana, Centers for Medicare and Medicaid Services (CMS): 1986 – present
- b. eQSuite® supports key care management processes such as patient identification and stratification, case management, disease management, analytics, Johns Hopkins predictive modeling and reporting.
- c. Subcontracting with Cognizant Technologies to bring their breadth and depth of knowledge in health care software development and program management.

### 2. Cognizant

- a. \$8.8B annual revenue, \$1B net income, publicly traded, founded in 1994 as a division of Dun & Bradstreet, 187,400 employees, <http://www.cognizant.com/>, #308 in Fortune 500, #40 in Information Week 100, HQ: College Station, TX; Teaneck, NJ is the office serving VT); Cognizant's healthcare business segment represents over 25% of total revenue.
- b. Core competencies: Business process, operations and IT consulting, application development and systems integration, enterprise information management, application testing, application maintenance, and IT infrastructure services.

**3. CSG Government Solutions**

- a. Financials unknown, 300 employees, founded in 1997; Offices in Atlanta, GA, Boise, ID, Columbus, OH, Indianapolis, IN, Lansing, MI, Portland, OR, Tallahassee, FL, Washington, D.C.
- b. Core competencies: Government Operations Consulting

## 1.1 Cost Summary

IT Activity Lifecycle:	7 Years
Total Lifecycle Costs:	\$ 32M
Total Implementation Costs:	\$ 11.9M
New Annual Operating Costs:	Range from \$2.1M to \$2.4M annually over the life of the project
Difference Between Current and New Operating Costs:	Annual reduction of \$ .2M of Operating Costs (referred to as M&O by project staff), however, there are some Operational Costs that warrant review to ensure this annual reduction is in fact realized. (See Risk Register and cells O80 and O112 of Cost Analysis spreadsheet)
Funding Source(s) and Percentage Breakdown if Multiple Sources:	Centers for Medicare and Medicaid Services (CMS) and State of Vermont General Fund ranging from 60-90% CMS and the remainder State of Vermont.  <b>CMS: \$23.5M</b> <b>State of Vermont: \$8.6M</b>  (See Cost Analysis spreadsheet (FINAL-REVIEW-SOV-AHS-MMIS-CARE_STS_Project_Cost_Detail.xlsx) and Summary of Funding Source table below for details)

### Summary of APPROVED Funding Source:

Design, Development, and Implementation (DDI) Costs (Total)		
Approved Budget	Federal CMS APD (90%) of Approved Budget	State General Fund (10%) of Approved Budget
\$12,600,000	\$11,340,000	\$1,260,000

Maintenance and Operations (M&O) Costs			
	Budget	Federal CMS APD (60%)	State General Fund (40%)
<b>5 years (approved CMS APD funding time period)</b>	\$12,000,000*	\$6,730,831	\$4,800,000
<b>7 years</b>	\$16,800,000*	\$9,607,510	\$6,720,000

\*2.4M annually

There are additional funds anticipated beyond those APPROVED funds above to cover additional project costs. Per an email from Joe Liscinsky, MMIS Program Deputy Business Lead, on 4/10/2015 in response to the question of where additional funding for DDI and M&O will come, Mr. Liscinsky replied: *“The shortage for DDI will be addressed in the APD update that’ll be submitted but not until this summer – the timing with wrapping up budget and other activities. CMS knows that’s coming and won’t be a problem.”*

Further follow up questions and responses between the Independent Reviewer and Mr. Liscinsky follow:

Independent Reviewer: *“If your APD update covers DDI, and that is submitted in the summer, when will you know if you’ve been approved, and is it reasonable to expect that you will cover the \$1.6M shortage with that approval?”*

Mr. Liscinsky: *“CMS has 60 days to review and approve an APD submittal. That APD submittal will include any necessary DDI additional funding needed.”*

Independent Reviewer: *“What mechanism is used to request and obtain additional M&O funding to cover the \$1.1M shortage, when will that be requested, and when will you receive an answer?”*

Mr. Liscinsky: *“The State will address necessary M&O costs through increase in likely General Fund – keep in mind that this is not 100% State dollars, this too will have Federal dollars – not at the 90/10 rate but closer to 60/40. We will request this need as we adjust budgets each year.”*

## 1.2 Disposition of Independent Review Deliverables

Deliverable	Highlights from the Review <i>Include explanations of any significant concerns</i>
Acquisition Cost Assessment	Costs seem reasonable and in line with comparable projects, pending cost allocation discussion.
Technology Architecture Review	Sound technology architecture based on Windows Desktop and Windows Server, Microsoft .NET Framework, IIS, SQL Server, and zero footprint browser client.
Implementation Plan Assessment	Consistent project management approach and methodology has yielded positive results on all previous projects. 4 work streams cover all 11 Functional Requirement areas, overlaying an “Immediate” and “Future” designation on specific Functional Requirements, aligning timing of deliverables with business need to use those deliverables.
Cost Analysis and Model for Benefit Analysis	Cost analysis provides accurate 7 year costs. <u>Small</u> tangible monetary benefits defined due to reduction in annual operating costs. <u>Significant</u> non-tangible benefits defined when using ROI calculations, which will cover entire project costs with a 1 year payback period. Other benefits include person-centric care and better analytics available to recommend treatments that yield better care results.
Impact Analysis on Net Operating Costs	Expected reduction in Operating Costs of \$200K annually.

### 1.3 Identified High Impact &/or High Likelihood of Occurrence Risks

Risk Description	State's Planned Risk Response	Reviewer's Assessment of Planned Response
See Risk Register		

### 1.4 Other Key Issues

*Recap any key issues or concerns identified in the body of the report.*

1. No other issues identified.



## 1.5 Recommendation

*Provide your independent review recommendation on whether or not to proceed with this technology project and vendor(s).*

It is recommended the project proceed as specified in this report.

## 1.6 Certification

**I hereby certify that this Independent Review Report represents a true, independent, unbiased and thorough assessment of this technology project/activity and proposed vendor(s).**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## 2. Scope of this Independent Review

*Add or change this section as applicable.*

### 2.1 In-Scope

The scope of this document is fulfilling the requirements of Vermont Statute, Title 3, Chapter 45, §2222(g):

*The Secretary of Administration shall obtain independent expert review of any recommendation for any information technology initiated after July 1, 1996, as information technology activity is defined by subdivision (a)(10), when its total cost is \$1,000,000 or greater or when required by the State Chief Information Officer.*

The independent review report includes:

- An acquisition cost assessment
- A technology architecture review
- An implementation plan assessment (which includes a Risk Analysis)
- A cost analysis and model for benefit analysis; and
- An impact analysis on net operating costs for the Agency carrying out the activity

### 2.2 Out-of-Scope

*If applicable, describe any limits of this review and any area of the project or proposal that you did not review.*

A separate deliverable contracted as part of this Independent Review may be procurement negotiation advisory services, but documentation related to those services are not part of this report *at this time*.

### 3. Sources of Information

#### 3.1 Independent Review Participants

*List the individuals that participated in this Independent Review.*

Name	Employer and Title	Participation Topic(s)
Alexia Venaфра	SOV; Care Management Project Manager	Primary Point of contact for IR, Discussed Project Management Approach, Coordinate meeting schedules with vendor and project participants
Tim Holland	SOV; DII Oversight Project Manager	Project Management Oversight
Donna Amiot	SOV; MMIS Program Manager	Role in Agency, Role on project, Success criteria, Concerns/Risks
Eileen Girling	SOV; VCCI Director and Program Lead on this project	Role in Agency, Role on project, Success criteria, Concerns/Risks
Dawn Weening	SOV; VCCI Manager and SME on this project	Role in Agency, Role on project, Success criteria, Concerns/Risks
Kelly Gordon	SOV; Care Management Business Lead	Role in Agency, Role on project, Success criteria, Concerns/Risks
Michael Hall	SOV; MMIS Program Technical Lead	Technical Standards, Architecture
John Hunt	SOV; MMIS Program Enterprise Architect	Technical Standards, Architecture
Phil Messina	SOV; Care Lead Business Analyst	Role in Agency, Role on project, Success criteria, Concerns/Risks, Project Schedule, Staffing, Testing Approach and Toolset
Michelle Mosher	SOV; MMIS Program Procurement Lead	Contract-related items
Joe Liscinsky	SOV; MMIS Program Deputy Business Lead on this project	Project oversight
Lori Collins	SOV; Deputy Commissioner, Policy, Fiscal & Support Services Division and MMIS Program Business Lead on this project	Project oversight
Marlena Pellon	SOV; IV&V Project Manager	IV&V Scope of Work
Mayur Yermaneni	eQHealth; CSO (Chief Strategy Officer)	Roles, responsibilities, vendor/subcontractor working process and how worked together in the past (they had not), pricing model, comparable projects, how VT pricing compares to comparable projects, ability to meet functional requirements (out of box, 3 <sup>rd</sup> party, or through development), technical architecture, PM approach, Training approach, DDI approach, Testing Approach, Conversion Approach, Deployment Approach, Risk Management Approach, CMS Certification, 3 <sup>rd</sup> Party Product descriptions, pricing, and where/how used

Name	Employer and Title	Participation Topic(s)
Sean Marchiafava	eQHealth; CIO and Chief Architect	Ditto
Marina Brown, RN	eQHealth; Director of Clinical Programs	Ditto
Srivaths Srinivasan	Cognizant Healthcare; Project Manager	Ditto
Jim Gesek	Cognizant Healthcare; Program Director (Account Director for this project)	Ditto
Brian Fitzgerald, R.N., M.S.A.	Cognizant Healthcare; Health Informatics Analyst	Ditto

### 3.2 Independent Review Documentation

Complete the chart below to list the documentation utilized to compile this independent review.

Document Name	Description	Source
Vermont Care Management_RFP Narrative.Am3.pdf), including Templates A-O (i.e. VT_Care_Management_Template_A....pdf) and several documents in the PROCUREMENT LIBRARY	Originating CARE MANAGEMENT RFP	Project SharePoint Site
MMISCare.Vendor Recommendation for OSC ESC.Final.pptx	PRT (Program Review Team) recommendation to HSE Governance to contract with eQHealth	Project SharePoint Site
CARE Architecture Assessment.pptx	Enterprise Architecture Assessment by John Hunt on eQHealth and CaseNet	Project SharePoint Site
NFR - Non-Functional RTM_IR.xlsx	Non-Functional Requirements Traceability Matrix (RTM)	Project SharePoint Site
Care.Schedule.20150121.mpp	CARE Procurement Schedule (at a point in time)	Project SharePoint Site
Project_Weekly_Report_MMIS_CARE_20150120.pdf	CARE Project Status (at a point in time)	Project SharePoint Site
Care.RisksandIssues.20150123.xlsx	CARE Project Risk Matrix (at a point in time)	Project SharePoint Site
HSE Structure and Governance.pdf	HSE (Health and Human Services Enterprise) Governance Model	Project SharePoint Site
HSE Portfolio Organization Chart_V8.pdf	HSE (Health and Human Services Enterprise) Org Chart	Project SharePoint Site
CARE.RACI.20141229.xls	CARE RACI matrix during <b>Procurement</b>	Project SharePoint Site
Care.Org Chart.20141215.pptx	CARE Project Org Chart	Project SharePoint Site
1 BAFO Requirements Narrative eQHealth 12 13 14.pdf	Best and Final Offer Narrative from eQHealth	Project SharePoint Site
BAFO 3.0 eQHealth 01 02 2015.xlsx	Best and Final Offer Pricing from eQHealth	Project SharePoint Site
eQHealth - Orals Invitation and Agenda.pdf including all vendor responses: <i>a Questions COMBINED_ 11 7 2014.pdf</i> <i>b Vermont Workplan- MY- 11-04-14.pdf</i> <i>c Visio-Product Roadmaps.pdf</i> <i>d Srivaths Srinivasan-Resume.pdf</i> <i>e Template_D_- Vendor_Project_Organization_and_Staffing_Srivaths Sri.pdf</i> <i>f Template_E_-_Staff_Experience_Srivaths Srinivasan.pdf</i>	Orals Invitation and Agenda and Vendor Responses	Project SharePoint Site

Document Name	Description	Source
Technical Proposal.pdf	eQHealth's proposal, detailing the information requested in the originating RFP via Templates A-O	Project SharePoint Site
12_VT Project.pdf	A PDF of the MPP of the eQHealth Project Gantt chart	Project SharePoint Site
Care.PRT2.Group Scoring Workbook_Final.xlsx	Finalist Vendor Scoring Matrix	Project SharePoint Site
List_of_HEDIS_2015_Measures.pdf	Summary of Measures, Product Lines, and Changes in HEDIS* 2015	Web
MMIS Business Case 5_Dec_2013.pdf	MMIS Business Case supporting project initiation	Project SharePoint Site
MMIS_PreliminaryLifeCycleCostAnalysis28Jun2013.xls	MMIS Life Cycle Cost Analysis supporting Business Case	Project SharePoint Site
1vt-mmis-ivv-rfp-narrative-v7-11.4.14-03410-141-15-.pdf	Independent Verification and Validation (IV&V) for the Design, Development, and Implementation of a Medicaid Management Information System and Integrated Contact Center System and Services	Project SharePoint Site
CSG Government Solutions - RFP No. 03410-141-15 - Technical Proposal_REDACTED.pdf	CSG Government Solutions Proposal – Redacted Version	Project SharePoint Site
CSG_MMISIVV_v4_2015_FINAL_.pdf	Draft contract with IV&V Vendor CSG Government Solutions	Michelle Mosher and Alexia Venafr
DII HSE Project Waiver.pdf	Waiver of Oversight and Budget Reporting requirements for Health Service Enterprise projects, including MMIS,	Project SharePoint Site

\*Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 81 measures across 5 domains of care. Because so many plans collect HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis.

## 4. Project Information

### 4.1 Historical Background

*Provide any relevant background that has resulted in this project.*

#### **SUMMARY**

In 2006, Vermont enacted a comprehensive health care reform that created over 36 separate initiatives focused on improving access (e.g., Catamount Health and premium assistance programs), increasing quality (e.g., Blueprint for Health, Vermont Chronic Care Initiative (VCCI) high risk / cost Medicaid recipients, community wellness grants, hospital report cards), and containing health care costs.

Additional legislation has been enacted in each subsequent year since 2006 to supplement these initial reforms, including the enactment of Act 48 (2011) and passage of Act 171 (H.559).

DVHA, which administers nearly all of the publicly funded health care programs for the State of Vermont, assists Members in accessing clinically appropriate health services, administers Vermont's public health insurance system efficiently and effectively, and collaborates with other health care system entities in bringing evidence-based practices, quality of care and quality of life through a holistic approach to Vermont Medicaid Members.

### 4.2 Project Goal

*Explain why the project is being undertaken.*

The State has utilized **APS Healthcare** for MMIS Vermont Chronic Care Initiative since 2006. APS maintains a local presence in Williston.

The State of Vermont, Agency of Human Services (AHS), and Department of Vermont Health Access (DVHA) is procuring an enterprise solution for Care Management (CM) for the Agency of Human Services (AHS) to replace the solution currently provided by APS.

The CM Solution needs to be implemented to comply with Centers for Medicare and Medicaid Services (CMS) Seven Conditions and Standards and CMS' Medicaid Information Technology Architecture (MITA) 3.0. The CM Solution needs to closely integrate with Vermont's Medicaid Management Information System (MMIS), which is an integral part of Vermont's Health and Human Services Enterprise (HSE).

Of note: APS not only hosts the systems used to support Care Management for VCCI, but they provide related services with APS staff, including Medical Director, Pharmacist, 5 Nurse Case Managers (telephonic), 2 Social Workers (telephonic Outreach), Clinical Manager, as well as other staff support positions (14-15 FTEs in total). There is no budget to hire their FTE equivalents. VCCI hopes that State nurses and local community health teams can cover the staffing decrease due to the APS contract ending. See the Risk Register for a full disposition of this item.

<b>KEY STATISTICS</b>	
Total Number of Medicaid Enrolled (as of October 2013)	187,019
VCCI Eligible Candidates	103,058
Total Number in the top 5%	Under 21 yrs old – 3,549 Over 21 yrs old – 6,553 Total – 10,102
Total Number of Medicaid Members Engaged via face-to-face and/or telephonic case management (SFY 2012)	3,015
Average Episode of Care Duration	77 days
Target Caseload by Case Manager	Field – 25 Embedded – 50 Phone – 50 minimum

*The chart below details member count by area.*

<b>Area</b>	<b>TOP 5% MEMBERS</b>
Barre	911
Bennington	816
Brattleboro	658
Burlington	1939
Middlebury	534
Morrisville	477
Newport	586
Randolph	233
Rutland	1300
Springfield	655
St. Albans	917
St. Johnsbury	489
White River Junction	555
Unknown	32



## 4.3 Project Scope

*Describe the project scope and list the major deliverables. Add or delete lines as needed.*

The first recipient of the **Care Management Solution** will be **Vermont Chronic Care Initiative (VCCI)**. The State expects that the Care Management Solution will be built so that after implementation with VCCI it can be expanded concurrently for use by other Programs at the AHS' direction. Should AHS decide to proceed with the onboarding of other Programs, it is expected to start with the Department for Children and Families (DCF) Children's Integrated Services (CIS) program then with Department of Aging and Independent Living's (DAIL) Developmental Disability Services (DDS). Ultimately, it will be expanded for use by other Programs and Initiatives within AHS.

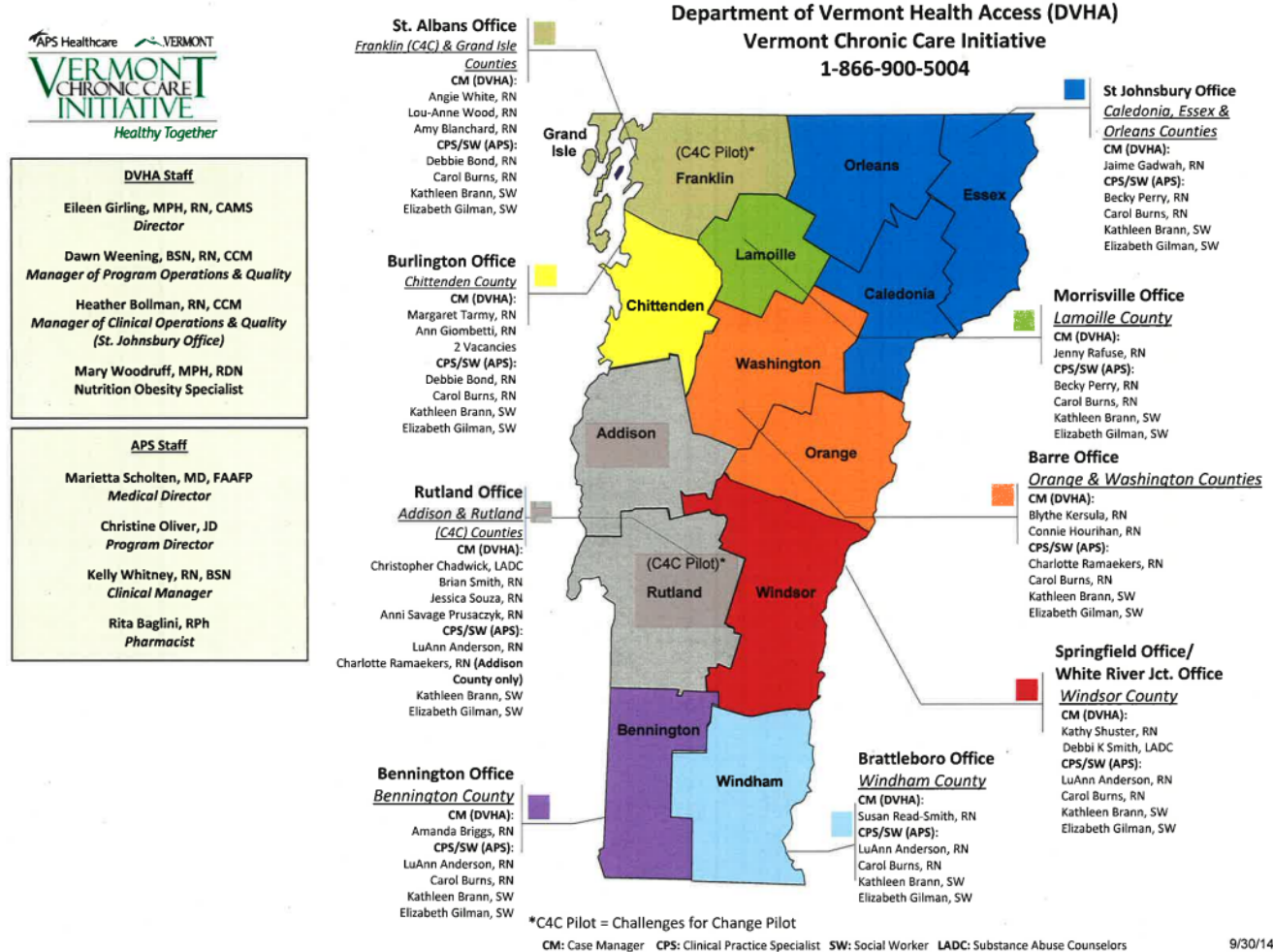
### **Vermont Chronic Care Initiative including High-Risk Pregnancy:**

*The Vermont Chronic Care Initiative (VCCI) is a statewide program that provides care coordination and intensive case management services to non-dually-eligible Medicaid beneficiaries with one or more chronic conditions and/or high utilization of medical services, with a focus on improving outcomes and reducing unnecessary utilization. The VCCI modified approach to focus on the top five percent of Vermont Medicaid beneficiaries with the highest utilization in state fiscal year 2012.*

### **Medicaid/VCCI High Risk Pregnancy Case Management Program**

The High Risk Pregnancy (HRP) Program is a new program through the Vermont Chronic Care Initiative (VCCI) at the Department of Vermont Health Access. The goal of this program is to improve pregnancy outcomes for Medicaid covered pregnant women and their babies. Research has demonstrated that prenatal care that includes non-medical and medical support services improves birth outcomes, especially among at-risk populations. Enhanced prenatal care that includes a comprehensive psychosocial assessment, care coordination, an individualized maternity care plan, and improved access to services may result in improved pregnancy outcomes.

The graphic below provide a visual representation of how VCCI services are broken out by office



**The Solution must support Vermont AHS' Care Management needs in the following areas:**

- Utilize clinically relevant predictive risk modeling tools and gaps in care analysis of various Member populations for early screening, case identification and risk stratification of Medicaid Members including, but not limited to:
  - Members who will benefit most from some form of care management intervention(s) (e.g., those with high utilization patterns, multiple providers, multiple conditions, polypharmacy, care gaps; possible readmissions and those who are at risk for chronic disease sequelae (*a condition that is the consequence of a previous disease or injury*)).
  - Members who are not currently at risk but may become at risk in the future.
  - Members whose future inpatient admissions and Emergency Department (ED) visits can be prevented and readmissions prevented.
- Proactive outreach to Members who are at risk, and to their providers to offer information, guidance and support to:
  - Improve health outcomes by: closing gaps in care, increasing adherence to evidence-based care, increasing the use of preventive care, and improving self-management and provider management of chronic illnesses.
  - Lower healthcare costs by minimizing redundancies and reducing utilization and expenses.
- Develop, monitor, share and reassess an evidence-based care plan to ensure clinically appropriate health care information and services are provided and communicated to improve the health outcomes of Medicaid Members.
- Coordinate efficient and effective delivery of health care with Medicaid Members, their providers and community partners by removing communication barriers, bridging gaps, and exchanging relevant and timely Member information.
- Conduct real-time care management analytics that include the ability to collect multiple sources of data (including hospital census, claims data, pharmacy data, and clinical/bio-medical data from providers) to identify opportunities that a Member or provider can take to improve clinical and financial outcomes.
- Provide robust and user-friendly reporting capabilities and Web-based tools necessary to effectively conduct Vermont Care Management Programs' strategic planning, quality, and performance management including clinical, utilization and financial changes among intervened populations.
- Provide additional Care Management capabilities including:
  - Receive custom assessments, Funding, Care Plans, Services from provider Agencies for State review and authorization.
  - Communicate state authorization of funding, care plans, services and providers to provider agencies and Members.
  - Conduct comparative analysis of provider agencies.
  - Accept from internal and external sources (Web-based) critical Incidents. Alert state staff of critical incident reports.
  - Communicate necessary follow-up steps and actions.
  - Perform Critical Incident analysis for agency and provider trends.
  - Manage state authorized agency and provider information including Life Safety and Accessibility Inspections.
  - Interface with VT Adult Protective Service (APS) for State reporting & tracking.
  - Interface with other solutions for master Agency and Provider list (including Life safety and accessibility inspections).

### 4.3.1 Major Deliverables

See Section 4.4.

## 4.4 Project Phases, Milestones and Schedule

*Provide a list of the major project phases, milestones and high level schedule. You may elect to include it as an attachment to the report instead of within the body.*

The Project Schedule table outlined below details the Functional Requirements grouped into their respective Work stream IDs, and the associated beginning and ending dates of each Work stream.

Functional Requirement ID	Functional Requirement Name	Functional Requirement Subgroups	Project Work stream ID	Work stream Schedule*
FR1	General	Document Management; Member, Authorized Representative, and Community Provider/Partner Portal; Alerts and Notifications; Workflow Management; Centralized Mailing	1	7/1/15-9/1/16 (2/2/15-4/4/16)
FR2	Establish Case Criteria	Rules Management; Candidate Identification / Risk Stratification; Eligibility Determination	1	7/1/15-9/1/16 (2/2/15-4/4/16)
FR3	Establish Case	Intake: Outreach; Case Assignment	2	7/1/15-3/17/17 (2/2/15-10/17/16)
FR4	Screening and Assessments	Member Profile Summary, Perform Screening and Assessments	2	7/1/15-3/17/17 (2/2/15-10/17/16)
FR5	Treatment Plan and Outcomes	Create Plan of Care, Develop Action Plans, Provide Education Materials	2	7/1/15-3/17/17 (2/2/15-10/17/16)
FR6	Manage Case Information	Case Documentation; Scheduling; Disposition; Transition; Care Coordination; Case Closure	2	7/1/15-3/17/17 (2/2/15-10/17/16)
FR7	Population Health Outreach	Manage Population Health Outreach	3	7/1/15-5/12/17 (2/2/15-12/12/16)
FR8	Manage Registry		3	7/1/15-5/12/17 (2/2/15-12/12/16)
FR9	Authorization Determination	Referral Management; Service and Treatment Plan Authorization	4	7/1/15-1/22/17 (2/2/15-8/22/16)
FR10	Reporting		4	7/1/15-1/22/17 (2/2/15-8/22/16)
FR11	Consent Management		4	7/1/15-1/22/17 (2/2/15-8/22/16)
<b>OVERALL PROJECT SCHEDULE</b>				<b>7/1/15-5/12/17 (2/2/15-12/12/16)</b>

*\* Original dates in parenthesis, as we are now assuming a 7/1/15 start date vs. 2/1/15 start date, so 5 months have been added to original dates. However, CMS approval will drive the actual project start date. DDI may begin as early as April or May 2015 and all immediate requirements (save for a handful of scheduling requirements in FR6) would then Go-Live in December 2015. Vermont team and Vendor are still yet determining when future requirements will Go-Live.*

The Project Schedule is further broken out to identify items which are needed IMMEDIATELY (initial release) and others needed in the FUTURE (future release). Each FR has activity that falls into either the IMMEDIATE or FUTURE category.

Functional Requirement ID	Project Work stream ID	Work stream Schedule*
FR1, FR2 - Immediate	1	7/1/15-12/20/15 (2/2/15-7/20/15)
FR1 – Future	1	12/27/15-9/1/16 (7/27/15-4/4/16)
FR3, FR4, FR5, FR6 – Immediate	2	7/1/15-12/20/15 (2/2/15-7/20/15)
FR3, FR4, FR5, FR6 – Future	2	12/27/15-3/17/17 (7/27/15-10/17/16)
FR7, FR8 - Immediate	3	7/1/15-12/20/15 (2/2/15-7/20/15)
FR7, FR8 – Future	3	12/27/15-5/12/17 (7/27/15-12/12/16)
FR9, FR10, FR11 - Immediate	4	7/1/15-12/27/15 (2/2/15-7/27/15)
FR9, FR10, FR11 – Future	4	12/27/15-1/22/17 (7/27/15-8/22/16)

The table below shows the Deliverables grouped by Task, per the original RFP. State and Vendor are reconciling the actual Deliverables and timing of each Deliverable as part of the Contract discussions.

<b>TASK</b>	<b>DELIVERABLE</b>	<b>PAYMENT MILESTONE</b>
Task 1 – Project Initiation and Planning	Deliverable 1 – Project Kick-off Presentation	
	Deliverable 2 – Project Management Plan	
	Deliverable 3 – Project Work Plan and fully resourced Schedule	X
	Deliverable 4 – Requirements Analysis, System Design and Development Strategy	
	Deliverable 5 – System Implementation Strategy	
	Deliverable 6 – Master Testing Strategy	
	Deliverable 7 – Requirements Traceability Plan	
Task 2 – Requirements Analysis and System Design	Deliverable 8 – Functional Specification and System Design Document	X
	Deliverable 9 – Data Integration and Interface Design Document	X
	Deliverable 10 –System Architecture	X
	Deliverable 11 – Technical Design Document	X
Task 3 – System Configuration and Development	Deliverable 12 – System Implementation Plan	
	Deliverable 13 – Data Integration and Synchronization Plan, including multiple test files (MMIS/claims, PBM, eligibility, VCCI legacy, etc.)	
	Deliverable 14 – System Maintenance Support Plan	
Task 4 – Testing	Deliverable 15 – Test Plan	X
	Deliverable 16 – Test Scenarios, Test Cases and Test Scripts	
	Deliverable 17 –Documented System Test Results	
Task 5 – Training	Deliverable 18 – Training Plan	X
	Deliverable 19 – Training Manuals, End-User Guides and Materials	X
	Deliverable 20 – Documented Evidence of Successful End-User Learning	X
Task 6 - Deployment	Deliverable 21 – Deployment Plan	
	Deliverable 22 – System Incident and Defect Resolution Report	X
	Deliverable 23 – Completed Detailed Functional and Technical Specifications Traceability Matrix	X
	Deliverable 24 – System Source Code and Documentation	X
	Deliverable 25 – Performance SLAs	
Task 7 – Phase and Project Closeout	Deliverable 26 – Phase and Project Closeout	X
Task 8 – CMS Certification Planning	Deliverable 27 – CMS Certification Planning and Documentation	X
Task 9 – System M&O	Deliverable 28 – System Incident Reports – M&O	X
	Deliverable 29 – Adaptive Maintenance Reports	X
	Deliverable 30 – System Enhancement Reports	X
	Deliverable 31 – Operations and system administration procedures manual	X
	Deliverable 32 – Tier 2 Service Desk Plan	X

The **IV&V Vendor** proposed the following **Tasks, Deliverables** and associated **Payment Schedule**:

<b>TASK</b>	<b>Timeframe</b>
TASK 1 - Develop, Maintain, and Execute the QA/IV&V Plan	(3/2015-10/2017)
TASK 2 - Perform Initial, Periodic, and Final QA/IV&V Assessments	(3/2015-3/2018)
TASK 3 - Perform Ongoing Risk and Issues Management	(3/2015-1/2018)
TASK 4 – Review and Evaluate DDI Vendor Deliverables	(3/2015-10/2017)
TASK 5 – Support MMIS Certification	(4/2015-7/2018)
TASK 6 – Report on Status	(3/2015-3/2018)

<b>TASK</b>	<b>DELIVERABLES</b>
TASK 1 - Develop, Maintain, and Execute the QA/IV&V Plan (3/2015-10/2017)	<ol style="list-style-type: none"> <li>1. Holding an initial introductory meeting with the State Authorized Representative and MMIS Project Managers, and Business Leads to understand the State’s expectations for the QA/IV&amp;V project, status for MMIS Projects (PBM, Care Management, MMIS Core, and Contact Center), review project templates, and discuss any required forms for the QA/IV&amp;V staff (i.e. project document repository access request form).</li> <li>2. Preparing and submitting a document request to the State Authorized Representative for foundational level project documentation, such as an organizational chart, HSE/MMIS program structure, project contact lists by role (including state and vendor contacts), vendor project schedules (DVHA MMIS Projects), and a schedule of existing standing meetings by project.</li> <li>3. Obtaining access to the State’s SharePoint sites.</li> <li>4. Developing a QA/IV&amp;V Plan and Work Plan. The QA/IV&amp;V Plan will include processes for governing the ongoing management of project scope, schedule, cost, quality, resources, risks, issues, and communications, and the Work Plan will include milestones for DDI Vendors’ tasks that are dependencies for completing QA/IV&amp;V deliverables defined in this contract. The QA/IV&amp;V Plan will also detail when and how the DDI Vendors will be engaged in the process.</li> </ol>
TASK 2 - Perform Initial, Periodic, and Final QA/IV&V Assessments (3/2015-3/2018)	<p>The QA/IV&amp;V assessments and corresponding reports will include:</p> <ol style="list-style-type: none"> <li>1. Bi-Weekly Status Reports</li> <li>2. Executive Status Reports</li> <li>3. Ad Hoc Reports</li> <li>4. Meeting Minutes (for Contractor-led meetings)</li> </ol>
TASK 3 - Perform Ongoing Risk and Issues Management (3/2015-1/2018)	<ol style="list-style-type: none"> <li>1. Establish an online Risk Assessment Tracking Tool in TeamCSG<sup>SM</sup> that provides a platform for risks and issues identified for the DVHA MMIS Projects to be reviewed, triaged, assigned, and tracked.</li> <li>2. Prepare action plans to enhance opportunities or minimize threats</li> </ol>
TASK 4 – Review and Evaluate DDI Vendor Deliverables (3/2015-10/2017)	<ol style="list-style-type: none"> <li>1. Conduct formal, independent, detailed assessments of the DEDs and contract deliverables for each MMIS DDI Vendor to evaluate completeness, to identify any potential risks or issues, and to ensure that each DDI Vendor’s deliverables align with the contractual expectations and meet the needs of DVHA.</li> <li>2. Validate the documents, policies, and procedures utilized and created by the DDI Vendor. The Contractor will verify and validate the existence of the deliverables, documents and deficiencies, and propose a plan for how the State and the DDI Vendor can remediate identified deficiencies.</li> </ol>
TASK 5 – Support MMIS Certification (4/2015-7/2018)	<ol style="list-style-type: none"> <li>1. Provide Certification training for DVHA staff.</li> </ol>

	<p>2. Determine if DVHA MMIS Projects will be subject to the Traditional Certification method or the MMIS Gate Review Certification that is currently being piloted with select states.</p> <p>3. Assess the State’s compliance with the CMS Certification including adherence to MITA 3.0, Vermont’s MITA SS-A, and the Seven Conditions and Standards. The Contractor will provide support and oversight to the State and DDI Vendors effort to prepare for the Certification, conduct a mock Certification Review to evaluate certification compliance, and work with the State and DDI Vendor to develop the Vermont-specific Certification checklist requirements. This evaluation is completed 90 days prior to the scheduled CMS Certification Review, to allow time for remediating any identified deficiencies.</p> <p>4. Upon receipt of the CMS Certification Review Report, the Contractor shall review the report and provide recommendations to the State Authorized Representative for inclusion in the CMS Certification Review Response Letter.</p>
<p>TASK 6 – Report on Status (3/2015-3/2018)</p>	<p>1. Bi-weekly status meetings with the State to provide an update regarding: (i) the QA/IV&amp;V activities and deliverables in accordance with the Work Plan; (ii) results from the ongoing risk and issue management task (Task 3); and (iii) outstanding actions from the Review and Evaluate Vendor Deliverables task (Task 4).</p> <p>2. Provide periodic executive status reports on QA/IV&amp;V reviews and recommendations to stakeholders such as the Executive Committee and Medicaid project teams regarding project status and risk anticipation, prevention and mitigation.</p> <p>3. Develop and deliver ad hoc reports regarding the QA/IV&amp;V efforts to stakeholders such as the Executive Committee and Medicaid project teams upon request.</p> <p>4. Prepare and distribute minutes from the meetings to discuss the status and other QA/IV&amp;V reports to stakeholders such as the Executive Committee and Medicaid project teams.</p>



**IV&V Payment Schedule: Payments are tied to contractually-defined deliverables:**

<b>Payment Milestone</b>	<b>Anticipated Due Date</b>	<b>Amount</b>
Monthly Invoice #1	3/31/2015	\$29,000
Monthly Invoice #2	4/30/2015	\$424,230
Monthly Invoice #3	5/31/2015	\$222,829
Monthly Invoice #4	6/30/2015	\$222,829
Monthly Invoice #5	7/31/2015	\$222,829
Monthly Invoice #6	8/31/2015	\$161,329
Monthly Invoice #7	9/30/2015	\$161,329
Monthly Invoice #8	10/31/2015	\$161,329
Monthly Invoice #9	11/30/2015	\$161,329
Monthly Invoice #10	12/31/2015	\$161,329
Monthly Invoice #11	1/31/2016	\$161,329
Monthly Invoice #12	2/28/2016	\$112,129
Monthly Invoice #13	3/31/2016	\$112,129
Monthly Invoice #14	4/30/2016	\$112,129
Monthly Invoice #15	5/31/2016	\$112,129
Monthly Invoice #16	6/30/2016	\$112,129
Monthly Invoice #17	7/31/2016	\$112,129
Monthly Invoice #18	8/31/2016	\$112,129
Monthly Invoice #19	9/30/2016	\$112,129
Monthly Invoice #20	10/31/2016	\$112,129
Monthly Invoice #21	11/30/2016	\$112,129
Monthly Invoice #22	12/31/2016	\$112,129
Monthly Invoice #23	1/31/2017	\$112,129
Monthly Invoice #24	2/28/2017	\$112,129
Monthly Invoice #25	3/31/2017	\$112,129
Monthly Invoice #26	4/30/2017	\$112,129
Monthly Invoice #27	5/31/2017	\$112,129
Monthly Invoice #28	6/30/2017	\$112,129
Monthly Invoice #29	7/31/2017	\$112,129
Monthly Invoice #30	8/31/2017	\$112,129
Monthly Invoice #31	9/30/2017	\$112,129
Monthly Invoice #32	10/31/2017	\$112,129
Monthly Invoice #33	11/30/2017	\$50,000
Monthly Invoice #34	12/31/2017	\$50,000
Monthly Invoice #35	1/31/2018	\$50,000
Monthly Invoice #36	2/28/2018	\$55,000
Monthly Invoice #37	3/31/2018	\$30,000
Monthly Invoice #38	4/30/2018	\$130,000
Monthly Invoice #39	5/31/2018	\$30,000
Monthly Invoice #40	6/30/2018	\$15,000
Monthly Invoice #41	8/15/2018	\$25,000
Defect Prevention, Detection, and Fixes (Ad Hoc Section)	As requested	\$75,000
<b>TOTAL:</b>		<b>\$4,954,400</b>

## 5. Acquisition Cost Assessment

List all acquisition costs in the table below (i.e. the comprehensive list of the one-time costs to acquire the proposed system/service). Do not include any costs that reoccur during the system/service lifecycle. Add or delete lines as appropriate. Based on your assessment of Acquisition Costs, please answer the questions listed below in this section.

The following chart represents the Acquisition Costs over a 7 year period.

Acquisition Costs	Cost	Comments
Hardware Costs	\$30K	Earmarked for Mailing/Fulfillment Center (printer, scales, etc.) but which may not actually be used
Software Costs	\$4.5M	
Implementation Services	\$12M	
Maintenance and Operations	\$12.6M	Includes Hosting, DR, Contingency
Staffing (Internal)	\$1.3M	
IV&V	\$.8M	
Other	\$1M	EPMO Services
<b>Total Acquisition Costs</b>	<b>~\$32M</b>	

## 5.1 Cost Validation

*Describe how you validated the Acquisition Costs.*

The Acquisition Costs were validated through the following methods:

*The Acquisition Costs were validated through discussions with Vendor regarding how the Vermont project scope compared with other similar projects Vendor has undertaken. Their response follows in grey background:*

Florida, the Agency for Healthcare Administration (Medicaid), is valued at \$18 – \$20M annually compared to SoV which is valued at \$32M for 7 years. The Florida project includes implementation of the entire eQSuite® system, along with medical management services.

When then asked the cost of the Medical Management services, so as to compare the remainder (eQSuite) to Vermont project and taking out the medical management services, and confirming whether that is an apples to apples comparison, the following response was provided:

Approximately 35% of the contract value is attributed to the software. The scope of the system implemented for the Florida contract is also limited compared to SoV care management solutions requirements. Specifically, the Florida eQSuite® system implementation did not require the extensive service oriented integration that is required in the SOV scope and eQHealth was able to leverage a much more significant amount of existing code limiting our development expenses. In, addition there will be an initial investment to integrate with the existing MMIS infrastructure and a subsequent refactoring to connect to the newly implemented MMIS system.

Using the information gleaned from the response above, 35% of \$20M FLA contract is considered an apples-to-apples cost allocation. As such, 35% of \$20M = \$7M. Carrying that cost over 7 years = \$49M. **The Vermont project at \$32M, is below that cost.**

**NOTE:** Commissioner Boes had the following question when reading a draft of the report: *“This seems in conflict with page 49 that states, “Service-oriented integration (SOI) is at the core of the eQSuite® system. All internal modules of the system currently integrate via a services interface layer.”)*

eQHealth responded to Commissioner Boes question with the following response:

The eQSuite system did not have a SOA interface at the time of implementation for the Florida contract and it did not initially require it. So the contract cost did not include the expenses for this development. We have since developed our “Gateway Services” layer which was implemented in later versions of eQSuite that can be leveraged for the Vermont implementation. Also, the state of FL Implementation did not include services integration to external systems beyond simple file based batch FTP exchanges and was limited to claims, eligibility and prior-authorization data only. Comparatively VT integration extends well beyond the aforementioned data sets to include scheduling, gateway services (HL7, xml) with external provider systems to incorporate clinical and administrative feeds for integration with other programs and health registry data sets to name a few. All these are true service oriented standards based services that would meet MITA 3.0 Architecture requirements. In addition, because of the disparate sources of data the VT project would require an enterprise master patient index (eMPI) to uniquely identify each record type (Patient, Provider etc.). VT is benefiting from all the extended work we did beyond Florida implementation that was not initially required in the scope of that project.

Additional future costs were sought out as well, as some of the annual software costs are a function of the population served (currently 187,019). The pricing Vermont has been proposed is valid for up to 200,000 beneficiaries. Pricing beyond that is detailed in the chart below:

	<b>Vermont Pricing As Proposed</b>	<b>Covered Lives</b>	<b>Annual Pricing</b>
eQSuite® Licensing	\$215,000	200K-250K	\$240,000
		250K – 500K	\$360,000
Predictive Modeling	\$120,000	200K-250K	\$150,000
		250K - 500K	\$180,000
HEDIS	\$83,250	200K-250K	\$120,000
		250K – 500K	\$180,000

Other costs were validated through readily available market data, including analysis of:

1. Professional Services Rates
2. Hosting Rates (difficult to measure separately, as those are bundled into the annual software costs, but there is some data here, as Vendor proposed hosting during initial Implementation period where incumbent and new solutions were running simultaneously)

## 5.2 Cost Comparison

*How do the above Acquisition Costs compare with others who have purchased similar solutions (i.e., is the State paying more, less or about the same)?*

1. Vermont costs are comparable in terms of DDI and M&O, given the underlying professional service rates and effort necessary to implement.
2. Vermont costs are comparable in terms of overall solution costs when compared to other eQHealth comparable projects.

## 5.3 Cost Assessment

*Are the Acquisition Costs valid and appropriate in your professional opinion? List any concerns or issues with the costs.*

It is the opinion of the report writer that the Acquisition Costs as outlined in the associated costing spreadsheet are appropriate.

### **Additional Comments on Acquisition Costs:**

None.

## 6. Technology Architecture Review

*After performing an independent technology architecture review of the proposed solution, please respond to the following.*

See **ATTACHMENT 4** for a summary of the proposed solution's underlying technology/toolset.

1. **State's IT Strategic Plan:** Describe how the proposed solution aligns with the [State's IT Strategic Plan](http://dii.vermont.gov/sites/dii/files/pdfs/DII-Strategic-Plan-FY2014-2019.pdf) (<http://dii.vermont.gov/sites/dii/files/pdfs/DII-Strategic-Plan-FY2014-2019.pdf>).
  - a. The State's 2014-2019 IT Strategic Plan contains 5 major goals and uses 6 key principles in designing and prioritizing work.
    - i. 5 Major Goals:
      1. To modernize critical technologies.
      2. To ensure sustainability of the state's information services.
      3. To operate IT effectively and efficiently.
      4. To use IT to improve the productivity of all state services.
      5. Create new solutions partnering with State Agencies.
    - ii. 6 Key Principles:
      1. Leverage successes of others, learning best practices from outside Vermont.
      2. Leverage shared services and cloud-based IT, taking advantage of IT economies of scale.
      3. Adapt the Vermont workforce to the evolving needs of state government.
      4. Leverage modern IT delivery frameworks and enterprise architectures.
      5. Couple IT with business process optimization, to improve overall productivity and customer service, not just IT itself.
      6. Optimize IT investments via Enterprise Architecture and Project Management methodologies.
  - b. The following describes how this project exploits these principles:
    - i. Leverage successes of others, learning best practices from outside Vermont.
      1. *In the last 5 years eQHealth has implemented 3 major medical management operations: Florida Agency for Healthcare Administration, Simply Better Health and Mississippi Division of Medicaid. This includes statewide rollout of our medical management platform including Prior Authorization and Care Coordination Integration with MMIS. These contracts are responsible for 3,892,207 covered lives.*
    - ii. Leverage shared services and cloud-based IT, taking advantage of IT economies of scale.
      1. *This solution is vendor hosted.*
    - iii. Adapt the Vermont workforce to the evolving needs of state government.
      1. *The proposed solution facilitates and supports the change underway at AHS in support of patient-centered services.*
    - iv. Leverage modern IT delivery frameworks and enterprise architectures.
      1. *The platform upon which the proposed solution is based is modern IT framework and enterprise-class architecture.*

- v. Couple IT with business process optimization, to improve overall productivity and customer service, not just IT itself.
  - 1. *The Vermont project team is comprised of a blend of business and technical staff, with the very intent of not only implementing the solution, but improving business processes.*
- vi. Optimize IT investments via Enterprise Architecture and Project Management methodologies.
  - 1. *The project meets most of the Enterprise Architecture standards. Vendor is proposing both an Account Director and a Project Manager to manage the project. Both people have had success with similar projects. Vermont team also has a dedicated Project Manager assigned to the project.*

**2. Service Level(s):** What is the desired service level for the proposed solution and is the technical architecture appropriate to meet it?

Yes, the technical architecture in the proposed solution will meet the desired Service Level Requirements (SLRs). Vendor answered in the AFFIRMATIVE and with Core functionality (indicated by L=Leverage) for ALL SLRs outlined in the **RFP TEMPLATE H – NON-FUNCTIONAL REQUIREMENTS**, tab G3: SLRs and PERFORMANCE, and which is provided below.

RFP Req #	Requirement Description	Vendor Response: Y or N	Vendor Response: L, T or D
G3.1	The System response time during operations will be 5 seconds or less for 95 percent of the search and lookup queries (does not include ad hoc queries and analytics). Maximum response time will not exceed 15 seconds except for agreed to exclusions. Response time is defined as the time elapsed after depressing an ENTER key (or clicking on a button that submits the screen for processing) until a response is received back on the same screen	Y	L
G3.2	The System will return a Dashboard report within 5 seconds or less, 95% of the time	Y	L
G3.3	The System will return a Static Standard report within 5 seconds or less, 95% of the time	Y	L
G3.4	The System will return a parameter-based report within 20 seconds or less	Y	L
G3.5	The System will achieve performance for interactive transactions other than the reporting-related transactions above, conforming to the minimum acceptable performance standard of 5 seconds response time, for 95% of interactions	Y	L
G3.6	The components of the Solution under vendor control as delivered into production shall be available at a level agreed in the contract (the contracted target level of availability) this will be chosen from one of the three availability levels 99.9%, 99.95% or 99.99%	Y	L
G3.7	The System will be architected with no single point of failure, supporting a high-availability enterprise	Y	L

RFP Req #	Requirement Description	Vendor Response: Y or N	Vendor Response: L, T or D
G3.8	The System's hours of operations will be 24 hours per day, 7 days per week, and 365 days a year	Y	L
G3.9	The System will have the ability to support session replication and transparent failover using high-availability architectural options	Y	L
G3.10	The System will be designed to support the planned Vermont systems and any anticipated expansion in scope of connectivity	Y	L
G3.11	The System Administration staffing requirements and workload should be minimally impacted with expanded system usage	Y	L
G3.12	The System must be built so that there is a near linear relationship between each additional server added, and the additional load that can be accommodated (load vs. capacity added), up to specified limit	Y	L
G3.13	The System's Recovery Time Objective (RTO) will be within 4 hours. In case of a disaster that effects the Care Management operations, the entire service will be restored within 4 hours	Y	L
G3.14	The System's Recovery Point Objective (RPO) will be no more than 1 hour of data loss. In case of a disaster that effects the Care Management operations, 1 hour of data inputs to the system (but no more) may be lost and need to be re-entered	Y	L
G3.15	The System will use fully redundant network and hardware. Hardware components (such as processor and memory) should have built-in redundancy to allow a second component to take over in the event of a failure in the primary component. Similarly, redundant paths should also exist for networks	Y	L
G3.16	The System will leverage virtualization to expedite disaster recovery. Virtualization enables system owners to quickly reconfigure system platforms without having to acquire additional hardware	Y	L
G3.17	The System will have the ability to support either a Production and hot (real time replication) disaster recovery design or a multi host site Production design that would allow one site to seamlessly be offline and the other site would maintain service without interruption	Y	L
G3.18	The System will include a disaster recovery plan and provide contingency plans for client lookup capabilities and online collaboration in the event of a disaster	Y	L
G3.19	The System will provide the ability to recover from data loss due to end user error and end application error	Y	L
G3.20	The System will provide the ability to perform archival/incremental backups and the ability to perform open/closed database backups	Y	L
G3.21	The System will provide tools for managing an environment that supports both high availability and disaster recovery	Y	L



RFP Req #	Requirement Description	Vendor Response: Y or N	Vendor Response: L, T or D
G3.22	<p>The System will include the capability to maintain all data according to state defined records retention guidelines (i.e. record schedule). General schedules can be found at: <a href="http://vermont-archives.org/records/schedules/general/">http://vermont-archives.org/records/schedules/general/</a>. Specific retention disposition orders can be found at: <a href="http://vermont-archives.org/records/schedules/orders/">http://vermont-archives.org/records/schedules/orders/</a>.</p> <p>In general, document retentions range from 3 to 10 years. In addition to the above, note that case records including Child Support-related data must be retained for a minimum of 3 years after Case closure and the youngest child in the case is 18 years old.</p>	Y	L
G3.23	<p>The System will include the capability to maintain all images and electronic documents according to state defined document retention guidelines (i.e. record schedule). General schedules can be found at: <a href="http://vermont-archives.org/records/schedules/general/">http://vermont-archives.org/records/schedules/general/</a>. Specific retention disposition orders can be found at: <a href="http://vermont-archives.org/records/schedules/orders/">http://vermont-archives.org/records/schedules/orders/</a>.</p> <p>In general, document retentions range from 3 to 10 years.</p>	Y	L
G3.24	The System will provide on-line access of all active cases and up to 12 months for closed cases	Y	L
G3.25	All software developed and delivered by the Vendor must be free of viruses, malware, backdoors	Y	L
G3.26	The service provider must resolve Severity 1 Maintenance requests within 4 clock hours	Y	L
G3.27	The service provider must resolve Severity 2 Maintenance requests within 8 clock hours	Y	L
G3.28	The service provider must resolve Severity 3 Maintenance requests within 3 calendar days	Y	L
G3.29	All priority 3 or higher defects (testing defects) resulting from software development activities shall be resolved by the Vendor prior to the software being delivered for User Acceptance Testing and prior to deployment to production	Y	L
G3.30	The Vendor must respond to priority 1 test defects within 1 hour	Y	L
G3.31	The Vendor must resolve priority 2 test defects within 4 clock hours	Y	L
G3.32	The Vendor must respond to priority 3 test defects within 8 hours	Y	L
G3.33	The Vendor must respond to priority 4 test defects within 5 days	Y	L
G3.34	The Vendor must report on all priority 5 test defects with each reporting phase	Y	L

Additionally, the chart below shows the certain Service Levels that have an associated “Service Credit” desired by Vermont, and the right-most column shows Vendor response to the question of Service Credit Assessment, should the Service Level not be met:

<b>SLR NAME</b>	<b>SERVICE LEVEL REQUIREMENT</b>	<b>MEASUREMENT OF NONCOMPLIANCE</b>	<b>FREQUENCY OF MEASUREMENT</b>	<b>VENDOR ASSESSMENT OF SERVICE CREDITS (SC)</b>
<b>Virus Contamination</b>	All software developed and delivered by the Vendor must be free of viruses.	Each virus that is included in software developed and delivered by the Vendor.	Monthly after deployment of VCCI Go-Live Date	[\$ 10,000.00] per virus
<b>On-line Availability</b>	The components of the Solution under Vendor control as delivered into production shall be available at a level agreed to in the Contract (the contracted target level of availability). This will be chosen from one (1) of the three (3) availability levels shown in Table 3 Levels of Availability of the future Case Management System**.	Each tenth of percentage point less than the contracted level of availability.	Monthly after deployment of VCCI Go-Live Date	[\$ 5000.00] for each Percentage point below the contracted level of availability for the month
<b>On-line Search and Lookup queries Response Times</b>	The System response time during operations will be 5 seconds or less for 95 percent of the search and lookup queries (does not include ad hoc queries and analytics). Maximum response time will not exceed 15 seconds except for agreed to exclusions. Response time is defined as the time elapsed after depressing an ENTER key (or clicking on a button that submits the screen for processing) until a response is received back on the same screen.	Each .5 second that the monthly average response time exceeds the maximum response time.	Monthly after deployment of VCCI Go-Live Date	[\$ 5000.00] per 0.5 seconds that the monthly average response time exceeds the maximum response time. For purposes of this SLR and the following response time SLRs, seconds will be rounded up to the nearest 0.5 of a second.
<b>Dashboard Report Response Times</b>	The System will return a Dashboard report within 5 seconds or less, 95% of the time.	Each .5 second that the monthly average response time exceeds the maximum response time.	Monthly after deployment of VCCI Go-Live Date	[\$ 500.00] per 0.5 seconds that the monthly average response time exceeds the maximum response time.
<b>Static Standard Report Response Times</b>	The System will return a Static Standard report within 5 seconds or less, 95% of the time.	Each .5 second that the monthly average response time exceeds the maximum response time.	Monthly after deployment of VCCI Go-Live Date	[\$ 500.00] per 0.5 seconds that the monthly average response time exceeds the maximum response time.

<b>SLR NAME</b>	<b>SERVICE LEVEL REQUIREMENT</b>	<b>MEASUREMENT OF NONCOMPLIANCE</b>	<b>FREQUENCY OF MEASUREMENT</b>	<b>VENDOR ASSESSMENT OF SERVICE CREDITS (SC)</b>
<b>Parameter-based Report Response Times</b>	The System will return a parameter-based report within 20 seconds or less.	Each .5 second that the monthly average response time exceeds the maximum response time.	Monthly after deployment of VCCI Go-Live Date	[\$ 500.00] per 0.5 seconds that the monthly average response time exceeds the maximum response time.
<b>On-line Application Response Times</b>	The System will achieve performance for interactive transactions other than the reporting-related transactions above, conforming to the minimum acceptable performance standard of 5 seconds response time, for 95% of interactions.	Each .5 second that the monthly average response time exceeds the maximum response time.	Monthly after deployment of VCCI Go-Live Date	[\$ 500.00] per 0.5 seconds that the monthly average response time exceeds the maximum response time.
<b>Software Maintenance Request Resolution Times: *Severity 1 — Emergency</b>	The service provider must resolve Severity 1 Maintenance requests within 4 hours.	Each hour beyond the requirement for resolving Severity 1 Maintenance requests.	Monthly after deployment of VCCI Go-Live Date	[\$5000.00] per hour beyond the 4 hour time requirement.
<b>Software Maintenance Request Resolution Times: *Severity 2 — Urgent</b>	The service provider must resolve Severity 2 Maintenance requests within 8 hours.	Each hour beyond the requirement for resolving Severity 2 Maintenance requests.	Monthly after deployment of VCCI Go-Live Date	[\$ 2000.00] per hour beyond the required 8 hour time requirements.
<b>Software Maintenance Request Resolution Times: *Severity 3 — Important</b>	The service provider must resolve Severity 3 Maintenance requests within 3 calendar days.	Each calendar day beyond the requirement for resolving Severity 3 Maintenance requests.	Monthly after deployment of VCCI Go-Live Date	[\$ 1000.00] per calendar day beyond the required 3 calendar days.
<b>Quality of Code Delivered to UAT</b>	All priority 3 or higher defects (testing defects) resulting from software development activities shall be resolved by the Vendor prior to the software being delivered for User Acceptance Testing (UAT) and prior to deployment to production.	Each priority 3 or higher defect that is uncovered in UAT.	Monthly after start of the UAT phase of each implementation release	[\$1000.00] per priority 3 or higher defect discovered in User Acceptance Testing.

<b>SLR NAME</b>	<b>SERVICE LEVEL REQUIREMENT</b>	<b>MEASUREMENT OF NONCOMPLIANCE</b>	<b>FREQUENCY OF MEASUREMENT</b>	<b>VENDOR ASSESSMENT OF SERVICE CREDITS (SC)</b>
<b>UAT Defect Resolution Times: Response to *Priority 1 test defect</b>	The Vendor must respond to priority 1 test defects within 1 hour.	Each instance that a response is not provided within the required timeframe for each test defect.	Monthly after start of the UAT phase of each implementation release	[\$ 2500.00] per instance of failure to meet response timeframe for each test defect.
<b>UAT Defect Resolution Times: Response to *Priority 2 test defect</b>	The Vendor must respond to priority 2 test defects within 4 hours.	Each instance that a response is not provided within the required timeframe for each test defect.	Monthly after start of the UAT phase of each implementation release	[\$ 2000.00] per instance of failure to meet response timeframe for each test defect.
<b>UAT Defect Resolution Times: Response to *Priority 3 test defect</b>	The Vendor must respond to priority 3 test defects within 8 hours.	Each instance that a response is not provided within the required timeframe for each test defect.	Monthly after start of the UAT phase of each implementation release	[\$1500.00] per instance of failure to meet response timeframe for each test defect.
<b>UAT Defect Resolution Times: Response to *Priority 4 test defect</b>	The Vendor must respond to priority 4 test defects within 5 days.	Each instance that a response is not provided within the required timeframe for each test defect.	Monthly after start of the UAT phase of each implementation release	[\$ 1000.00 SC] per instance of failure to meet response timeframe for each test defect.
<b>UAT Defect Resolution Times: Response to *Priority 5 test defect</b>	The Vendor must respond to priority 5 test defects with each reporting phase (timeframe to be determined with State).	Each instance that a response is not provided within the required timeframe for each test report.	Monthly after start of the UAT phase of each implementation release	[\$ 500.00] per instance of failure to meet response timeframe for each test defect.
<b>Disaster Recovery RTO</b>	The System's Recovery Time Objective (RTO) will be within 4 hours. In case of a disaster that affects the Care Management operations, the entire service will be restored within 4 hours.	For each 10 minutes longer than the 4 hours it takes to restore the entire service.	Annual review of any disaster incidents.	[\$ 500.00] per each 10 minutes or part of 10 minutes over the RTO.

SLR NAME	SERVICE LEVEL REQUIREMENT	MEASUREMENT OF NONCOMPLIANCE	FREQUENCY OF MEASUREMENT	VENDOR ASSESSMENT OF SERVICE CREDITS (SC)
<b>Disaster Recovery RPO</b>	The System's Recovery Point Objective (RPO) will be no more than 1 hour of data loss. In case of a disaster that affects the Care Management operations, 1 hour of data inputs to the System (but no more) may be lost and needs to be re-entered.	For each 10 minutes more than 1 hour of data loss.	Annual review of any disaster incidents	[\$ 500.00] per each 10 minutes or part of 10 minutes over the RPO.
<b>Record Retention</b>	<p>The System will include the capability to maintain all data according to State-defined records retention guidelines (i.e., record schedule). General schedules can be found at: <a href="http://vermont-archives.org/records/schedules/general/">http://vermont-archives.org/records/schedules/general/</a>. Specific retention disposition orders can be found at: <a href="http://vermont-archives.org/records/schedules/orders/">http://vermont-archives.org/records/schedules/orders/</a>.</p> <p>In general, record retentions range from 3 to 10 years. In addition to the above, note that case records including Child Support-related data must be retained for a minimum of 3 years after Case closure and the youngest child in the case is 18 years old.</p>	Each record instance the System fails to achieve compliance with the agreed schedule for the class or type of records.	Annual review of record retention.	[\$ 100.00] per record instance out of compliance with the defined retention schedule.
<b>Document Retention</b>	<p>The System will include the capability to maintain all images and electronic documents according to State-defined document retention guidelines (i.e., record schedule). General schedules can be found at: <a href="http://vermont-archives.org/records/schedules/general/">http://vermont-archives.org/records/schedules/general/</a>. Specific retention disposition orders can be found at: <a href="http://vermont-archives.org/records/schedules/orders/">http://vermont-archives.org/records/schedules/orders/</a></p> <p>In general, document retentions range from 3 to 10 years.</p>	Each document instance the System fails to achieve compliance with the agreed schedule for the class or type of documents.	Annual review of document retention.	[\$ 100.00] per document instance out of compliance with the defined retention schedule.

SLR NAME	SERVICE LEVEL REQUIREMENT	MEASUREMENT OF NONCOMPLIANCE	FREQUENCY OF MEASUREMENT	VENDOR ASSESSMENT OF SERVICE CREDITS (SC)
<b>On-line Case Retention</b>	The System will provide on-line access of all active cases and up to 12 months for closed cases.	Each case instance the System fails to achieve compliance with the agreed schedule for the cases.	Annual review of online case retention.	[\$ 100.00] per case instance out of compliance with the defined retention schedule.

Additionally, the table below shows possible levels of availability that Vermont expects the Vendor to propose at differing price levels, and which will be decided at Contracting.

AVAILABILITY %	DOWNTIME PER YEAR	DOWNTIME PER MONTH	DOWNTIME PER WEEK
99.9% ("three nines")	8.76 hrs	43.2 min	10.1 min
99.95%	4.38 hrs	21.56 min	5.04 min
99.99% ("four nines")	52.56 min	4.32 min	1.01 min

The pricing submitted by Vendor assumes support at the 99.9% (three nines) level.

The additional costs are as follows for the other two levels:

AVAILABILITY %	TOTAL COSTS OVER 7 YEARS	AVERAGE ANNUAL COST
99.95%	\$182,411	\$25,059
99.99% ("four nines")	\$395,224	\$56,461

**3. Sustainability:** Comment on the sustainability of the solution’s technical architecture (i.e., is it sustainable?).

- a. It appears that the technical architecture is sustainable, given the following considerations:
  - i. It utilizes industry standard technology (.NET Framework, SQL Server, Windows Server Operating System, desktop browser (zero footprint).
  - ii. It utilizes technology that is supported by State of Vermont EA staff.
  - iii. It utilizes technology that many users are already trained in/familiar with.

**4. License Model:** What is the license model (e.g., perpetual license, etc.)?

- a. The software is an Enterprise license and is priced based on number of people served.
- b. License agreement is detailed on Pages 692-702 of the proposal submitted by Vendor.

The chart below shows the software components comprising the solution and License Type, as well as other information such as pricing:

Software Item	Environment (e.g., Development, Test, Training, Production)	Manufacturer	License Type (e.g., enterprise, per user, per server)	Brand Name	Annual Fee
eQHealth eQSuite®Licensing	All	eQHealth	Enterprise	eQHealth eQSuite™ Licensing	\$215,000
Healthwise - Education Materials	All	Healthwise	Enterprise		\$158,000
InterQual - Guidelines for UM criteria	All	McKesson	Enterprise	Interqual	\$0
First Data Bank - Drug Database	All	First Databank	Enterprise	MedKnowledge	\$26,000
Geocoding	All	Texas A&M Geoservices	Volume Dependant	Google	\$10,000
Coding Libraries (CPT, ICD9-10 APDRG etc.)	All	AMA	Annual		\$5,000
in-Rule - Business Rules Management Systems	All	In-Rule	Enterprise		\$1,500
Mirth Match - Mast Data Index	All	Mirth	Enterprise	Match	\$24,000
HEDIS	All	Cognizant	PMPM		\$83,250
Johns Hopkins ACG - Predictive Modeling	All	DST Health Solutions	PMPM	Care Analyzer	\$120,000

**5. Security:** Does the proposed solution have the appropriate level of security for the proposed activity it will perform (including any applicable State or Federal standards)? Please describe.

In short, yes it does. Details follow:

**a. Security Architecture and Design**

a. eQHealth Solutions has an in-house certified security specialist on staff that holds one or more of the following certifications:

- Information Assurance Manager (IAM)
- Information System Security Manager (ISSM) Certification
- Certified FISMA Auditor
- ISC2 Certified Information System Security Professional (CISSP)
- ISACA Certified in Risk and Information Systems Control (CRISC)
- ISACA Certified in the Governance of Enterprise IT (CGEIT)
- EC Council Certified Ethical Hacker (CEH)
- Certified EC-Council Instructor (CEI)
- HITRUST Common Security Framework (CSF) Practitioner
- Certified HIPAA Professional (CHP)
- Certified HIPAA Security Specialist (CHSS)

This staff is tasked to monitor and control all aspects of the security program for the entire infrastructure. They subscribe to all published standards and models and attend industry related conferences to be versed in all the latest security related guidance and practices. They analyze the surface area vulnerability of the systems to ensure all known vectors of attack are considered and hardened well beyond industry best practices. A critical step in the SDLC and ITIL infrastructure change control processes is a security related review of all functional and technical specifications to ensure a vulnerability is not introduced to the system. This step is mandatory and absolutely no development or implementation can proceed without an approval from the security team. If an exception is noted in review, guidance is provided by the security team to completely mitigate the finding. eQHealth also contracts annually with an external highly regarded third party security firm to conduct penetration testing and provide a thorough security analysis and deliver a risk mitigation strategy plan.

The security team **classifies all data** in order to assure appropriate security measures are considered throughout the lifecycle of information processing in the systems. A data sensitivity matrix is applied to all data sources to understand the associated sensitivity rating (high, medium, and low) and the required level of controls needed to secure each. This includes criteria such as:

- Who should access and how much harm would be done if disclosed?
- What is subject to state and federal regulations and would require a notification in the event of a disclosure?

All risk level controls significantly exceed industry best practices and are reviewed frequently to make sure they continue to do so.

The eQSuite® system allows no access whatsoever without secure user authentication and resource authorization (specific functionality). All login user names must be unique and be associated with an industry best-practices strong password. A user must change this password on a configured expiration timeframe and the reuse of passwords is limited.

eQSuite® system is SaaS application accessed via SSL secured web browsers, yet there are use cases that require VPN remote connectivity to the infrastructure for maintenance and support. eQHealth Solutions deploys several SonicWall™ NSA 3500 SSL VPN appliances to secure all remote connectivity needs within the infrastructure. These appliances provide intrusion detection, malware protection and packet level scanning real-time while continuing to maintain a very low latency and responsive connection.

The eQSuite® system is deployed on no single point of failure topology that allows recovery from a failure of any element within the infrastructure. Fault tolerance and failovers are accomplished with both redundancy of critical hardware such as routers, switches, firewalls and server hosts, but also via a virtualization fabric of network load balanced servers and routing. Virtualization delivers a significantly improved level of ease when it comes to serviceability and operations of a complex network and application delivery environment. When you place this topology in a commercial datacenter it makes for a state of the art scalable, maintainable, fault tolerant and highly recoverable infrastructure.

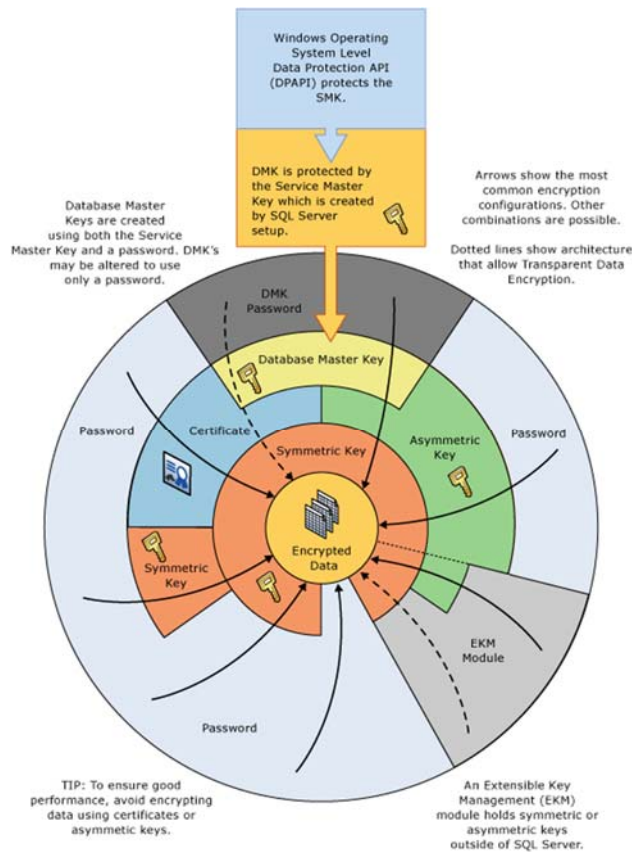


## b. Identity and Access Management (IAM)

The eQSuite® system leverages a centralized provider model pattern for IAM. This means that the identification of users and their associated security is abstracted from the data source that persists it. The provider supports all service methods for creating users, deleting or de-provisioning users, verifying login credentials, changing passwords and applying roles or permissions. Currently the system integrates with a SQL Server based storage mechanism but can support many different storage sources or services such as a lightweight directory access protocol (LDAP) capable repository like Microsoft Active Directory. *(Per Michael Hall: Vendor have also agreed to migrate to the HSEP IAM when SOV has it available.)* The provider model of security in eQSuite® enables a consistent integrated login experience across all user interfaces regardless of the platform it is being accessed from. A styled delivery of login that is most appropriate for each interface channel is rendered by detecting the accessing application or browser type. The audit trail for each channel is centralized, consistent and verbose in its level of data capture and supports the scrutiny of security analysis or forensics exceeding all compliance requirements for chain of custody and activity. The user accounts in eQSuite® are augmented by a profile provider. This provider allows for the addition of typed property values to be added to a user to store all additional information required to provide context for functionality like business rules, workflow, processes and user preferences. This is managed from the respective user's profile screen of eQSuite® and can also be managed by authorized administrative users in the security module.

## c. Application Encryption

The eQSuite® SQL Server 2008 R2® database server provides several options for database encryption. eQHealth utilizes transparent data encryption (TDE), which is a full-database-level **bulk encryption technique** that exceeds all regulatory security standards. TDE works at the file level for all data at rest, which is similar to the Encrypting File System (EFS) and BitLocker™ drive encryption. TDE operates at the I/O level through the buffer pool. Thus, any data that is written into the database file (\*.mdf) is encrypted including all database columns and indexes. Snapshots and backups are also designed to take advantage of the encryption provided by TDE so these are encrypted on disk as well. **Data that is in use, however, is not encrypted because TDE does not provide protection at the memory or transit level.** Data in motion is protected by the **SSL/TLS** protocol standard between the server and any browser clients consuming or writing data over un-trusted networks. The eQSuite® database schema includes several instances where cell or field-level encryption is implemented for those scenarios where the database is accessed by a non-browser based custom application that may or may not be protected over a secure protocol or has the potential of storing data locally for later use. This data is not decrypted or in clear text at transport however it requires a key management mechanism to support the encrypt/decrypt steps. Extensible Key Management (EKM) is a feature of SQL Server that supports strong asymmetric keys for our encryption approaches. EKM integrates with our cryptographic key provider and provisions keys to support both TDE and field-level encryption. The following figure shows the full encryption hierarchy. The dotted lines represent the encryption hierarchy used by TDE.



#### d. Privacy and Consent

The eQSuite® security module is a flexible secure web-based utility that provides administrators with a user friendly console to manage all aspects of role-based application security. An administrator may allow/restrict access to various components of eQSuite® by adding users to pre-defined roles that are configured by default for each standard user type in the system. In addition to configurable security elements (roles, permissions), eQSuite® includes the ability to store user specific configurable data fields such as an email address to facilitate automated notifications and indicators such as internal/external user or department that can be leveraged by business rule logic to support workflow. Administrators are able to self-service deactivate users temporarily restricting their access to the system as well as reset passwords without requiring a customer service representative. Only data elements necessary to manage the account are displayed and are de-identified to an appropriate level to ensure privacy.

#### e. Security Audit

eQHealth contracts with highly regarded third party security firms to conduct annual security audits and examine network security controls from the perspective of an independent source. eQHealth is also proactive in handling security requirements that come from within the organization, as well as from outside regulators. The contracted firm reviews the following:

- Agreements, contracts, work obligations, or statements of work
- Efficiency of network connections and their current security status
- Current policies and procedures, and how those relate to data access
- Engagement management tools, controls, and reporting
- Level of compliance in regards to regulatory requirements
- Current industry standing, and corporate health, of the service provider

Web applications are a critical component of our service delivery and securing those applications is paramount. In addition to the network security audit, the security firm conducts application penetration testing using a well-developed matrix of existing threats, vulnerabilities, and real world recommendations to identify any potential security weaknesses. A report is produced by the firm detailing the results of the audit and any detected deficiencies or threats.

Cognizant's information security structure is based upon the ISO27001 framework which is in line with HIPAA and HITECH acts. Following are the activities performed to ensure the current and future compliance:

- All health care associates in Cognizant are mandated to undergo four stages of e-learning sessions on HIPAA; they must complete an assessment on their HIPAA understanding.
- All health care associates are mandated to undergo e-learning session on revised HITECH act and liability of a business associate.
- All Cognizant employees are mandated to complete a course on acceptable use policy, which covers aspects of privacy and security. (annually)
- In addition to above information security awareness training program is conducted for associates and security controls agreed with client are briefed to associates (semi-annually).
- Cognizant follows a detailed and well-documented approach to risk management. As per the risk management framework of Cognizant, facility level risks and account security risks assessments are being conducted on an annual basis where physical security risks and risks associated with compliance controls agreed in MSA to comply with HIPAA/HITECH and State Statutes will be tracked. Account level security risk assessment is conducted on a quarterly basis checking the operating effectiveness of the controls requested by client.
- SAS 70 / ISO 27001 and Third party audits are performed to check the control effectiveness in addition to above said internal audit.
- Global information security team sends out CSO blogs where discussions on security are done, security awareness notes are sent to all associates on a monthly basis.

Further, Infrastructure and applications are tracked at an extremely granular level across all tiers. eQHealth licenses dynaTrace's PurePath Technology® that captures all transactions, end-to-end, from a user click, to the database record and back. This exact detail allows for more accurate and timely reporting, granular business transaction grouping and precise SLA management. This gives the eQHealth Solutions IT team complete visibility into the applications, operating system and hardware layers from a single dashboard. It supports user auditing, performance and scalability initiatives and allows Vendor to be proactive in diagnosing any problem across each critical layer. Each transaction step can be "drilled" in on to view the detailed data related to that step. Tracking values like transaction time, IP address, browser type, execution duration and many more are available for viewing. All dashboards are monitored daily by systems engineers and logs are archived and available for auditing purposes.

## f. Database Security

### Confidentiality:

- Data Encryption – See Application Encryption above.
- Access Control - Authentication with strong passwords.
- Object level authentication – Access to specific tables, stored procedures, views etc. are restricted at the user level.
- Upgrades and patches – As soon as patches and upgrades are available and thoroughly tested as they are released to production.
- Intrusion Detection and Prevention (IDS) – Packet level network IDS and profiling with alerts.

### Integrity:

- Database Backups - Enterprise level SAN replication at the block level. Data is de-duped and transmitted to disparate data center for immediate restoration of data in the unlikely event of corruption.
- Track and Audit – Capture all security related events and all changes to database objects and raw data.
- Constraints – Database design standards include enforcement of entity relationships, primary keys, foreign keys and default values.
- Hardware Configuration – Redundant Disk Arrays (RAID 10/5) to provide data partitioning/stripping to reduce risk of data loss on drive failure.

### Availability:

- Scalable redundant hardware – Multiple routers, switches, and virtualization hosts
- Fault tolerance and failovers – No single point of failure infrastructure.
- Virtualization of web servers in conjunction with Network Load Balancing (NLB) across farm.
- Disaster Recovery – In the unlikely event of loss of primary location, vendor is near real-time replicating to a hot site that can be promoted to primary with no loss of data.

## g. Software and Hardware Security *(phrased from eQHealth's perspective)*

### Server OS Security

We ensure all server operating systems are properly deployed, configured and managed to meet the highest security standards and guidelines concerning HIPAA, HITECH and FISMA Compliance. At a minimum we follow the following guidelines in the form of system/configuration management and proactive preventive maintenance:

- All of our server operating systems are setup and maintained by qualified System Administrators
- We strictly adhere to Microsoft's best practices and software lifecycle management directives
- All servers are periodically scanned for malicious software, unnecessary services and access
- We patch, upgrade and test each operating environment for the latest releases from Microsoft®. We have procedures in place to control the installation of software on operational systems
- We remove or disable all unnecessary services, applications, and network protocols where practical
- All security-related events on critical or sensitive systems are logged and audit trails saved
- Access to services are logged and protected through access-control methods

- We adhere to Least Privilege concepts and practices to include governing all Privileged User access
- We perform periodic security and penetration testing
- We allow 3rd Party audits to include review of controls within the server operating systems
- We conduct periodic reviews of server logs to identify suspicious activities

#### Client OS Security

We ensure all client operating systems are properly deployed, configured, and managed to meet the highest security standards and guidelines concerning HIPAA, HITECH and FISMA Compliance. At a minimum we adhere to the following guidelines in the form of system/configuration management and proactive preventive maintenance:

- All client operating systems are setup and maintained by qualified System Administrators
- Vendor uses and support Microsoft Windows 7 and 8
- Vendor strictly adheres to Microsoft's best practices and software lifecycle management directives
- All servers are periodically scanned for malicious software, unnecessary services and access
- Vendor will patch, upgrade and test each operating environment for the latest releases from Microsoft, and have procedures in place to control the installation of software on operational systems
- Vendor removes or disables all unnecessary services, applications, and network protocols where practical
- All security-related events on critical or sensitive systems are logged and audit trails saved
- Access to services are logged and protected through access-control methods
- Vendor adheres to Least Privilege concepts and practices to include governing all Privileged User access
- Vendor performs periodic security and penetration testing
- Vendor allows 3rd Party audits to include review of controls within the server operating systems
- Vendor conducts periodic reviews of server logs to identify suspicious activities

#### Mobile Devices Security

Mobile devices, such as smart phones and tablets, typically need to support multiple security objectives. To achieve these objectives eQHealth Solutions enforces enterprise security policies on all mobile devices, such as restricting access to hardware and software, managing wireless network interfaces, and automatically monitoring and reporting when policy violations occur. At a minimum we adhere to the following guidelines:

- Vendor develops and maintains a mobile device security policy which defines which types of mobile devices are permitted to access corporate resources, the degree of access and how provisioning should be handled.
- Vendor implements and tests all prototypes of mobile devices solution(s) before rolling into a production environment.
- Vendor fully secures each mobile device before allowing user access.
- Vendor supports strongly encrypted data communications and data storage, and remotely wiping the device if it is lost or stolen and is at risk of having its data recovered by an untrusted party.

- Vendor requires authentication before accessing organization resources, resetting forgotten passwords remotely, automatically locking idle devices, and remotely locking devices suspected of being left unlocked in an unsecured environment.
- Vendor restricts which applications may be installed (through whitelisting or blacklisting), installing and updating applications, restricting the use of synchronization services, digitally signing applications, distributing our applications from a dedicated mobile application store, and limiting or preventing access to the enterprise based on the mobile devices' operating system version or mobile device management software client version.

#### Web Server and Browser Security

Vendor ensures the security of Web Servers through augmentation of traditional security mechanisms consisting of frameworks based on use of authentication, authorization, confidentiality, and integrity controls. At a minimum we adhere to the following guidelines:

- Use of Secure Socket Layer and Transport Layer Security (SSL and TLS). Secure Sockets Layer uses a public key to encrypt data transferred over the SSL connection.
- Vendor counters Denial of Service (DoS) attacks through replication of data and services for improved availability. Replication and redundancy can ensure access to critical data in the event of a fault and will enable the system to react in a coordinated manner to overcome disruptions.
- Vendor uses logging of transactions to improve non-repudiation and accountability. Non-repudiation and accountability require logging mechanisms involved in the entire Web Service transaction.
- Vendor uses threat modeling, harden our operating environments with the latest fixes, patches and configurations, and conduct software security testing to include scheduled penetration testing. Vendor solutions provide a secure operating environment to withstand a variety of attacks.
- Vendor patches and upgrades operating system (OS), remove or disable unnecessary services and applications, configure OS user authentication, and periodically test the security of the OS.
- Vendor uses performance analysis and simulation techniques for end to end quality of service and quality of protection.
- Vendor uses Web Service security standards, tools, and techniques required for traditional security mechanism, such as firewall, intrusion detection systems (IDS), and secured operating systems. These controls are in effect before implementation or deployment of Web Services applications.
- Vendor supports web browsers that use the latest security measures/controls and are supported by the provider.
- Vendor only supports the last three (3) browser versions to ensure the latest security architecture.
- Vendor uses the latest utilities to conduct an optimization study, which enables them to maintain a proactive security posture in terms of browser types, versions and configurations.

#### POS Terminal Security

- Not applicable

6. **Disaster Recovery:** What is your assessment of the proposed solution’s disaster recovery plan; do you think it is adequate? How might it be improved? Are there specific actions that you would recommend to improve the plan?

- a. Overall the plan is solid, and well laid out. Supported by two data centers, Baton Rouge, Louisiana and Lombard, Illinois.
- b. There are specific Recovery Plans for each of the following:
  - a. Infrastructure Summary
  - b. Database Server
  - c. Server Backups and Replication
  - d. File and Application Servers
  - e. Exchange Email Server
  - f. Storage Area Network
  - g. User Access
  - h. Web Server
  - i. Voice, Data and Fax Circuits and PBX Telephone System
  - j. Printers, Switches and Routers
  - k. Firewall
  - l. Anti-Virus Server
- c. Disaster Declaration: The **TYPE** of Disaster declared (classified as minor, major and catastrophic) drive the Recovery Time Objective (RTO) and Recovery Point Objective (RPO) as follows:

TYPE	RTO	RPO
Minor	< 30 minutes	Indicates no data loss
Major	< 4 hours	Indicates no data loss
Catastrophic	> 4 hours	Indicates no data loss

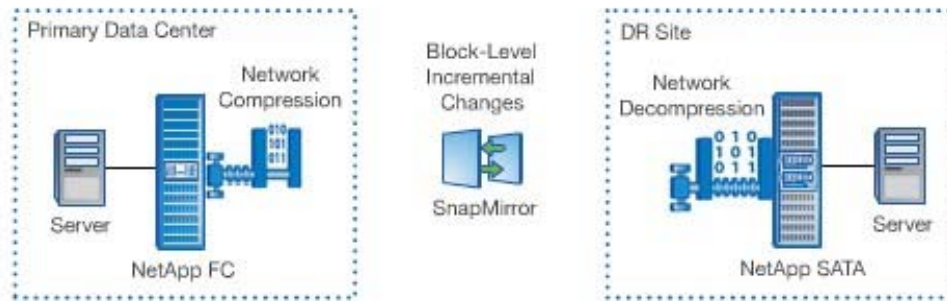
d. The following chart is used by eQHealth to further describe this:

Risk Category	Risk Factor Event	Impact to Business Operations	Impact to Facility or Equipment	Recovery Time Objective	Risk Probability of Event Occurring
Weather	Tornado	Catastrophic	Catastrophic	Catastrophic	Minor
Weather	Hurricane	Catastrophic	Catastrophic	Catastrophic	Minor
Weather	Flood	Major	Minor – assuming no damage to voice/data/fax circuits	All	Minor
Weather	Snow	Minor	Minor	Minor	Minor
External Destructive Forces	Fire	Major	Major – assuming no damage to voice/data/fax circuits	Minor	Minor
External Destructive Forces	Terrorist Attack	Minor	Minor	All	Minor
Physical	Facility	Minor	Minor	Minor	Minor

Plant	location				
Physical Plant	Power Outage	Major	Minor	Minor	Minor
Information Systems	Computer Virus Attack	Minor	Not applicable	Minor	Minor
Information Systems	Loss of Operation of WAN	Not Applicable	Not Applicable	Minor	Minor
Information Systems	Telephone Outage	Major	Not Applicable	Minor	All
Information Systems	Computer/ Printer Breakdown	Major	Not Applicable	Minor	Minor
Security	Facility Security	Major	Major	Minor	Minor
Security	Access to Network and Computer Resources	Minor	Not applicable	Minor	Minor

- e. Recovery Time Objectives (RTOs) are the classifications for Risk Factors. A minor disaster disrupts customer service for less than 30 minutes. A major disaster disrupts customer service for less than 4 hours. A catastrophic event disrupts customer service greater than 4 hours. If an event is possibly a minor, major and catastrophic event, the event is categorized as “All”.
- f. eQHealth retains a thoroughly tested Disaster Recovery Plan and Business Continuity Plan on file for each of their contracts that can be executed in the event of an unforeseen emergency/disaster. Each finalized plan includes the configuration and procedures specific to each client. Annually, they conduct testing of these plans or “Code Blues” to determine the validity of the plan and if it needs to be revised to meet the current situation of IT resources and personnel. These plans ensure that data is protected and operations will resume as soon as possible. The distributed system architecture provides an environment with no single point of failure. This includes immediate redundancy locally to a secondary hardware footprint as well as a secondary location within Vendor wide area network. Vendor WAN is comprised of private circuits that do not carry public traffic. In the unlikely event a catastrophe causes loss of the primary location, a series of automated failovers and manual failovers will be enacted to cutover and promote the secondary location to reestablish a production environment. This can be accomplished well within required recovery time objectives with virtually no loss of data. This level of failover and recovery is achieved through a combination of a NetApp fiber channel SAN technology and virtual hosting capabilities of VMware products. The following image depicts Primary and Secondary sites with Block-Level replication via SnapMirror®





In addition to the hardware and networking switch equipment redundancy, access to the data center utilizes redundant services:

- Wide Area Network Circuit: eQHealth Solutions utilizes a private IP switched fully meshed national fiber network for the Wide Area Network connection. The service level agreement for the WAN circuit has a 4 hour turnaround on outage repairs. This redundancy reduces the possibility of corporate operations or critical data replication from going down for any length of time.
- Internet Circuit: eQHealth Solutions utilizes multiple circuits on a switched fully meshed national fiber network for the Internet connection. The service level agreement for the WAN circuit has a 4 hour turnaround on outage repairs.

**7. Data Retention:** Describe the relevant data retention needs and how they will be satisfied for or by the proposed solution.

- a. **The data backup/retention requirements are:** Database and application backup procedures must be updated to include backups for the System; Full online data backups must occur, as well as offline backups using tape storage.
- b. Vendor response:
  - i. All eQSuite® SQL Server® database data is hosted on the NetApp® Fibre Channel Storage Area Network (SAN). This state of the art SAN fabric helps manage and protect with high availability, massive scalability and tremendous efficiencies. The data backup management of the SAN is handled by NetApp's SnapMirror® software. This technology provides fast, efficient data replication and disaster recovery (DR) for all eQSuite® system data. The data is replicated near real-time and failover is automated. Nightly full online scheduled SQL Server® file level backups are snapped locally and replicated to our disparate DR data center to utilize in ancillary activities such as reporting and development.
  - ii. eQHealth Solutions' storage area network (SAN) implements a tiered storage approach. Operational database data may be dynamically moved among each tier depending on its current classification. Each class dictates exactly which storage media tier that the data should be resident on to align storage cost and performance with policies and regulatory guidance. Tiers where archived data resides utilize lower performing SATA drive technology which are less costly but achieve the service level required. Our data retention policies dictate the lifecycle of data and the timeframe at which operational databases are truncated and archived. We typically maintain 7 years of data at the highest performing tier of storage and archive the expiring longitudinal dataset on a quarterly basis to our lower tiers. A scheduled maintenance utility flags all candidate data and performs the archival in a hierarchical approach ensuring all data dependencies are considered. This data remains retrievable via our database management system but is segregated by schema to exclude it from the eQSuite®

system during normal operation. This data can be restored to the production tier of storage by our archiving utilities if necessary.

- c. Schedule:
    - i. Data: Hourly snapshots for mission critical; multiple times/day for mission essential; Hourly asynchronous replication of mission critical data. Nightly asynchronous replication of mission essential data
    - ii. Servers: Weekly snapshots; Asynchronous replication of mission critical data
  - d. What is the backup and retention schedule (what data is backed up, on what schedule, how long is that data retained)?
    - i. *Per Michael Hall: Further details beyond those above of data classification and retention will be defined during JAD sessions in DDI including what should be on archival media.*
  - e. Per vendor, methods available include disk to disk (local and off site), disk to other media (i.e. tape).
- 8. Service Level Agreement:** What is your assessment of the service level agreement provisions that the proposed vendor will provide? Are they appropriate and adequate in your judgment?
- a. See SERVICE LEVEL section above for details.
  - b. Additionally, the “HOW” the Service Level is supported is through various system administration-related tools. The following describes key tools that are used:

For workload management eQHealth utilizes the **ChangeGear platform version 4.6 MR2** from **SunView Software**. ChangeGear is a full IT service management software package built on ITIL (Information Technology Infrastructure Library) best practices. ChangeGear is comprised of a service desk module for incident and problem management, change management module for change and release management, knowledge management, and configuration management database module for service asset and configuration management. The integration of the modules into the ChangeGear platform allows for tracking, reporting, and management of key ITIL processes. Service and work requests are received through a self-service portal in ChangeGear or entered manually if needed and routed to the appropriate group for handling of the ticket. By having all work items entered into ChangeGear, users are able to track, monitor and measure the workload to ensure Vendor is meeting or exceeding our service level agreements.

**SonicWall’s Global Management System 7.0** is the unified threat management network security appliance. The Global Management System provides centralized logging for all security events and logs while conducting network security monitoring, analytics, reporting and alerting.

Compuware application performance monitoring (APM) monitors Web requests end-to-end.

eQHealth Solutions licenses **Ipswitch’s WhatsUpGold®** to monitor IIS application pools, web site availability, load balancing status, IIS logs and Windows events for all production Web sites. It also delivers all audit trail services related to servers and storage resources. Real-time alerts are attributed to all events of interest, which are defined, by our security team and policies.

9. **System Integration:** Is the data export reporting capability of the proposed solution consumable by the State? What data is exchanged and what systems will the solution integrate/interface with? **Please create a visual depiction** and include as **Attachment 1** of this report. Will the solution be able to integrate with the State’s Vision and financial systems (if applicable)?
- Per Michael Hall: Integrating with VISION/Financial Systems is not applicable although the solution is capable.
  - See **Attachment 1** for details regarding WHAT is being exchanged.
  - In terms of HOW data is being exchanged, the following summary describes the approach and methodology:
    - The clinical integration capabilities of the eQSuite® system are extensive. With the **Clinical Integration Framework (CIF)** module eQHealth can exchange clinical data in multiple standard protocols and formats. The following table lists formats currently in production channels developed for as well as the protocols we support.

Data Formats	
HL7 v2.x-v3.x	CCD,CCR
CDA	XML
DICOM	EDI
X12	Raw ASCII or Binary

Protocols	
MLLP	Web Services (SOAP)
HTTP/HTTPs	(s)FTP
TCP/IP	

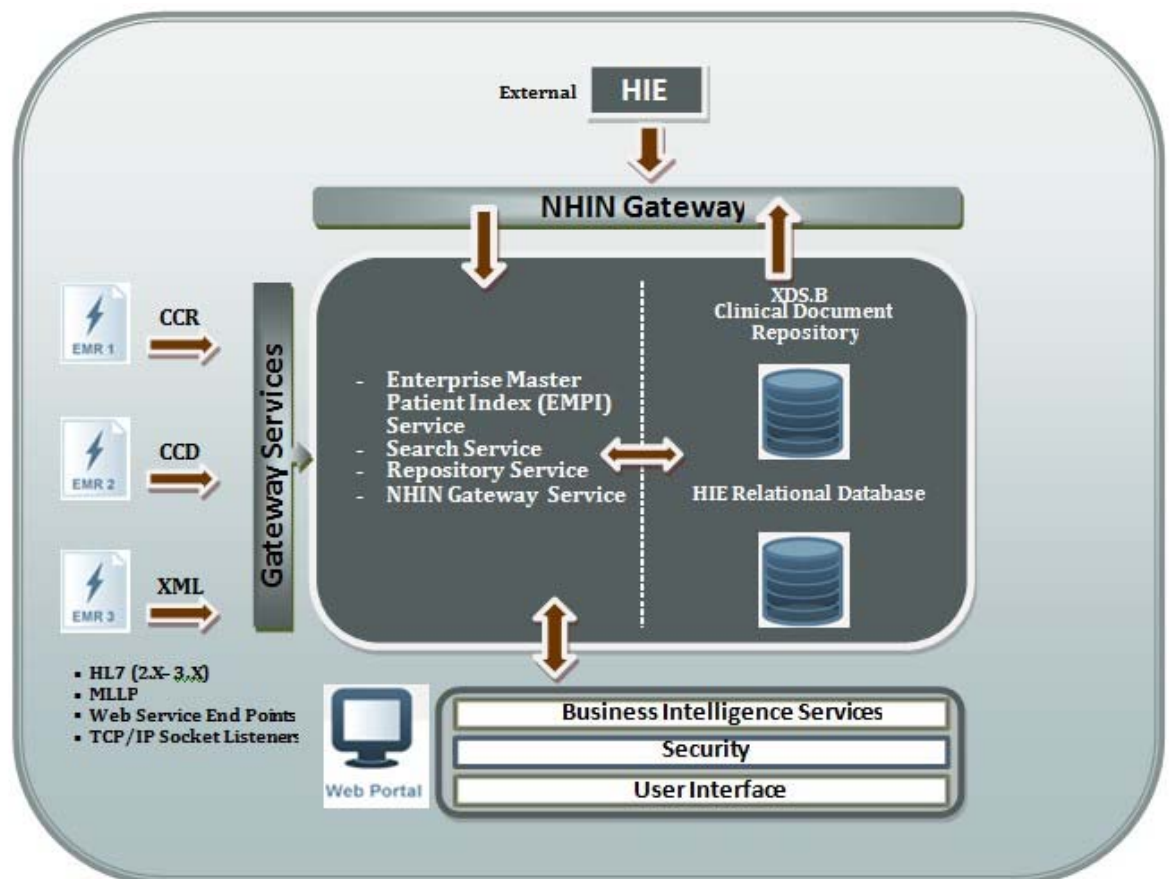
**Service-oriented integration (SOI)** is at the core of the eQSuite® system. All internal modules of the system currently integrate via a services interface layer. Vendor integrates between disparate external trading partners via secure standards based XML web services. A considerable amount of external integration is facilitated by the **Clinical Integration Framework (CIF)** module as depicted by the “Gateway Services” portion in the image below. The CIF would be the equivalent to the State’s deployments of its **Master Data Management / Master Person Index** technologies. This integration supplies a holistic view of all data related to a given member including both administrative (claims, eligibility etc.) and clinical sources (EMR CCD/CCR, Lab Results etc.). The approach would be to redirect those service calls to the State’s infrastructure where appropriate. An analysis of each of the states’ available service contracts would be conducted to understand the methods and data associated with each. A gap analysis would be performed to identify those instances where eQSuite® functionality cannot be fully supported and simply remapped. Where there is an identified gap Vendor will work closely with the State on a plan of action to augment the State’s services to ensure Vendor is able to continue to provide users with a full 360’ view of each member. Where a state managed service is not available Vendor would continue the integration with their service until an equivalent replacement is implemented by the state. Vendor is capable of integrating with the statewide HIE system and public registries to aggregate additional data that AHS may not manage directly. Where bi-directional services are required a service registry will be available

for the state that supports the use of Web Services Description Language (WSDL) to discover all services and understand each contract.

eQSuite® current services:

<ul style="list-style-type: none"> <li>Enterprise Master Patient Index (EMPI)</li> <li>Clinical Data Repository</li> <li>Member Eligibility</li> <li>Health Education</li> </ul>	<ul style="list-style-type: none"> <li>Claims Warehouse</li> <li>Service Authorizations</li> <li>Medication Database</li> <li>Home and Community Based Services repository</li> </ul>
<ul style="list-style-type: none"> <li>Business Rules Engine</li> </ul>	<ul style="list-style-type: none"> <li>Business Intelligence/Analytics Platform</li> </ul>
<ul style="list-style-type: none"> <li>Workflow Engine</li> <li>Provider (Physician/Facility)</li> <li>Mapping/Geocoding</li> </ul>	<ul style="list-style-type: none"> <li>Member Census</li> <li>Clinical Guidelines/Criteria</li> </ul>

The following is a graphic of the Clinical Integration Framework depicting the technology and services that eQSuite® currently integrates with to provide a comprehensive view of all available data related to a member.



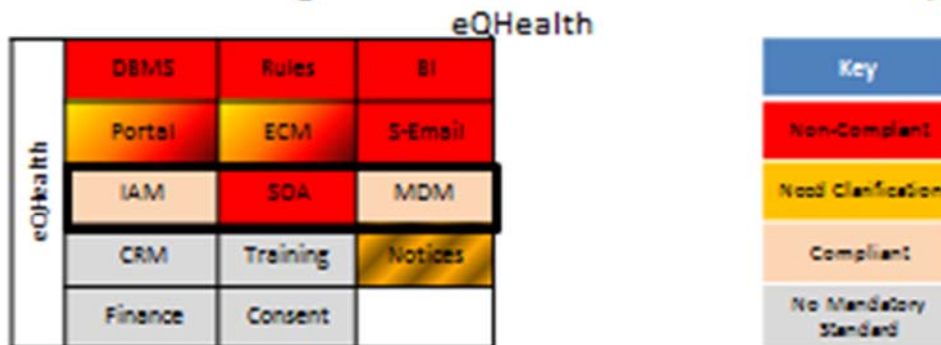
**Additional Comments on Architecture:**

In terms of looking at Architecture through the State of Vermont EA lens, specifically:

1. Business Architecture
2. Application Architecture
3. Information Architecture
4. Technology Architecture...

... the following heat chart was prepared by the EA team, and provides a good assessment:

## HSE Platform Alignment and Software Reuse Compliance



HSDP Criteria	Technology / Approach	Justification/Rationale: Pluses (+) and Minuses (-)
State Standards Compliance		<ul style="list-style-type: none"> <li>- Integration with the HSE Platform is more complex due to non-compliant SOA infrastructure but remains viable</li> <li>- State users will need to contend with a non-OPA rules engine and non-OBIEE analytics</li> <li>- Important to clarify how a common UI can be presented when eQSuite is deployed</li> <li>- What document capture and management technology will be deployed?</li> <li>- Additional secure email solution will cause admin overhead</li> </ul>
Additional Components Included	<ul style="list-style-type: none"> <li>• Microsoft Exchange Web services with IIS and brokered authentication and no ESB</li> <li>• SQL Server 2008</li> <li>• In-Rule rules engine</li> <li>• MS Reporting and Analytical tools</li> </ul>	<ul style="list-style-type: none"> <li>- Challenges for business users to learn multiple tools for Analytics, Rules and Document management</li> <li>- Adds substantial complexity and costs to support systems and integration</li> </ul>
Proprietary Components and potential Lock-in	eQSuite custom development without using Siebel infrastructure	<ul style="list-style-type: none"> <li>+ SOA System</li> <li>+ Source code, documentation and training provided</li> </ul>
Platform Integration	Non-compliant approach to SOA and ESB technology will increase complexity and challenges in providing required application integration	
Additional Licensing	Products from Healthwise, McKesson, First Databank, Texas A&M, AMA, In-Rule, Mirth, Cognizant and DST	

**Vendor commits to providing the following environments:**

1. Production – High Availability
2. QA/Staging – High Availability
3. Development – Non-High Availability
4. Test – Non-High Availability
5. Training – Non-High Availability
6. Disaster Recovery – Non-High Availability

# 7. Assessment of Implementation Plan

## 7.1 Implementation Readiness

*After assessing the Implementation Plan, please comment on each of the following.*

### 1. The reality of the implementation timetable

- a. PRIMARY PROJECT:
  - i. The overall proposal contemplates a 7 year period, comprised of a 2 year implementation schedule followed by 5 years of maintenance and operations.
  - ii. Given other project experiences by Vendor, the 2 year implementation period seems very achievable.
- b. IV&V PROJECT:
  - i. This project contemplates a 3 year window (3/2015 – 3/2018) and aligns with the deliverables of the Primary project.

### 2. Training of users in preparation for the implementation

- a. Vendor acknowledges that people learn differently. Having said that, they shared their findings that in most cases the most practical approach to knowledge transfer is through **peer mentoring**. This involves the embedding of knowledge receivers in all current activities. This is a dynamic, reciprocal relationship aimed at developing the skill required of the receiver to take over the designated responsibility. Learning agendas and action plans are developed so the mentor can provide feedback throughout the mentoring process. After a recipient has applied the knowledge, there should be an **assessment** of its effectiveness relative to the expected results.
- b. The specific methods, called “eQUniversity”, includes:
  - i. State-wide workshops to train users on our program, policies, technology, and clinical decision support tools.
  - ii. Frequent scheduled and ad-hoc webinars.
  - iii. Videos on specific system tasks and workflow related processes.
- c. The Non-Functional requirements called for Vendor to respond to specific Training-related requirements, per the chart below. The Vendor answered in the AFFIRMATIVE for all, and suggests it is part of the core offering.

RFP Req #	Requirement Description	Vendor Response: Y or N
I3.1	The Vendor will develop (in cooperation with the State) and execute a Knowledge Transfer and Training Plan that describes roles and responsibilities of the State and Vendor and the approach for bringing managers, end users, and technical personnel to an appropriate level of understanding with the System	Y

RFP Req #	Requirement Description	Vendor Response: Y or N
13.2	<p>The Knowledge Transfer and Training Plan will address and describe, at a minimum:</p> <ul style="list-style-type: none"> <li>- Training goals/standards and the specific plan for training technical personnel and end users.</li> <li>- Size of population and types of roles that need training</li> <li>- Strategy for providing training early in the project to allow the training goals to be implemented throughout the project life Phase.</li> <li>- Tasks, deliverables and resources necessary to complete the training effort and identify tools and documentation that will be necessary to support proposed effort.</li> <li>- Types of training, the specific courses and course materials, the training approach for both technical personnel and end users, and how training effectiveness will be measured and addressed.</li> <li>- Deliverables to support initial and ongoing training including user manuals, System manuals, and on-line help and training materials for technical/non-technical personnel.</li> <li>- Knowledge Transfer to enable the State personnel to operate, maintain, configure and modify the System including operation of the testing tools, supporting infrastructure, and security as agreed between the State and Vendor.</li> <li>- Metrics for tracking progress in achieving training and knowledge transfer objectives.</li> <li>- Reporting progress of training and knowledge transfer activities.</li> <li>- Additional training for technical staff on development, reporting and maintenance including processes and tools as needed</li> </ul>	Y
13.3	The Vendor will provide train-the-trainer and end user training documentation (including user manuals, online content, reference cards, etc.)	Y
13.4	The Vendor will provide the State a training course outline for review and acceptance at least thirty (30) calendar days prior to the beginning of scheduled training	Y
13.5	The Vendor will submit all training packages to the State for review and acceptance at least twenty-one (21) calendar days prior to the beginning of scheduled training	Y
13.6	The Vendor will provide (customized as required) training manuals for all classroom training they provide	Y
13.7	The Vendor will provide all training materials developed for the system to the State. Those materials will become the property of the State and may be modified and duplicated by the State	Y
13.8	The Vendor will provide electronic copies of all training materials (end-user, technical, trainee and instructor) in a format that can be easily accessed, updated and printed by State staff using software for which the State owns licenses, prior to deployment onto the staging platform. This includes but not limited to CDs/DVDs, and online.	Y
13.9	The Vendor will provide updated training documentation for all departments and agencies using the platform, as necessary, to incorporate new processes or functionality due to system releases, upgrades, or changes throughout the contract term	Y
13.10	The Vendor will schedule all training during regular work hours as approved by the State, unless the Vendor receives advance approval from the State for specific training at other times	Y
13.11	The Vendor will provide all training within the State of Vermont at locations convenient to the attendees of the training, unless the Vendor receives advance approval from the State for specific training at other locations	Y

RFP Req #	Requirement Description	Vendor Response: Y or N
13.12	The Vendor will schedule staff training in a manner that is least disruptive to the normal business operations	Y
13.13	The Vendor will provide instructions to the State on Vendor tools and procedures used to support the training	Y
13.14	The Vendor will ensure that Vendor staff members are not assigned to train State staff and work on critical path development tasks concurrently	Y
13.15	The Vendor will assist the State in developing end-user training on the System business functionality	Y
13.16	The Vendor will provide both end-user classroom training/Train-the-trainer sessions and on-line, interactive training as agreed with the State for all end-users	Y
13.17	The Vendor will develop and perform train-the-trainer training sessions, as appropriate	Y
13.18	The Vendor will identify the number of staff necessary for maintenance and operations of the System as well as the skill sets necessary, with the State's agreement	Y
13.19	The Vendor will develop and provide training for the technical support staff including State staff and contractors	Y
13.20	For the duration of the contract, the Vendor will continue to provide training to the technical staff if system upgrades have been installed and there is a change in System components functionality	Y
13.21	The Vendor will create a training approach and needs analysis early in each project Phase which will determine the training requirements.  The State of Vermont has invested in the Oracle User Productivity Kit (UPK) and has a strong preference to use this investment to provide training to end users.	Y

**3. Readiness of impacted divisions/ departments to participate in this solution/project**

- a. The team is in place and ready for this project. The team has the governance structure, skill set, time allocation, and experience to undertake a project of this scope.

**4. Adequacy of design, conversion, and implementation plans**

- a. The Design, Conversion, and Implementation plans are proven and adequate. eQHealth has had 68 successful implementations without a single failure. Details follow:
  - i. eQHealth Solutions has implemented a lightweight effective software development lifecycle approach known in the industry as SCRUM Agile. SCRUM Agile is an iterative development methodology derived from the well-known Agile development methodology used for years by Fortune 500 companies around the world. The lifecycle process includes several carefully managed and monitored environments.
  - ii. Historically, system architecture was a primary function of the system architect. But the most common Agile methods don't define or even support such a role. Since Agile focuses on harnessing the power of the collective team, rather than any one individual, the system architect no longer dictates technical direction. Instead, we utilize **Joint Application Design (JAD)** to design our systems. This includes a cross sectional team of key stakeholders with



both technical and business expertise. This does not by any means discount the value of a systems architect and we should value their input, but a team approach has proven to be much more successful.

- iii. 31 JAD sessions are estimated to cover the 4 work streams, which is an average of 1.3 meetings/month:
  1. Work Stream I – FR 1, FR 2
  2. Work Stream II – FR 3, FR4, FR5, FR6
  3. Work Stream III – FR7, FR8, FR9
  4. Work Stream IV – FR10, FR11
- iv. JAD sessions have 5 steps:
  1. Planning ahead
  2. Assembling the right team
  3. Ensuring everyone is committed to the project
  4. Staying on course
  5. Following through - At the conclusion of the JAD sessions, the IT team will produce the detailed design specification document within the timeframe agreed upon during the planning stage.
- b. In the development environment the development team tests the software and provides integration testing to ensure the software is working as designed. Once checked in to the test environment, the software is reviewed by a team of quality control analysts. The QA/QC team performs functional, performance, and regression testing to ensure the quality of the software. Once approved, the code is migrated to a stage environment for User Acceptance Testing and the final sign-off before release into the production environment.

When the software has been fully tested, a cross-functional team of developers, system administrators, and quality assurance analysts, led by a project manager, meet to prepare for the migration process. In this meeting risks are documented and resources are assigned to facilitate the roll-out and review the standardized procedures. Before any new software is migrated, a full system backup is created to ensure the integrity of customer data. SQL Compare and the SQL Data Compare tools from Red Gate Software are used to avoid errors and ensure accurate data and design synchronization between environments. After implementation, the released software is validated in the new environment by the release team.

eQSuite® is a centrally hosted Web-based solution. All enhancements are immediately available to internal and external customers eliminating the need to install eQSuite® software updates on end user machines thus ensuring consistency across all clients. By having a robust, multi-client environment, there is not the added overhead of managing many disparate systems. With the fore-mentioned implementation process and use of the Red Gate database tools, new versions of the eQSuite® system can be placed into production very quickly with little impact to customers.

c. The Chart below describes Agile principles and processes used by Cognizant:

	1	2	3	4	5	6
Agile Principles	Our highest priority is to satisfy the customer through early and continuous delivery of valuable products	Welcome changing requirements, even late in delivery. Agile processes harness change for the customer's competitive advantage	Deliver working products frequently, from a couple of weeks to a couple of months, with a preference to the shorter timescale.	Business people and developers must work together daily throughout the project.	Build projects around motivated individuals. Give them the environment and support they need, and trust them to get the job done.	The most efficient and effective method of conveying information to and within a development team is face-to-face conversation.
Delivery Benefit	Early and more regular opportunities to measure and prove success	More and regular known opportunities to meet requirements	Evolve the IT landscape more frequently to meet unpredictable business and market changes	Decisions are made sooner and with more real-time business validation	The team is configured for optimal delivery over the full project life not only at stages	Higher opportunity for faster and higher quality communication and decision making
Processes	Iterative Delivery 1-2weeks	Customer Demos	Reduce the path to production and define your definition of Done	Daily Stand-ups	SCRUM Master or Team Leader focus on removing impediments	Co-location or distributed agile framework.

- d. Further, Cognizant strongly believes that the presence of a robust engagement governance model is critical to the success of innovative technology implementations.
- e. Cognizant also recognizes that many organizations are often involved with large projects, and to manage those disparate groups, deploys this approach:
- i. Alignment of Organizational Cultures
  - ii. Alignment of Processes and Procedures
  - iii. Alignment of Systems and Applications
  - iv. Sharing of Intellectual Property
- f. The approach to **Conversion** is described below, and appears sound and adequate:
- i. On contract award the IT project managers will immediately begin the Analysis Phase where they will work with DVHA to identify their transition data needs and make a formal request on their behalf to the source entity. This is begun well ahead of go-live and typically takes 30-45 days depending on the complexity and quality of the data received. The data for each transition project is transmitted via a secure FTP site provided by eQHealth Solutions. They work closely with those parties identified to get file specifications (format, layout etc.) and mapping to understand all the various types of datasets. This is generally called "data classification" and is a vital initial step of the transition plan. *Per Michael Hall, as part of the data migration and classification planning, State will define data retention policies.*
  - ii. After a complete understanding of the data is gained, a gap analysis is performed to determine if the transition dataset includes all data elements required to successfully extract, transform and load (ETL) into the eQSuite® system. There will be potential gaps like missing required data fields, improper data types and general data entity mapping conflicts that must be resolved prior to continuing with the project. Once the gap issues are resolved the database administrators begin with the Design Phase. This phase includes the logical and physical plan on how the data will be migrated. Included in this plan are the

tools used for migration and the Acceptance Criteria that will be applied by the Quality Assurance team and ultimately DVHA during the Deploy Phase. The Deploy Phase includes an execution of the conversion/transition plan with a subsequent Acceptance Test. This is when reconciliation and data checking reports are run to determine that all quantitative and qualitative metrics are achieved and a go/no go decision takes place. There will always be minor post-migration “data fixes” but these will be limited as much as possible with a thorough design plan.

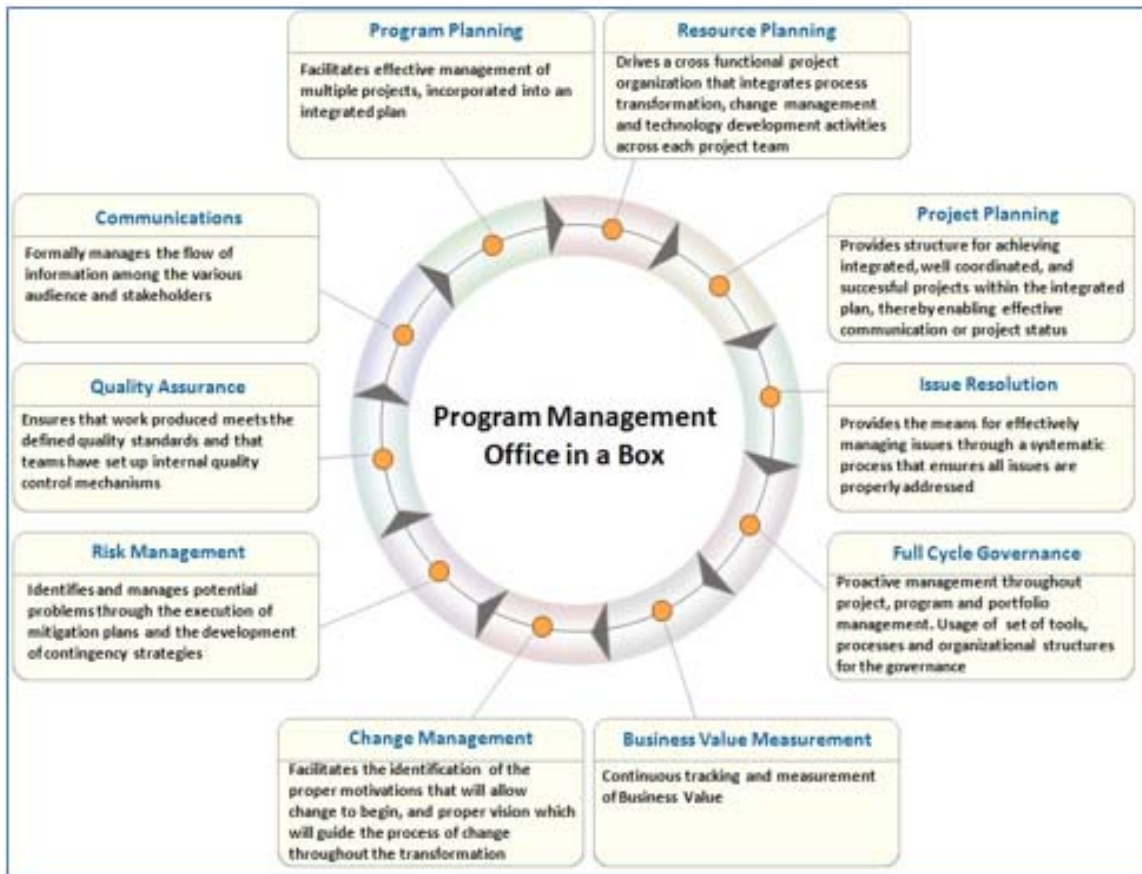
**5. Adequacy of support for design/conversion/implementation activities**

- a. The project appears adequately staffed and skilled to carry out the design, conversion, and implementation activities.

**6. Adequacy of agency and partner staff resources to provide management of the project and related contracts (i.e. vendor management capabilities)**

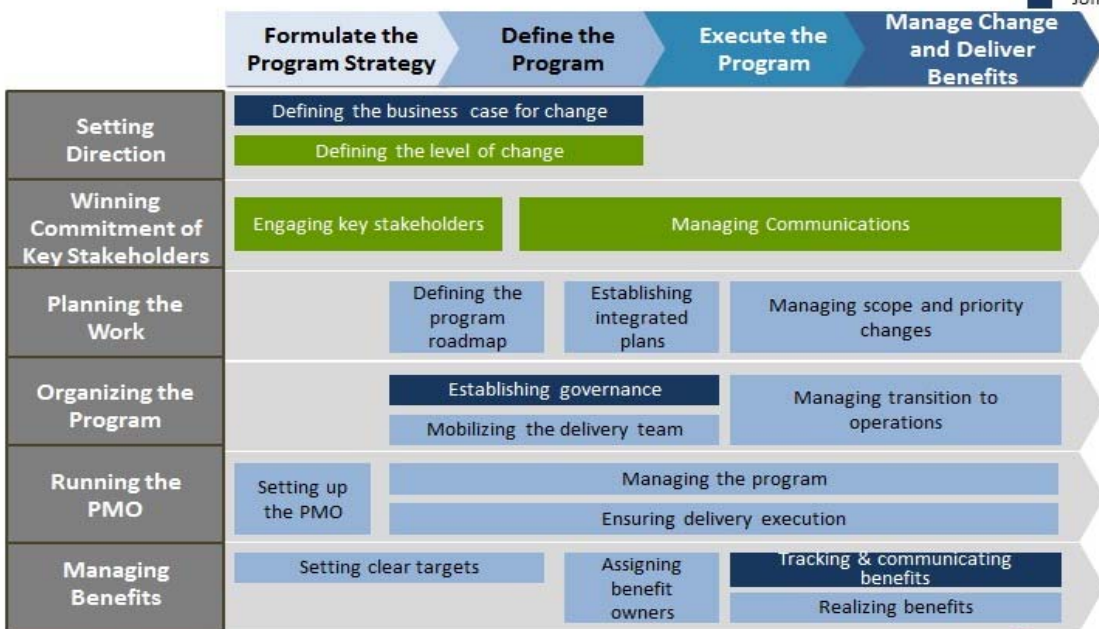
- a. Vermont has assigned Alexia Venafrá as Project Manager.
- b. Vermont has assigned Donna Amiot as Program Manager, providing Ms. Venafrá support and an avenue to escalate issues through.
- c. Cognizant is assigning Srivaths Srinivasan as Project Manager. Mr. Srinivasan does not have a PMP certification, and it is difficult to discern from the resume provided, how much experience he has managing projects of similar scope. However, Vermont did not make PMP certification a requirement. Also, Ms. Venafrá conducted additional reference checking specifically on Mr. Srinivasan because of these questions, and he received very strong favorable recommendations.
- d. Cognizant is assigning Jim Gesek, Account Director, providing an avenue of support for Mr. Srinivasan.
- e. eQHealth is assigning Sean Marchiafava, Chief Information Officer, as the Vendor's primary point of contact with the State's contract administrator and other State executive sponsors for activities related to contract administration, overall project management and scheduling. Mr. Marchiafava is authorized to commit the resources of both the prime and sub vendors in matters pertaining to the implementation performance of the contract, and is ultimately responsible for ensuring all Vendor (both eQHealth and Cognizant) resources identified by project manager are staffed on time.

f. Cognizant utilizes the following approach to Project Management:



**Program Management Approach**

■ PMO Activity  
■ OCM Activity  
■ Jointly Owned



- g. eQHealth and Cognizant state the following, however, they have not yet worked together, so this approach has not been proven nor validated\*:
  - i. *Cognizant and eQHealth Solutions will follow project management methodologies that are consistent with the Project Management Institute's (PMI) Project Management Body of Knowledge (PMBOK) Guide, as requested by the State.*

\* Upon discovering that Primary Vendor and Subcontractor have not yet worked together, the Primary Vendor was asked for examples of projects where:

1. eQHealth was Primary, and another company was a subcontractor performing tasks similar to those that Cognizant will perform on this project. eQHealth indicated the following:
  - a. *"To date eQHealth has not contracted with a sub for services and SOW similar to that of VT. We have subcontracted for other types of work within the Medicaid space. Examples below."*
2. Cognizant was a subcontractor performing tasks similar to those that Cognizant will perform on this project.

**Examples for #1 above (eQHealth was Primary, and another company was a subcontractor):**

1. *eQHealth Illinois Medicaid HCBS Contract (PRIME)*  
 HCBS Strategies (Steve Lutzky – SUB)  
 HCBS Quality Monitoring Consulting Services Contract  
 2006 through 2013  
 Develop policies and procedures and incorporate into operational manuals; train and mentor project manager; provide staff support for designing quality systems with other agencies across a wide range of home and community based-services including consultation on level of care reviews, person centered service plans, incident management systems, assuring qualified providers and financial accountability. Assist in the identification and validation of performance measures, support the tracking analysis of HFS' waiver quality outcome and improvement strategies. Work collaboratively with eQHealth and Client.
2. *eQHealth Illinois Medicaid HCBS Contract (PRIME)*  
 Health Services Advisory Group (HSAG – SUB)  
 HCBS Quality Monitoring Consulting Services Contract  
 2006 - 2007  
 Conduct face to face interviews with waiver participants, participate in a Readiness Review, record interviews using the survey tools provide, provide a process by which field employees may report problems or concerns arising from field interviewing to an RN team leader, report any incident or situation where it is determined that a waiver participant may be harmed or potentially harmed, identify, document and provide any recommendations where participants are experiencing unmet needs or quality problems, ensure that quality assurance procedures are in place that ensure compliance with state and federal law regarding confidentiality and privacy.
3. *eQHealth Illinois Medicaid HCBS Contract (PRIME)*  
 CIMRO (SUB)  
 HCBS Quality Monitoring Contract  
 2007-2009  
 Conduct face to face interviews with waiver participants, participate in a Readiness Review, record interviews using the survey tools provide, provide a process by which field employees may report problems or concerns arising from field interviewing to an RN team leader, report any incident or situation where it is determined that a waiver participant may be harmed or potentially harmed, identify, document and provide any recommendations where participants are experiencing unmet

needs or quality problems, ensure that quality assurance procedures are in place that ensure compliance with state and federal law regarding confidentiality and privacy.

4. *eQHealth/Mississippi Division of Medicaid (PRIME)*

University Medical Center (SUB)

Family Planning Waiver Assessments

March 1, 2010 through June 30, 2010

Conducted a telephone survey of a population consisting of beneficiaries who were eligible for Family Planning Waiver services utilizing survey questions developed by eQHealth. Upon completion of the survey, the University provided the outcomes to eQHealth for analysis. Analysis of the responses found the participation rate among beneficiaries increased 17.6 percentage points.

**Examples for #2 above** (Cognizant was a subcontractor):

1. *State of California MMIS*

a. Systems integrator and implementation subcontractor to Xerox.

2. *State of Georgia, Department of Administrative Services*

a. Oracle Taleo development and implementation - implementation partner to Ernst & Young.

3. *State of New York MMIS*

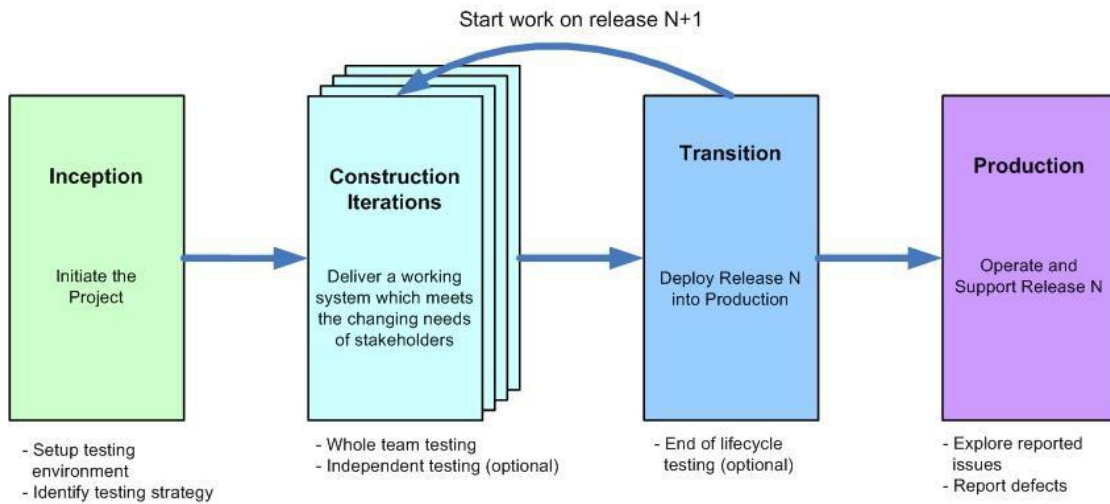
a. Systems integrator and implementation subcontractor to Xerox.

**7. Adequacy of testing plan/approach**

a. Vermont is engaged in and committed to Vendor approach to end-to-end application testing, stress tests, performance tests, and UAT tests.

b. The methodology described below is sound, and has been proven and adequate in other implementations by Vendor:

i. Vendor testing strategy is a key component of the Agile development methodology described above. The testing strategy objective is to achieve higher quality and shorter lead times with minimum overhead, frequent deliveries, close teamwork with team and the customer, continuous integration, short feedback loops and frequent changes of the design. Test strategy guides process through the common obstacles with a clear view of how to evaluate the system. Testing starts with the exploration of the requirements and what the customer really wants by elaborating on the user stories from different perspectives. Testing then becomes a continuous and integrated process where all parties in the project are involved. The most important part to understand about the testing strategy is that it happens throughout each construction iteration or "Sprint" of the continuous integration process and not at the end when the developers "throw it over the wall" to a team that has done nothing more than read the requirements of the item they are about to test. This strategy is called "whole team" and is an organizational strategy popularized by Kent Beck in the book "Extreme Programming Explained". The following image depicts this process.



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Disciplined Agile Consortium

## 8. General acceptance/readiness of staff

- a. Staff appear ready, well-prepared, and willing to adopt the solution.



## Additional Comments on Implementation Plan:

Vendor has successfully completed other implementations for the following organizations in the past 3 years:

REF #	PROJECT NAME	CUSTOMER NAME	CUSTOMER CONTACT	PROJECT DURATION	BUSINESS DISPUTE?	
					YES	NO
1	Florida Medicaid Medical Management	Florida Agency for Health Care Administration	Leigh Meadows AHC Administrator 2727 Mahan Drive, MS#20 Tallahassee, FL 32308 Phone: (850) 412-4258 E-mail Address: <a href="mailto:leigh.meadows@ahca.myflorida.com">leigh.meadows@ahca.myflorida.com</a>	June 1, 2011 through June 30, 2014. Currently in year one of three possible one-year renewal terms.	YES	<u>NO</u>
2	Mississippi Medicaid Medical Management	Mississippi Division of Medicaid	Dorothy Young Walter Sillers Building, Suite 1000 550 High Street, Suite 1000 Jackson MS 39201 Phone: (601) 359-6150 E-mail Address: <a href="mailto:dorothy.young@medicaid.ms.gov">dorothy.young@medicaid.ms.gov</a>	Multiple consecutive contract renewals from July 1997 through 2016	YES	<u>NO</u>
3	Illinois Medicaid Medical Management	Illinois Healthcare and Family Services	Jeffrey Todd, MS, CMPE Bureau Chief 401 South Grand Avenue East 2nd Floor Bloom Building Springfield, IL 62763 (217) 557-5438 E-mail Address: <a href="mailto:Jeffrey.Todd@illinois.gov">Jeffrey.Todd@illinois.gov</a>	Multiple consecutive contract renewals from 2001 through 2016	YES	<u>NO</u>
4	Simply Healthcare Medical Management	Simply Healthcare Plans	Lourdes Rivas, CEO 804 Douglas Road Suite 600 Coral Gables, Florida 33134 (786)441-4730 <a href="mailto:LRivas@simplyhealthcareplans.com">LRivas@simplyhealthcareplans.com</a>	October 2012 – September 2014	YES	<u>NO</u>
5	IntegraNET Care Medical Management	IntegraNET	Vincent Roth, Director of Contracting 333 N. Sam Houston Pkwy East Suite 1200 Houston, Texas 77060 (281) 447-6800	May 2013 - ongoing	YES	<u>NO</u>
6	People's Health Care Coordination	People's Health Network	Barbara Girard, VP Three Lakeway Center 3838 N. Causeway Blvd., Suite 220 Metairie, Louisiana 70002 (504)849-1300 <a href="mailto:Barbara.gerard@peopleshealth.com">Barbara.gerard@peopleshealth.com</a>	December 2010 - ongoing	YES	<u>NO</u>
7	Pinnacle Care Coordination	Pinnacle Health	Pinnacle Health System George H. Beauregard, Senior Vice President and Chief Clinical Officer (717) 782 – 5228 <a href="mailto:gbeauregard@pinnaclehealth.org">gbeauregard@pinnaclehealth.org</a>	August 2013 - ongoing	YES	<u>NO</u>
8	LSU Health System Medical Management	LSU Health System	Amy Kirby Manager Health and Supplemental Benefits 110 Thomas Boyd Hall Baton Rouge, LA 70803 Phone: (225) 578-8397 Fax: (225) 578-6571 <a href="mailto:aamoroso@lsu.edu">aamoroso@lsu.edu</a>	January - ongoing	YES	<u>NO</u>



9	WebTPA Medical Management	WebTPA	Megan Rigby, EVP 8500 Freeport Parkway South Suite 400 Irving, Texas 75063 (469)417-1715 <a href="mailto:megan@webtpa.com">megan@webtpa.com</a>	July 2013 - ongoing	YES	<b><u>NO</u></b>
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**Vendor references include:**

1. Florida Agency for Health Care Administration (Medicaid)
2. Mississippi Division of Medicaid (DOM)
3. Simply Healthcare Plans (in Florida)

**Subcontractor references include:**

1. Fallon Health (MA)
2. Express Scripts (MO)
3. CIGNA (CT)

**The following references on some of the proposed Cognizant Key Personnel were contacted:**

Proposed Key Personnel Role	Proposed Key Personnel Name	Reference Name	Reference Contact
Project Manager	Srivaths Srinivasan	Walgreens	Mike Jennings
Project Manager	Srivaths Srinivasan	MD Anderson Cancer Center	Bruce Raby
Account Director	Jim Gesek	RBS Americas/Citizens Bank	Lisa Peros

**Key IV&V Staffing Include:**

1. Account Executive: Robin Chacón
2. QA/IV&V Project Manager: Michael Horowitz
3. Functional Lead: Randy Houpe
4. Technical Lead: John Thurman

## 7.2 Risk Assessment & Risk Register

After performing a Risk assessment in conjunction with the Business, please create a **Risk Register** as an **Attachment 2** to this report that includes the following:

- 1) **Source of Risk:** Project, Proposed Solution, Vendor or Other
- 2) **Risk Description:** Provide a description of what the risk entails
- 3) **Risk ratings to indicate:** Likelihood and probability of risk occurrence; Impact should risk occur; and Overall risk rating (high, medium or low priority)
- 4) **State's Planned Risk Strategy:** Avoid, Mitigate, Transfer or Accept
- 5) **State's Planned Risk Response:** Describe what the State plans to do (if anything) to address the risk
- 6) **Timing of Risk Response:** Describe the planned timing for carrying out the risk response (e.g. prior to the start of the project, during the Planning Phase, prior to implementation, etc.)
- 7) **Reviewer's Assessment of State's Planned Response:** Indicate if the planned response is adequate/appropriate in your judgment and if not what would you recommend.

See **Attachment 2**.

### Additional Comments on Risks:

None.

## 8. Cost Benefit Analysis

*This section involves four tasks:*

- 1) *Perform an independent Cost Benefit Analysis.*
- 2) **Create a Lifecycle Cost Benefit Analysis spreadsheet** as an **Attachment 3** to this report. A sample format is provided.
  - a) *The cost component of the cost/benefit analysis will include all one-time acquisition costs, on-going operational costs (licensing, maintenance, refresh, etc.) plus internal costs of staffing and "other costs". "Other costs" include the cost of personnel or contractors required for this solution, enhancements/upgrades planned for the lifecycle, consumables, costs associated with system interfaces, and any costs of upgrading the current environment to accept the proposed solution (new facilities, etc.).*
  - b) *The benefit side of the cost/benefit will include: 1. Intangible items for which an actual cost cannot be attributed. 2. Tangible savings/benefit such as actual savings in personnel, contractors or operating expense associated with existing methods of accomplishing the work which will be performed by the proposed solution. Tangible benefits also include additional revenue which may result from the proposed solution.*
  - c) *The cost benefit analysis will be for the IT activity's lifecycle.*
  - d) *The format will be a column spreadsheet with one column for each year in the lifecycle. The rows will contain the itemized costs with totals followed by the itemized benefits with totals.*
  - e) *Identify the source of funds (federal, state, one-time vs. ongoing). For example, implementation may be covered by federal dollars but operations will be paid by State funds.*
- 3) *Perform an analysis of the IT ABC form (Business Case/Cost Analysis) completed by the Business.*
- 4) *Respond to the questions/items listed below.*

1. **Analysis Description:** Provide a narrative summary of the cost benefit analysis conducted: The approach used was to gather all costs associated with project for a 7 year period, identify revenue sources for the project, and identify tangible benefits that might also be used as revenue sources or expense reductions.
  - a. **COST COMPONENT:** See the detailed spreadsheet referenced in **Attachment 3** to gain an understanding of:
    - i. Use of Funds
    - ii. Source of Funds
    - iii. Change in Operating Costs
  - b. **BENEFIT COMPONENT:**
    - i. See the Tangible and Intangible Benefits described below.
2. **Assumptions:** List any assumptions made in your analysis.
  - a. Staff reductions are not expected or contemplated through the implementation of this solution.
  - b. There is no revenue recovery available.
3. **Funding:** Provide the funding source(s). If multiple sources, indicate the percentage of each source for both Acquisition Costs and on-going Operational costs over the duration of the system/service lifecycle.
  - a. Two primary source of funds include:
    - i. CMS APD Funding ranging from 60% to 90% of project cost items.
    - ii. State of Vermont General Fund ranging from 10% to 40% of project cost items.
  - b. See the detailed spreadsheet referenced in **Attachment 3** for actual dollar amounts.

4. **Tangible Benefits:** Provide a list and description of the tangible benefits of this project. Tangible benefits include specific dollar value that can be measured (examples include a reduction in expenses or reducing inventory, with supporting details).

a. The monetary tangible benefits identified are:

i. 90% Federal financial participation (CMS APD Funding) for DDI over two years:	\$11,340,000
ii. 60% federal financial participation (CMS APD Funding) for M&O over 7 years:	\$11,700,000
ii. Reduction in annual operating costs:	\$1,400,000
<b>TOTAL:</b>	<b>\$24,440,000</b>

5. **Intangible Benefits:** Provide a list and description of the intangible benefits of this project. Intangible benefits include cost avoidance, the value of benefits provided to other programs, the value of improved decision making, public benefit, and other factors that become known during the process of analysis. Intangible benefits must include a statement of the methodology or justification used to determine the value of the intangible benefit.

- a. MMIS compliance with CMS requirements as outlined in their Seven Standards and Conditions.
- b. Move from silo'd service delivery model to beneficiary-centric service delivery model.
- c. Cost avoidance due to proactive and predictive diagnosis based on better data analytics.
- d. 360 degree view of beneficiary needs and treatment plan across AHS departments.
- e. A component of the infrastructure required for Act 48 implementation.
- f. Incorporate payment reform functionality, compliant with the Affordable Care Act.

6. **Costs vs. Benefits:** Do the benefits of this project (consider both tangible and intangible) outweigh the costs in your opinion? Please elaborate on your response.

- a. Based on dollar value only, the tangible benefits of **\$24.4M** do not outweigh the **\$32M** anticipated project costs.
- b. However, if we add the anticipated **ROI benefits** outlined in the "Additional Comments" section below, **the benefits clearly outweigh the costs.**

7. **IT ABC Form Review:** Review the IT ABC form (Business Case/Cost Analysis) created by the Business for this project. Is the information consistent with your independent review and analysis? If not, please describe.

- a. There was no IT ABC FORM conducted for this project, therefore, no analysis of the IT ABC FORM is provided here.
- b. In its stead, a separate [Business Case](#) (*MMIS Business Case 5\_Dec\_2013.pdf*) and [Preliminary Life Cycle Cost Analysis](#) (*MMIS\_PreliminaryLifeCycleCostAnalysis28Jun2013.xls*) were completed at project initiation and reviewed as part of the IR. The information in these two documents reconcile with this IR Report, although, AHS Management recently indicated that the 1.5+ year gap between when those documents were completed and the current date, render some of that information as "old and dated".

**Additional Comments on the Cost Benefit Analysis:**

Per Kelly Gordon, beginning in SFY 2012, DVHA VCCI entered into a full risk arrangement with the care management vendor, APS Healthcare. APS guaranteed a 2:1 ROI for adopting its newly developed care management system called C3. The proposed performance guarantee was based solely on using the system, and did not include using APS clinical staffing support to achieve the ROI. The annual cost of the system was

\$2.5M; therefore, APS guaranteed VCCI would achieve \$5M in savings or they would refund the amount of the savings shortfall to the State.

Working in conjunction with an independent consultant, the State and APS jointly agreed upon a methodology for determining cost savings that was based on recommendations from the Disease Management Association and also aligned with the Blueprint's cost savings approach. The methodology adopted is a risk adjusted Historical Control Design. Four years of historical claims data were used to develop a historical control trend from which future costs without VCCI intervention were predicted. Cost savings are the delta between actual and predicted costs. Savings in SFY 2012 net of VCCI and APS investments were \$11,485,000, or a 3:1 ROI. Net savings in SFY 2013 were \$23,476,000, a 6:1 ROI. SFY 2014 savings results are not yet available because they are currently being validated.

Care management reduces health care costs and improves health outcomes through a variety of activities, including: predictive modeling and risk stratification to identify those in need of services and health education; real-time data use to target outreach during high cost events such as hospital admissions or emergency department visits; health analytics to determine gaps in care such as non-adherence to medications; evidence-based health assessments and automated care plans to guide and assess services; and enhanced coordination of physical health care services, behavioral health care services, and community and social supports to address non-medical challenges that impact health. The new care management solution will provide more comprehensive and timely analytics, enhanced ability to interface with other data systems such as provider EMRs, greater system automation that will allow additional time for providing clinical services, and it will enable all members of a care team to have concurrent access to data for which they are authorized, providing more efficient, timely, and coordination across services and service settings.

The new vendor, eQHealth, has reported ROIs from other projects ranging from 4:1 to 13:1, although it is difficult to know how closely those projects align with Vermont's. Based on the past experience of both VCCI and eQHealth, we anticipate the new system, when fully implemented, will obtain ROIs between 5:1 and 10:1.

Based on the claims made of ROI between 4:1 and 13:1, eQHealth was asked to provide supporting documentation of the ROI claim. Those ROI numbers have been provided by eQHealth in the form of 3 confidential Annual Reports, and demonstrate said ROI for FY13 as follows:

### Achieving Cost Savings

eQHealth Solutions has 27 years experience working with federal, state, and commercial clients. We have developed a strong history of quality performance and cost savings through our extensive utilization management, utilization review, medical management, analytics and custom in-house IT systems.

The following table depicts actual cost savings and return on investment for several of our existing clients. The total cost savings includes medical management and utilization reviews across all settings for which eQHealth performs review.

Client	Timeframe	Reported Cost Savings/Million	ROI
Client A	F/Y 2013	\$53	6.71/1
Client B	F/Y 2013	\$24.5	4.21/1
Client C	F/Y 2013	\$222	13.38/1

**SUMMARY OF ADDITIONAL COMMENTS:**

Using the data outlined above in the “Achieving Cost Savings” table, we calculated a Weighted Average 9.88 ROI to apply to AHS.

Further, using the data highlighted above by Ms. Gordon of ROIs of 3:1 in 2012 and 6:1 in 2013, which demonstrate a net cost of \$3.8M, we can expect a **\$37.5M** Return on Investment (9.88 ROI x \$3.8M net cost).

This ROI calculation demonstrates that the **\$37.5M benefits** of this project clearly outweigh the **\$32M cost**, and as such, clearly covers State of Vermont costs component of this project.

## 9. Impact Analysis on Net Operating Costs

- 1.) *Perform a lifecycle cost impact analysis on net operating costs for the agency carrying out the activity, minimally including the following:*
  - a) *Estimated future-state ongoing annual operating costs, and estimated lifecycle operating costs. Consider also if the project will yield additional revenue generation that may offset any increase in operating costs.*
  - b) *Current-state annual operating costs; assess total current costs over span of new IT activity lifecycle*
  - c) *Provide a breakdown of funding sources (federal, state, one-time vs. ongoing)*
- 2.) *Create a table to illustrate the net operating cost impact.*
- 3.) *Respond to the items below.*

1. Insert a table to illustrate the Net Operating Cost Impact.
  - a. See the detailed spreadsheet referenced in **Attachment 3**.
  
2. Provide a narrative summary of the analysis conducted and include a list of any assumptions.
  - a. The program operates on a funding model of 60%/40%, with the former approved by CMS APD funding and the latter by State of Vermont General Fund. Up until the current year, that has been funded at \$2.6M. Going forward, that will be funded at \$2.4M. Therefore, we are allocating a Net Operating Cost reduction of \$200K.
  
3. Explain any net operating increases that will be covered by federal funding. Will this funding cover the entire lifecycle? If not, please provide the breakouts by year.
  - a. See #2 above.
  
4. What is the break-even point for this IT Activity (considering implementation and on-going operating costs)?
  - a. Using two models, the first shows actual hard dollars savings of \$200K annually, and which takes 40 years to breakeven.
  - b. The second model shows breakeven of less than 1 year when using the ROI benefit described above.

Total Project Cost:	\$32,167,885	\$32,167,885
Federal Funding:	\$29,400,000	\$29,400,000
State Funding:	\$7,980,000	\$6,720,000
Cost Reduction Annually:	\$200,000	\$0
ROI Benefit:	\$0	\$37,500,000
Breakeven Point: Federal	147	0.78
Breakeven Point: State	40	0.18

# Attachment 1 - Illustration of System Integration

The project calls for system integration as outlined in the Chart below, which is taken from **Template H – Non-Functional Requirements**, **General Requirements** section, **G4 Interface List** sheet. All items are positively responded to by Vendor, and provided via Core Functionality.

RFP Req #	Requirement Description	Vendor Response: Y or N	Vendor Response: L, T or D	Vendor Comment
G4.1	The System will draw data from the current MMIS system to confirm beneficiary eligibility on a monthly schedule. The System will interface with the future Integrated Eligibility System to confirm beneficiary eligibility in real-time	Y	L	
G4.2	The System will obtain beneficiary demographics from the current MMIS system on a monthly schedule. The System will obtain beneficiary demographics from the new EMPI and future MMIS systems on a monthly schedule	Y	L	
G4.3	The System will obtain medical and pharmacy paid claims details from the current MMIS system on a weekly schedule. The System will obtain medical and pharmacy paid claims details from the new MMIS system on a daily schedule.	Y	L	
G4.4	The System will interface with the current MMIS system to obtain surgical procedure codes on a weekly schedule and from the new MMIS system on a daily schedule	Y	L	
G4.5	The System will include a bi-directional interface with the future MMIS system for the processing of requests for Prior Authorization (PA) for certain medical services. This interface will support the submission of requests as they are created and the receipt of PA status messages as they become available.	Y	L	
G4.6	The System will obtain the master list of Providers and their demographics from the current MMIS System on a weekly basis. The System will interface with the future MPI system and new MMIS system as necessary to obtain the master list of Providers and their demographics in real-time.	Y	L	
G4.7	The System will interface with the current MMIS system on a weekly schedule and the future MMIS system in real-time to obtain third party liability information	Y	L	
G4.8	The System will interface with the Vermont HIE system (VHIE) to obtain details of interactions with and services provided to beneficiaries by the provider in real-time	Y	L	
G4.9	The System will interface with the State's future MMIS business analytics infrastructure to provide detailed data from the Care Management system for various analytic purposes on a weekly schedule	Y	L	
G4.10	The System will draw census data (including Emergency Department Visits and In-patient Stays) from a number of hospital systems on a mixture of weekly and daily schedules and will interface to receive this information in real-time in the future. Hospital systems include, but are not limited to: Fletcher-Allen, Coply, Central VT, Northwestern Med Center, NVRH, Bennington, and Rutland.	Y	L	eQHealth Clinical Integration Framework
G4.11	The System will obtain lab results in real-time from the statewide HIE system supported by VITL	Y	L	eQHealth Clinical



<b>RFP Req #</b>	<b>Requirement Description</b>	<b>Vendor Response: Y or N</b>	<b>Vendor Response: L, T or D</b>	<b>Vendor Comment</b>
				Integration Framework
G4.12	The System will interface with the current PBM Vendor to obtain medication data for use in case management and "gap analysis" on a weekly schedule. The System will interface with the future PBM Vendor to obtain medication data for use in case management and "gap analysis" on a daily schedule.	Y	L	eQHealth Clinical Integration Framework
G4.13	The System will draw data from the Breast and Cervical Cancer Registry	Y	L	eQHealth Clinical Integration Framework
G4.14	The System will draw data from the Immunization Registry	Y	L	eQHealth Clinical Integration Framework
G4.15	The System will draw data from the Vital Statistics Registry	Y	L	eQHealth Clinical Integration Framework
G4.16	The System will, in the future, draw data regarding Community Provider/Partner details and resources maintained by the United Ways of Vermont 211 organization on a monthly schedule	Y	L	eQHealth Clinical Integration Framework

The project calls for Interoperability/Interfaces as outlined in the Chart below, which is taken from **Template H – Non-Functional Requirements**, **General Requirements** section, **T1 Interoperability-Interfaces** sheet. All items except one are positively responded to by Vendor, but all require Development vs. Leveraging Core Functionality.

However, this concern is mitigated per the following response from Michael Hall: *“Not sure why they are marked as development as their clinical interface engine has the required functionality. I suspect that it is their way of indicating the requirements for the other system will need to be discovered and it will need to be configured as opposed to an out of the box solution.”*

RFP Req #	Requirement Description	Vendor Response : Y or N	Vendor Response : L, T or D	Vendor Comment
T1.18 a)	All software architecture documents and artifacts (views/viewpoints) will be modeled per ISO/IEC/IEEE 42010 Architecture Description Template as part of the Vermont Enterprise Architecture Program Requirements.	Y	D	
T1.18 b)	All SOA Services will be reviewed classified and cataloged prior to use. The documentation Artifacts and Templates will be provided to the Vendor by the State of Vermont Enterprise Architecture SOA Governance Team. Duplicate services will be rationed and retired appropriately.	Y	D	
T1.22	The System's SOA-related services hosted should be implemented in Java.	N		All Services for proposed system are hosted in vendor's environment. No requirement for state to host any services. All services are developed in .NET framework.
T1.24	The following metadata attributes will be tracked for all services in the services catalog: {name, lifecycle status, class, description, owner, version, revision history, release frequency, versioning policy, deprecation policy, message exchange patterns, compensating transaction support, availability requirements, volume, max message size, security attributes, sla, logging requirements}	Y	D	
T1.37	The System will have the capability to integrate with the VT MDM technology for Enterprise Master Person Index (EMPI) implemented as part of the HSE Platform in a centralized or registry style implementation. The State of Vermont has invested in enterprise licenses for Oracle MDM and strongly prefers that it is used however if the bidder cannot leverage this functionality initially it must provide for a probabilistic person index or person record matching function.	Y	D	
T1.38	The System will include the telephony integration required to satisfy the ability to dial a phone number directly from data within the System based on user request, and provide the capability to automatically bring up the caller's record upon the receipt of an incoming call	Y	D	VOIP system is capable of integration via API. Requirement will be met by third party tool or in-house development of application

## **Attachment 2 - Risk Register**

See attached document: [FINAL-REVIEW-SOV-AHS-MMIS-CARE STS Risk Register.pdf](#)

## **Attachment 3 – Lifecycle Cost Benefit Analysis**

See attached document: [FINAL-REVIEW-SOV-AHS-MMIS-CARE STS Project Cost Detail.xlsx](#)

## Attachment 4 – Technology Infrastructure

### Overview:

eQSuite® is architected as multi-tiered .NET enterprise application comprised of several loosely coupled autonomous modules. The general architecture of the system follows a service oriented (SOA) pattern which means the application is broken up into very manageable distinct pieces of functionality, or services. This architecture allows for encapsulating each client's business needs into an interchangeable component that can be easily plugged into the system.



The services cloud in the image above represents the web service integration with either internal or external standards based XML web services that augment the functionality and business logic of the core eQSuite® system.

### User Interface:

The eQSuite® user interface was designed from inception as a Rich Internet Application (RIA) Web-based application. The technology we leverage to deliver this RIA experience is **Asynchronous JavaScript and XML** or better known as **AJAX**. AJAX allows for eQSuite® to send and retrieve data in the background without interfering with or delaying user interface behavior in the browser. In addition to AJAX, the user interface design of eQSuite® also employs an adaptive or “smart” dynamic user interface based on a user’s role and permissions as well as the current state of user interaction at any given point in time. This is made possible via configurable business rules or branching logic that is associated with real-time responses. This provides a unique data entry experience by presenting only what is relevant to or required of the user to accomplish a specific data entry scenario while still ensuring all pertinent data is captured. All fields include appropriate user entry validation such as data type, masking, and length.

The use of zero footprint technology and architecture allow clients to maintain network policy compliance, client security, and desktop integrity by not requiring local modifications to their environment to use the eQSuite® system.

There are secure single sign-on options to integrate eQSuite® into an existing client portal, including SAML 2.0 Tokens and Protocol and Encrypted Post.

Finally, the application can be “styled” or “skinned” to the AHS color palette and logo.

**Details:**

The server-side code language environment of eQSuite® is **C# .NET** and follows a very strict coding standard. These standards are enforced by automated check in policies and constraints within the Team Foundation Server source code repository. In addition to those automated rules, our SDLC includes a peer review step to ensure developed code adheres to the intent and purpose of the original business requirements and follows typical patterns approved by the team.

The presentation layer of eQSuite® is developed on 100% native browser based technology. We require no additional “thin client” utility to access our system, only a modern web browser. The predominant technologies for this layer are ASP.net web forms and asynchronous JavaScript and XML or better known as AJAX. ASP.net is an application framework that allows for the development of dynamic Web pages. AJAX is used extensively throughout the eQSuite® application to provide a very desktop like user experience. This is accomplished via exchanges of data with the web server that refreshes the relevant part of the page without reloading the entire page. Mobile devices are supported by this same technology but have specific cascading style sheets (CSS) and HTML5 interfaces where content is rendered in a user-friendly mobile format.

The Business Intelligence module is delivered on another .NET client technology called Silverlight. The large volume of data being analyzed in this module coupled with the real-time ad-hoc analysis requirements dictated that the streaming and dynamic content capabilities that Silverlight delivers was necessary.

At eQHealth Solutions data is warehoused in a centralized **Microsoft® SQL Server 2008 R2** relational database system (RDMS) which is a comprehensive, integrated management and analysis platform that provides tremendous scalability, performance and security. We have standardized naming conventions for all object types in the RDMS, see Attachment #6 and validate them through our change management process (See Attachment #5 for Database Design Standards and Guidelines). We are currently sand box testing SQL Server 2014 and have targeted a migration to it by 1st quarter 2015.

The following table lists the hardware that will be provisioned for this project by eQHealth Solutions and which will be hosted in their currently existing commercial datacenter infrastructure.

HARDWARE ITEM #	HARDWARE ITEM	ENVIRONMENT (E.G., DEVELOPMENT, TEST, TRAINING, PRODUCTION)	MANUFACTURER	DETAILED DESCRIPTION (E.G., NUMBER OF PROCESSORS, AMOUNT AND TYPE OF STORAGE AND MEMORY, TYPE OF NETWORK CARD)	OPERATING SYSTEM	EARLIEST PROPOSED PURCHASE DATE
1	Virtual Host	All	Cisco	Unified Computing System (UCS) B200 servers, Dual 10 core Intel 3.0 GHz processors, 384 GB RAM, redundant 10 Gigabit Ethernet Fabric interconnects, redundant power supplies. Connected to high availability NetApp SAN via fiber. This server hosts all guest servers required for test, training and production and can be physically scaled to 10 times its current footprint.	VMWare VShpere 5.5	Currently own
2	Qty:2 Fax Servers	All	Hewlett Packard	Proliant DL 380 G5, Dual 6 core Intel processors, 8 GB RAM, 2 Gigabit network cards, 2 Brooktrout BRI/PRI/DS1 fax cards, redundant power, Connected to high availability NetApp SAN via fiber	Windows 2008 R2	Currently own
3	Qty:1 Storage Area Network	All	NetApp	FAS 2040 SAN Unit, 2 Tier 1 storage arrays with 15K RPM SAS drives 2 Tier 2 storage arrays with 7.5K RPM SATA drives 6 Gigabit network cards. Current capacity of 136 Terabytes. All servers and eQSuite® data are persisted on this SAN.		Currently own
4	Qty:3 Switches	ALL	Cisco	Nexus 7000 series		Currently own
5	Qty:2 Routers	ALL	Cisco	1800 series		Currently own
6	Qty:2 WAN Optimizers	ALL	SilverPeak	NX series appliance. Compresses and dedups network traffic effectively tripling a network pipes bandwidth.		Currently own

**Server Architecture:**

eQHealth Solutions utilizes a FlexPod for the datacenter infrastructure. A FlexPod is a pretested and validated design for converged computing, network and storage solution developed by Cisco and NetApp. The components include the Cisco Unified Computing System (UCS) server platform, Cisco Unified Fabric Technology (Nexus switches), NetApp Fabric Attached Storage (FAS) and VMware virtualization hypervisor. The FlexPod architecture is designed to provide scalable infrastructure while maintaining high-availability and disaster recovery capabilities for improved operational resiliency against system failures. The FlexPod uses a cooperative support model with Cisco, NetApp and VMware engineers that are supported by an advanced lab infrastructure. Meaning once a service ticket is placed, engineers from Cisco, NetApp and VMware work cooperatively to resolve the issue with a 98% resolution rate on first contact. All system updates for any of the components of the FlexPod are validated in an advanced multi- vendor lab to ensure compatibility before being released.

The eQHealth Solutions virtual environment is built on the Cisco Unified Computing System (UCS) platform. The Cisco UCS platform integrates compute, network and storage access into a unified system optimized for virtual environments. The system uses multiple redundant 10 Gigabit Ethernet network fabric connections from the chassis to the fabric interconnects and Nexus switches to eliminate the need to wire each individual physical server to allow for high scalability while maintaining bandwidth and security for existing virtual machines. The physical servers that host our virtual environment are configured for N+1 redundancy. If there is a system failure on one of the virtual host servers, the workload is automatically shifted to another server seamlessly with no downtime. The environment has been configured with resource pools to protect and isolate critical applications and servers and to provide extra resources as critical application workloads increase; resources can be added to the individual servers without any downtime. All of the virtual servers are built on the Microsoft Windows 2008 R2 server operating system.

**Client Architecture:**

eQSuite® system is a secure HIPAA compliant browser based Microsoft ASP.NET application which can be accessed over the Internet. To access the eQSuite® system, the following minimum software requirements must be met by end users:

- Computer with Intel Pentium 4 or higher
- Windows XP SP2 or higher
- Video RAM to support 1024 X 768 resolution or higher
- 1 GB free hard drive space for temp file and script caching
- 512 MB standard RAM
- Internet Explorer 7 or higher / Mozilla Firefox 3 or higher/ Safari 4 or higher
- Broadband internet connection

**Data Storage Architecture:**

Storage Area Networks and Capacity: EMC CX300 SAN with 2 disk arrays. Total raw capacity is 4TB with 3TB usable. Unit is expandable to 38TB. All volumes are configured with RAID 5.

NetApp FAS270 with 2 disk arrays. Total raw capacity is 32TB. All volumes are configured with RAID 5.

All storage area networks are full fiber channel with redundant fiber channel switches.

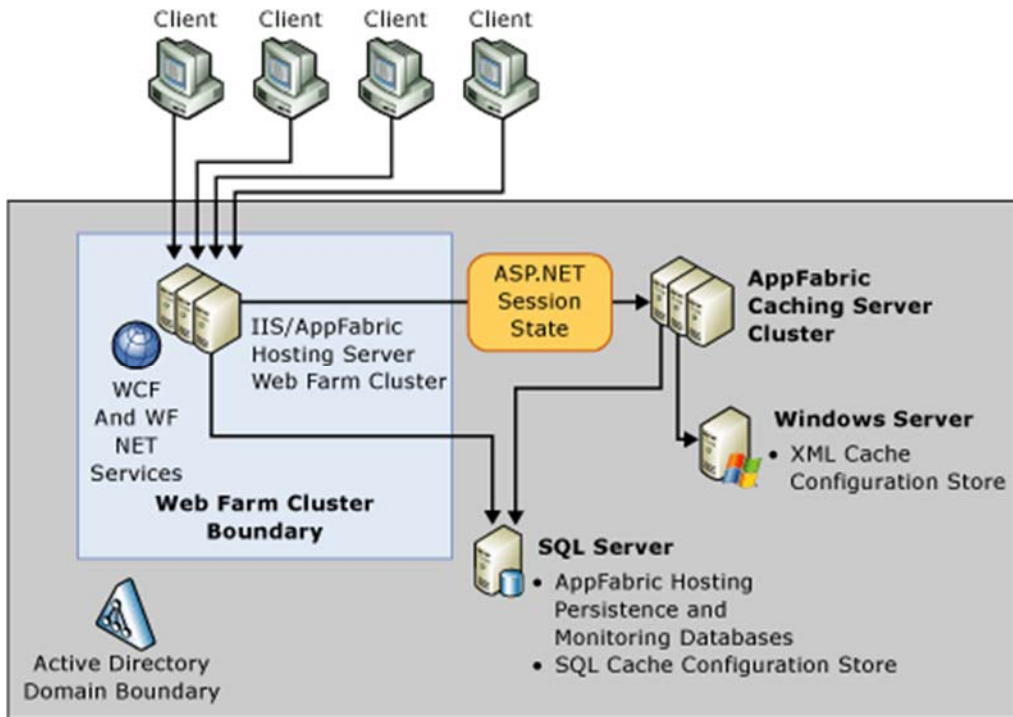
**Tool Set: design, build, test, deploy, report, monitor, and operate the System and its components:**

	Description
<b>Development</b>	
	Integrated Design Environment (Note: eQSuite® is written in C# .NET)
Telerik Ajax Controls	.NET Ajax user interface control suite
Telerik Data Access	Object Relational Mapping to database
Team Foundation Server 2013	Manages all development work items, iterative sprint scheduling,
<b>Quality Assurance</b>	
Coded UI	Test development environment for UI automation
Test Manager	Manages test plans and verification
Database	
SQL Server 2008 R2	Enterprise Relational Database Engine
<b>Reporting</b>	
Sql Server Reporting Services	Develop, deploy and manage server based reports
<b>Analytics</b>	
Dundas Dashboards	Web-based platform to develop interactive dashboards for
Sql Server Analysis Services	
<b>Business Rules Engine</b>	
InRule BRMS	Business Rules Management System
<b>Release Management</b>	
RedGate	Compare, difference and synch database schema and raw
<b>Application Monitoring</b>	
dynaTrace	Comprehensive proactive application performance
<b>Database Monitoring</b>	
Solarwinds Ignite	Database performance monitoring with thresholds and alerts
<b>Master Data Index</b>	
Mirth Match	Leveraged from our Clinical Integration Framework (CIF) module for
<b>Data Integration</b>	
Mirth Connect	Interface engine within Clinical Integration Framework (CIF)
Sql Server Integration Services	Enterprise-level data integration and data transformations solutions.
<b>Direct Messaging</b>	
DataMotion	CMS authorized HISP for secure emailing of clinical data



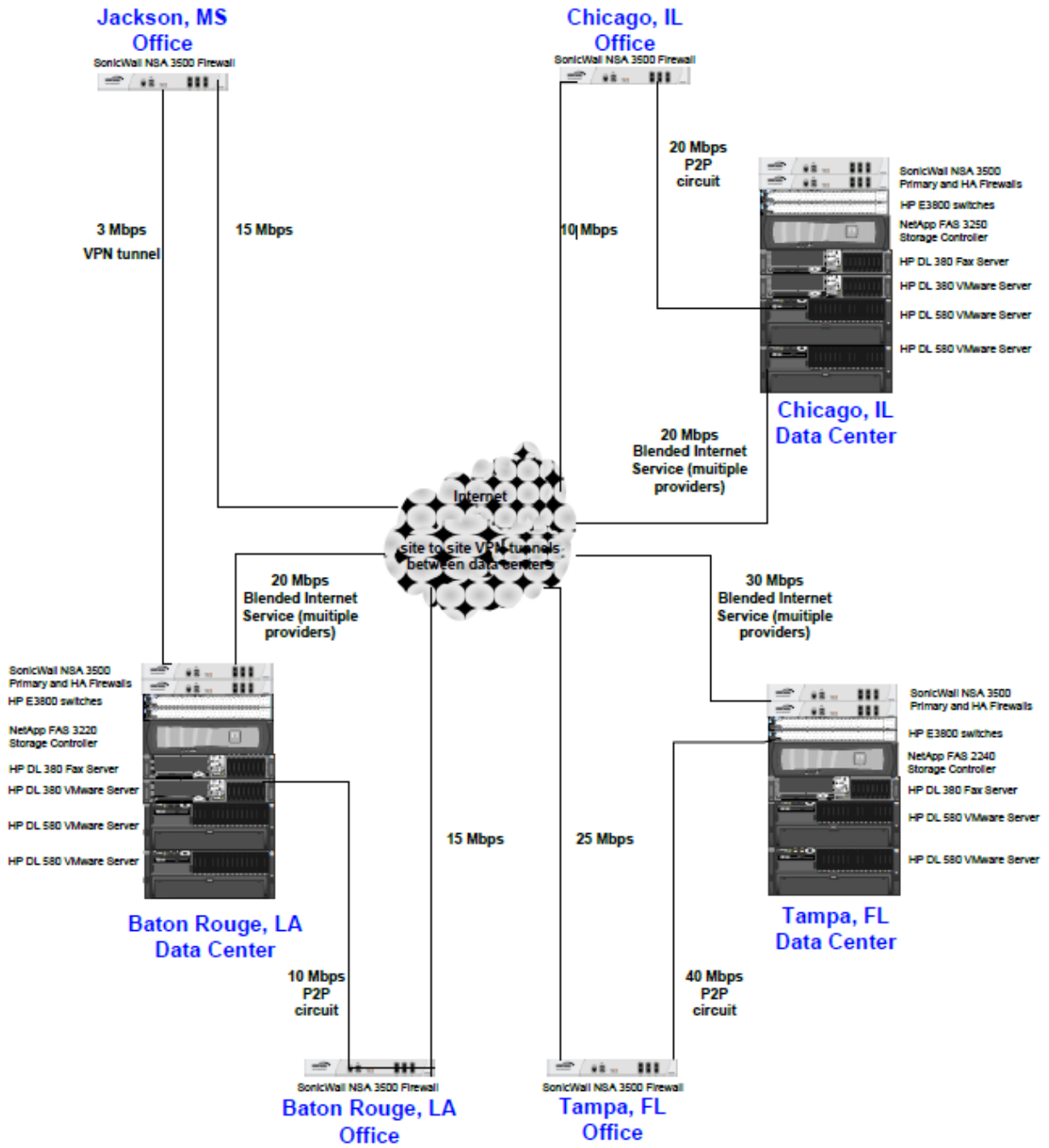
**Network Architecture:**

The network topology that supports the eQSuite® system is highly distributed and consists of three commercial level datacenters. Each datacenter hosts a cluster of web servers or a “web farm”. The web farm is software load balanced. Load balancing utilizes sophisticated algorithms to route all incoming requests to a given web server based on a servers reported load, response time, active connections and traffic. Each user session is stored out of process in the AppFabric state server which means there is no server affinity and each request can be handled by any server in the farm. This provides tremendous fault tolerance and eliminates the potential for the creation of orphaned sessions in the event a web server was to fail or is removed for maintenance. The following image depicts the load-balanced AppFabric Web Farm cluster the uses external caching services to store each user’s session state.



Each datacenter hosts a virtualized web farm which is isolated in a perimeter network (DMZ) that faces the internet. This perimeter network is isolated from our corporate Wide Area Network by switches, firewalls and routers.

The following image depicts the topology and makeup of the corporate network that will be used to host the eQSuite® system.



## MMIS CARE MANAGEMENT PROJECT

### RISK REGISTER DESCRIPTION:

1. Risk Description: Provide a description of what the risk entails
2. Source of Risk: Project, Proposed Solution, Vendor or Other
3. Risk Rating: Risk ratings to indicate: Likelihood and probability of risk occurrence; Impact should risk occur; and Overall risk rating (high, medium or low priority)
4. Risk Strategy: State's Planned Risk Strategy: **Avoid, Mitigate, Transfer or Accept**
5. Timing of Risk Response: Describe the planned timing for carrying out the risk response (e.g. prior to the start of the project, during the Planning Phase, prior to implementation, etc.)
6. State's Planned Risk Response: Describe what the State plans to do (if anything) to address the risk
7. Reviewer's Assessment of State's Planned Response: Indicate if the planned response is adequate/appropriate in your judgment and if not what would you recommend.

*NOTE: Hyperlinks are used on the Risk ID. From the Risk Register, CTL-CLICK on a link to see the Risk Response, or from the Risk Response, CTL-CLICK on a link to go back to the Risk Register.*

## RISK REGISTER:

Risk #:	Risk Description	Source of Risk	Risk Rating: Impact	Risk Rating: Probability	Risk Rating: Overall Risk	State Risk Strategy Summary	Timing of Response	Reviewer Assessment of Response
<a href="#">1</a>	<u>Budget/Funding:</u> With the extension of the APS contract for 6 months and \$1.3M, these costs were not accounted for in the original project budget	Current Solution	Medium	Low	Low	ACCEPT	Prior to starting project	Risk Adequately Mitigated
<a href="#">2</a>	<u>Budget/Funding:</u> It is not clear whether there are adequate Source of Funds for the project, as two key cost items are allocated at a PROGRAM LEVEL and not at a PROJECT LEVEL (IV&V and internal staffing). The costing model prepared for this IR indicates Vendor Costs (out of pocket costs) are adequately funded.	Proposed Solution	Low	Low	Low	ACCEPT	Prior to starting project	Risk Adequately Mitigated
<a href="#">3a</a>	<u>Vendor Risk:</u> eQHealth and Cognizant have not worked on a project together to date. As such, State of Vermont would be the proverbial guinea pig/test case in how these two vendors integrate their service offerings.  Additionally, the primary vendor eQHealth is a much smaller organization (\$40M annual revenue, 501(c)3 Not for profit privately owned, 340 employees vs. Cognizant with \$8.8B annual revenue, 187,400 employees)	Project	High	Medium	Medium	ACCEPT	Ongoing	Risk Adequately Mitigated
<a href="#">3b</a>	<u>Vendor Risk:</u> Address Cognizant provided in proposal is a mailing address only. Does State have requirement for a physical presence in Vermont? (145 Pine Haven Shores Road, Shelburne, VT 05482)	Project	Low	Low	Low	MITIGATE	Prior to starting project	Risk Adequately Mitigated
<a href="#">3c</a>	<u>Vendor Risk:</u> Cognizant recently acquired a software company, Trizetto, which has a Care Management solution called CareAdvance, raising the concern for these two vendors to have an open and honest working relationship without concern for Intellectual Property compromise.	Project	Low	Low	Low	ACCEPT	Prior to starting project	Risk Adequately Mitigated

<a href="#">4</a>	<u>VCCI Service Level/Staffing</u> : There is no provision for covering the drop in staff when the current provider (APS) contract ends on 12/31/2015. APS currently provides Care Management Staff (in addition to the Care Management System currently used) of 14-15 FTEs.	Proposed Solution	Medium	Medium	Medium	ACCEPT	Prior to starting project	Risk Adequately Mitigated
<a href="#">5a</a>	<u>Project Management Staffing</u> : Proposed Cognizant Project Manager does not have PMP qualifications.	Project	Medium	Medium	Medium	ACCEPT	Prior to starting project	Risk Adequately Mitigated
<a href="#">5b</a>	<u>Project SME Staffing</u> One SME assigned to this project. That seems light, although Leadership indicates it is adequate.	Project	Medium	Low	Low	MITIGATE	Prior to starting project	Risk Adequately Mitigated
<a href="#">6</a>	<u>Schedule and Contract</u> : No risks noted, based on revised project schedule due to APS contract extension.							N/A
<a href="#">7</a>	<u>Data Conversion</u> : No risks noted, based on conversations with Ms. Mosher that data conversion is in the contract extension with APS.							N/A
<a href="#">8a</a>	<u>Functionality</u> : All items in the table Template H – Non-Functional Requirements, General Requirements section, T1 Interoperability-Interfaces sheet are “DEVELOPMENT” items vs. “LEVERAGED/CORE FUNCTIONALITY”?	Project	Medium	Medium	Medium	ACCEPT	Prior to starting project	Risk Adequately Mitigated
<a href="#">8b</a>	<u>Functionality</u> : How are the gaps identified in the areas of Service Virtualization, Tightly vs. Loosely Coupled, Communication Plans, and Service Repository Standards being remediated?	Project	Medium	Medium	Medium	ACCEPT	Prior to starting project	Risk Adequately Mitigated
<a href="#">8c</a>	<u>Functionality</u> : The EA Group expressed concern about Non-Compliant approach to SOA and ESB technology. Where exactly are they not compliant?	Project	Medium	Medium	Medium	ACCEPT	Prior to starting project	Risk Adequately Mitigated
<a href="#">8d</a>	<u>Functionality</u> : The vendor submitted several “Assumptions” related to the Technical Requirements. Are these acceptable to State of Vermont?	Project	Medium	Low	Low	ACCEPT	Prior to starting project	Risk Adequately Mitigated

## RISK RESPONSE:

Risk #:	State's Planned Risk Response and Reviewer's Assessment of State's Risk Response
<p><u>1</u></p>	<p><b><u>STATE'S RISK RESPONSE:</u></b>            There would always be overlap between the 2 vendors to assure no interruption in VCCI services. DVHA CFO indicated there is no problem provided the 2 vendors are not concurrently in DDI. The new vendor will be in DDI the entire time the incumbent vendor continues in M&amp;O.</p> <p><b><u>REVIEWER'S ASSESSMENT:</u></b>            The vendor overlap is not a concern. That overlap was to occur between Feb, 2015 and June, 2015. Now, APS contract is being extended another 6 months for \$1.3M. That unbudgeted line item is the concern here. The risk is that there is not adequate funding for that additional line item. Can you acknowledge that while it is an unanticipated cost, the funding sources of the MMIS Funding (60%) and Vermont General Fund matching (40%) is adequate to cover it?</p> <p><b><u>STATE'S RESPONSE TO REVIEWER'S ASSESSMENT:</u></b>            The \$1.3M that will be paid to the incumbent vendor would have been paid to the new vendor had the original schedule been maintained, because the new vendor would have been in M&amp;O during the period that will now be devoted to DDI. It is not additional money and it was always budgeted – the only difference is to which vendor it will be paid. In addition, the current vendor is paid through the General Fund because it was not integrated with the overall MMIS program. Therefore, the State will be receiving federal matching dollars that we previously didn't.</p> <p><b><u>REVIEWER'S ASSESSMENT:</u></b>            Based on discussions with CARE Management team describing how cost is allocated at the M&amp;O level (Maintenance and Operations), it was explained that the total out of pocket costs over the same period of time will not change. The period of time in evaluated is 7/1/2015 – 6/30/2022, with the expectation that \$2.4M will be spent annually over that time for M&amp;O. So, while there is not an equivalent reduction of \$1.3M from eQHealth, the total M&amp;O costs remain the same over a 7 year period. However, now instead of all those M&amp;O funds going to eQHealth over that period, \$1.3M goes to APS over the first 6 months of M&amp;O for FY2016. Further, there is the expectation that those costs/reimbursements will continue at that pace beyond the 7 year window. For example, in this case, in Year 7-7.5, eQHealth will be the recipient of M&amp;O funds during that window. This still adds \$1.3M to the total PROJECT COST, but does not add any cost to ANNUAL OPERATIONS, because of the assumption that the \$2.4M annual budget can cover M&amp;O costs, regardless of which provider (APS or eQHealth) get that money, and assuming that BOTH are not receiving M&amp;O money simultaneously.</p> <p>Accept this risk mitigation response.</p>
<p><u>2</u></p>	<p><b><u>STATE'S RISK RESPONSE:</u></b>            CMS pays 90% of MMIS DDI, and approximately 60% of M&amp;O. New vendor M&amp;O will be paid with funding currently dedicated to incumbent M&amp;O.</p> <p><b><u>REVIEWER'S ASSESSMENT:</u></b>            Based on costing model developed for this IR, it appears there is adequate funding to cover the Vendor DDI and M&amp;O portions of the project (out of pocket costs). However, there remains a question of how <b>staffing costs</b> and <b>IV&amp;V costs</b> are allocated, in that, adding those costs to the total project costs exceed the funding source.</p> <p><b><u>STATE'S RESPONSE TO REVIEWER'S ASSESSMENT:</u></b>            Since there aren't any new staff resulting from this contract, there aren't any new staffing costs as a result of this contract. However, some existing staff will have a percentage of their salaries covered using federal funds, whereas they previously were funded through General Fund dollars only. See the revised cost spreadsheet for this information.</p> <p><b><u>REVIEWER'S ASSESSMENT:</u></b>            The Program Costs have been adequately allocated to a Project Level as follows:</p>

- a. FTE During DDI: Tech: .5; Business: 7.5
- b. FTE During M&O: Tech: .25; Business: .25

Further, per Joe Liscinsky and Donna Amiot: The amount allocated for the Care Management Solution DDI (\$12.6) is approximately 16.5% of the total amount allocated for all MMIS Program DDI costs. Based on this, 16.5% of the IV&V costs should be allocated to Care Management.

This cost allocation seems reasonable, resulting in acceptance of this risk mitigation response.

[3a](#)

**STATE’S RISK RESPONSE:**

SoV required eQHealth to strengthen its key personnel oversight. We recognize this risk, nevertheless. During BAFO and planning calls, we have been satisfied with how the 2 vendors have worked together.

The following response was added after the IR Presentation:

Cognizant and eQHealth have partnered on Business Development activities for almost (2) years for health plan clients. Part of this partnership has been evaluation of eQHealth’s software and how it compares in the market place. As a result Cognizant has a good understanding of the software. In each of our business development initiatives Cognizant’s role has been to understand the client needs and with the understanding of eQHealth software, propose a solution. This is very similar to how Cognizant will be working with eQHealth on SoV opportunity. Their primary role will be to understand SoV business requirements, support, facilitate JAD & requirements elicitation sessions, along with conducting first level QA validation and concurrently support program management to implement the solution. The eQHealth and Cognizant partnership is that of a strategic alliance where both organizations intend to continue to partner in opportunities outside of SoV Care Management Solution. For example, they have explored the following opportunities for joint partnership to name a few:

State of Illinois: Web-based solution for Long-term Support Services to administer Uniform Assessment Tool such as LOCET and supporting solution for workflow etc.

Company	Role	
eQhealth	Clinical Expertise & Technology Solution	Prime
Cognizant	Implementation Partner	Sub

Commercial Insurer for their Medicare Advantage Plan: Technology solution to support their Medical Management Services

Company	Role	
eQhealth	Clinical Expertise & Technology Solution	Sub
Cognizant	Implementation Partner	Prime

Commonwealth of Virginia HCBS Multi-Waiver Prior Authorization System

Company	Role	
eQhealth	Clinical Expertise & Technology Solution	Prime
Cognizant	Implementation Partner	Sub

In addition to these they have explored opportunities in the State of New Mexico, and a PTN Grant with CMS.

Moreover, eQHealth is committed to (and the contract requires eQHealth to) ensure that all Cognizant staff receive training on and have an in-depth understanding of eQSuite® before Cognizant staff begins its engagement on the project. For Cognizant’s staff that will be on the project at its inception, this training will be completed prior to project kickoff.

	<p><b>REVIEWER'S ASSESSMENT:</b> State of Vermont has typically been risk averse to being "first in" on new technologies or new partnerships.</p> <p>Further, eQHealth has not worked with a subcontractor on another project similar to this project, in terms of subcontractor providing the services contemplated by Cognizant, so has no similar experience.</p> <p>However, given the fact that the vendors have attempted to collaborate on other projects, and are not attempting to collaborate just for this project, it demonstrates interest in long-term partnership, and reduces the risk. That, along with an acceptance of this risk by key State of Vermont DII or other decision makers, allows the author to accept this risk.</p>
<p><a href="#">3b</a></p>	<p><b>STATE'S RISK RESPONSE:</b> EQHealth is obtaining office space in the Burlington, VT area, as required in the RFP. One of the options is in S. Burlington (30 Kimball Ave S )and the other two locations are in Williston (62 Merchants Row, 94 Zephyr).</p> <p><b>REVIEWER'S ASSESSMENT:</b> Accept this risk mitigation response.</p>
<p><a href="#">3c</a></p>	<p><b>STATE'S RISK RESPONSE:</b> The State recognizes this as a risk and are exploring mitigation strategies with our procurement/legal team.</p> <p><b>REVIEWER'S ASSESSMENT:</b> Accept this risk mitigation response.</p>
<p><a href="#">4</a></p>	<p><b>STATE'S RISK RESPONSE:</b> VCCI will not have outreach staff and will need to leverage relationships - hopefully - for direct referrals to the VCCI via CHT and ACO partners, including hospital case managers, so that current VCCI RN/professional staff are not doing cold calls to 'find' members to engage in our services - as APS staff perform our outreach functions.</p> <p>As regards the process for direct fax or phone referrals to APS , DVHA/VCCI will not have supplemental administrative support to pick up referrals, perform related data entry, screen members for eligibility, and perform outreach including initial assessments and respond to the provider/partner on the referral status. Likely this will mean that direct referrals - phone, fax (and hopefully electronic with new system )will go directly to the local professional staff which will impact their availability to be with members in a direct case management role - as they will now perform administrative functions that were formerly performed by APS.</p> <p>We will also lose nursing capacity (7 FTEs) with this contract transition. Thus, the overall total number of members engaged in VCCI case management services will decline, and as a result, cost savings will also decline.</p> <p>Specific staffing/capacity lost includes 13.5 FTE's as outlined below:</p> <ul style="list-style-type: none"> <li>- 2 FTE Social Worker staff responsible for outreach and intake (case load development) and who supported social service requirements - housing/food/fuel of members.</li> <li>- 1 FTE (net loss) reporting staff (given currently 3 at APS and VCCI hired one limited service FTE clinical analyst and the vendor will provide 1 FTE analyst</li> <li>- 7 FTE nurses including a nurse manager who did telephonic case management</li> <li>- 1 FTE local manager (no impact)</li> <li>- 1 FTE pharmacist (partially absorbed via the pharmacy unit and PBM/Gould)</li> <li>- .5 FTE medical director, which will presumably be absorbed by current medical director via UVM contract.</li> <li>- 1 FTE client services coordinator</li> </ul> <p>We have been advised that we will not be securing any replacement staff for the above positions in the budget adjustment for 2015; nor in SFY 2016.</p>



Per Kelly Gordon as a follow up to the above response:

The statement by one individual during the Independent Review that cost savings will decline because we are no longer contracting for clinical staff with the Care Management Solution vendor is speculative. There are several reasons a reduction in cost savings is not anticipated. The contracted APS nurses provide telephonic support only; the effectiveness of a telephonic approach has increasingly been questioned and research regarding its success in producing better health outcomes and reductions in the cost of care has not produced strong findings. As a result, Vermont Medicaid, the Blueprint Community Health Teams, and many other care management providers have moved away from telephonic care management in favor of an onsite, face-to-face approach. Face-to-face care management is particularly indicated for the complex, high risk population served by the VCCI, because they often are struggling with many challenges in addition to their health concerns.

In addition to providing only telephonic support, only one APS nurse is located in Vermont. The others are located in other states, limiting their familiarity and ability to integrate with Vermont's broader health and human services resources. Effective integration of physical health care, behavioral health care, and social services is known to be essential in achieving positive outcomes and reduced costs with Medicaid recipients. The new care management solution will provide greater automation and efficiency to care managers, improved ability to coordinate and integrate activities and to share data across providers and care settings. Lastly, it should be noted that APS' original guarantee of a 2:1 ROI was based solely on using their technology system and did not require their clinical staff augmentation in order to achieve the guaranteed results.

Kelly Gordon provided the following supporting evidence of the claims made above relative to the effectiveness of a telephonic approach has increasingly been questioned and research regarding its success in producing better health outcomes and reductions in the cost of care has not produced strong findings:

*Telephone-based disease management: Why it does not save money. American Journal of Managed Care, 2011. Jan, 17(1): e 10-6.*  
Summary of this article follows:

Objectives: To understand why the current telephone-based model of disease management (DM) does not provide cost savings and how DM can be retooled based on the best available evidence to deliver better value.

Study Design: Literature review.

Methods: The published peer-reviewed evaluations of DM and transitional care models from 1990 to 2010 were reviewed. Also examined was the cost-effectiveness literature on the treatment of chronic conditions that are commonly included in DM programs, including heart failure, diabetes mellitus, coronary artery disease, and asthma.

Results: First, transitional care models, which have historically been confused with commercial DM programs, can provide credible savings over a short period, rendering them low-hanging fruit for plan sponsors who desire real savings. Second, cost-effectiveness research has shown that the individual activities that constitute contemporary DM programs **are not cost saving** except for heart failure. Targeting of specific patients and activity combinations based on risk, actionability, treatment and program effectiveness, and costs will be necessary to deliver a cost-saving DM program, combined with an outreach model that brings vendors closer to the patient and physician. Barriers to this evidence-driven approach include resources required, marketability, and business model disruption.

**Conclusions: After a decade of market experimentation with limited success, new thinking is called for in the design of DM programs. A program design that is based on a cost-effectiveness approach, combined with greater program efficacy, will allow for the development of DM programs that are cost saving. –**

See more at: [http://www.aimc.com/publications/issue/2011/2011-1-vol17-n1/aimc\\_11jan\\_motheral\\_webx\\_e10/1](http://www.aimc.com/publications/issue/2011/2011-1-vol17-n1/aimc_11jan_motheral_webx_e10/1)

*This one segment, found in the link above summarizes the study well: “Much of the current emphasis in retooling DM is placed on the ability of vendors to motivate patients over the telephone rather than on fundamental economics. This is because research has shown that execution is an ongoing challenge for the industry on 2 levels, the ability to reach individuals via telephone and subsequently to motivate individuals to change behavior. For example, less than 5% of enrollees in Medicare Health Support were reached on a monthly basis.<sup>38</sup> Once reached via telephone, the ability to motivate individuals for behavior change has met with limited success, as evidenced by the weak and inconsistent clinical impact of the programs.<sup>38,39</sup> These findings are not particularly surprising, as even the successful investigations of TC have usually found that some element of face-to-face interaction is necessary after discharge.<sup>15</sup> A meta-analysis<sup>40</sup> of TC found that use of multidisciplinary teams and face-to-face intervention was significantly more effective than single-provider types or telephone-based programs.”*

Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services. Section 8: The Care Management Evidence Based. (See <http://www.ahrq.gov/professionals/systems/long-term-care/resources/hcbs/medicaidmgmt/medicaidmgmt8.html> )

The study offered the following introduction:

*“Considering the evidence on the efficacy of different care management interventions is important for States as they plan and design a care management program. States should use the evidence base for care management to gain support from stakeholders, choose diseases, and select interventions. The evidence also can help States determine the timeframe in which they should expect changes from their programs. This information allows States to better set expectations for their program and choose appropriate measures.*

*This section of the Guide, The Care Management Evidence Base, presents a review of published literature relating to care management programs in the public and private sectors. General findings appear in the body of the section, with more specific findings for diabetes, asthma, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and coronary artery disease (CAD) outlined in individual synopses that follow. The General Findings stated: “Many study participants received multiple interventions (e.g., **telephonic care management** and patient education), and the studies were unable to isolate the impact of each individual intervention. The literature is also limited regarding the timing needed to see the effects of care management interventions. Within the literature reviewed, study duration varied from 30 days to 5 years,*

*and the intervention length did not have a clear impact on the outcomes. Despite these study limitations, the literature review found evidence of care management interventions improving outcomes across all diseases successfully.”*

The table below, prepared by the Independent Reviewer, summarizes the findings from the study:

<b>Condition</b>	<b>In Person Care Management Impact on Utilization or Cost</b>	<b>Provider Education Impact on Utilization or Cost</b>	<b>Self-Management and Monitoring Impact on Utilization or Cost</b>	<b>Telephonic Care Management Impact on Utilization or Cost</b>
Diabetes	Greatest overall impact	Yes	Yes	Yes, but less frequently than the others
Asthma	Greatest overall impact	adherence to guidelines, followup visit rates, medication use, and utilization		Positive impact on clinical outcomes, process, activation, utilization, and cost measures. Telephonic care management especially impacted measures that reflect a patient's quality of life. For example, three studies found that telephonic care management significantly reduced the number of patient-reported symptoms.
Congestive Heart Failure	Greatest overall impact	Yes, but less frequently than other methods	One of the most effective, impacting clinical outcomes, process, utilization, and cost measures	Showed strong evidence for reducing utilization, specifically hospital readmissions, with some studies experiencing a 45 percent drop in hospital readmissions. Evidence for cost savings and improved clinical outcomes were less conclusive

COPD	Mixed results, some studies suggest improved clinical measures and utilization, others found no significant impact	No significant impact	Not reviewed	Not reviewed
Coronary Artery Disease	Most effective	Not reviewed	Improves clinical outcomes and processes	Not reviewed

When Kelly Gordon was asked whether she read the report the same as the IR Author in that, it seems like telephonic in fact DID provide value, she responded as follows: *“The second article compiles results from a number of different studies regarding disease management for specific chronic conditions. Although when VCCI began, it focused on disease management of 11 chronic conditions, it no longer has that focus. It now is focused on comprehensive care management of high cost/high risk (top 5%) Medicaid members, regardless of condition. This would dilute the potential savings associated with any particular disease. Congestive Heart Failure, for example, had the strongest results (as reported in this article) but represents a relatively small percentage of the VCCI population. In addition, few of our high cost members have just 1 condition – many, if not most, have a number of comorbidities that often are complicated by socioeconomic and behavioral health challenges.”*

When then asked the following: *“So, would you say then that the study referenced is not relevant for VCCI, in terms of evaluating whether Telephonic support is a good method of care, due to the type of conditions (multiple) and population served?”*, Ms. Gordon further clarified: *“It is the best that we have in terms of a national statement (coming from ahrq). VCCI is a sophisticated and mature program that is viewed by other states as a leader in this field. Therefore, the research on programs exactly like VCCI is nonexistent to my knowledge. Perhaps in 5 years or so there will be a comprehensive statement from ahrq on programs like VCCI. More to the point, however, is that these studies do not support the previous conclusion that eliminating the current vendor’s telephonic support necessarily presents a risk to the program and will seriously impact VCCI’s cost savings.”*

**REVIEWER’S ASSESSMENT:**

Accept this risk mitigation response.

<p><a href="#">5a</a></p>	<p><b>STATE’S RISK RESPONSE:</b> SoV did not require certification. Because of questions about the proposed PM’s qualifications, the State’s Care IT PM conducted reference checking specifically on the PM, who received very strong positive recommendations.</p> <p><b>REVIEWER’S ASSESSMENT:</b> Accept this risk mitigation response.</p>																											
<p><a href="#">5b</a></p>	<p><b>STATE’S RISK RESPONSE:</b> Additional VCCI expertise will be involved, as needed, in addition to the 1 full-time SME.</p> <p><b>REVIEWER’S ASSESSMENT:</b> Can you provide a project roster, with names, current position in the organization, and FTE % allocated to the project?</p> <p><b>STATE’S RESPONSE TO REVIEWER’S ASSESSMENT:</b></p> <table border="1" data-bbox="289 553 1780 829"> <thead> <tr> <th>NAME</th> <th>TITLE</th> <th>%FTE ON PROJECT</th> </tr> </thead> <tbody> <tr> <td>Brian Smith</td> <td>Nurse Case Manager</td> <td>15-25%</td> </tr> <tr> <td>Blythe Kersula</td> <td>Nurse Case Manager</td> <td>15-25%</td> </tr> <tr> <td>Christie Allen</td> <td>Nurse Case Manager – High Risk Pregnancy</td> <td>20%</td> </tr> <tr> <td>Lindsay Van Leir</td> <td>Clinical Informaticist/Analyst</td> <td>50%</td> </tr> <tr> <td>Eileen Girling</td> <td>VCCI Director</td> <td>50%</td> </tr> <tr> <td>Amber DeVoss</td> <td>MMIS SME for Department for Children and Families</td> <td>25%</td> </tr> <tr> <td>Nancy Marinelli</td> <td>MMIS SME for Department of Aging &amp; Independent Living</td> <td>25%</td> </tr> <tr> <td>Lily Sojourner</td> <td>AHS HSE Case/Care Management Enterprise Business Process Owner</td> <td>20%</td> </tr> </tbody> </table> <p><b>REVIEWER’S ASSESSMENT:</b> Accept this risk mitigation response.</p>	NAME	TITLE	%FTE ON PROJECT	Brian Smith	Nurse Case Manager	15-25%	Blythe Kersula	Nurse Case Manager	15-25%	Christie Allen	Nurse Case Manager – High Risk Pregnancy	20%	Lindsay Van Leir	Clinical Informaticist/Analyst	50%	Eileen Girling	VCCI Director	50%	Amber DeVoss	MMIS SME for Department for Children and Families	25%	Nancy Marinelli	MMIS SME for Department of Aging & Independent Living	25%	Lily Sojourner	AHS HSE Case/Care Management Enterprise Business Process Owner	20%
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Eileen Girling	VCCI Director	50%																										
Amber DeVoss	MMIS SME for Department for Children and Families	25%																										
Nancy Marinelli	MMIS SME for Department of Aging & Independent Living	25%																										
Lily Sojourner	AHS HSE Case/Care Management Enterprise Business Process Owner	20%																										
<p><a href="#">6</a></p>	<p><b>STATE’S RISK RESPONSE:</b></p> <p><b>REVIEWER’S ASSESSMENT:</b></p>																											
<p><a href="#">7</a></p>	<p><b>STATE’S RISK RESPONSE:</b></p> <p><b>REVIEWER’S ASSESSMENT:</b></p>																											
<p><a href="#">8a</a></p>	<p><b>STATE’S RISK RESPONSE:</b> Per Michael Hall: Not sure why they are marked as development as their clinical interface engine has the required functionality. I suspect that it is their way of indicating the requirements for the other system will need to be discovered and it will need to be configured as opposed to an out of the box solution.</p> <p><b>REVIEWER’S ASSESSMENT:</b> Accept this risk mitigation response.</p>																											

<a href="#">8b</a>	<p><b><u>STATE'S RISK RESPONSE:</u></b>  Per Michael Hall, EQH services are tightly coupled with the 3rd party applications used to support Risk and Critical CARE. SoV will not have access to EQH services for reuse for other applications, which would make the services within their application tightly as opposed to loosely coupled.  However, SoV has indicated to EQH that we are very interested in integrating care cases from EQH with the AHS Case Management System used by Contact Center, and other businesses throughout AHS.</p> <p><b><u>REVIEWER'S ASSESSMENT:</u></b>  Accept this risk mitigation response.</p>
<a href="#">8c</a>	<p><b><u>STATE'S RISK RESPONSE:</u></b>  Per Michael Hall, SoV wants vendors to use the ESB on the HSEP to host already built services (i.e. fetch case, look up SSN, etc). EQH is aware we do want to extend the features of their applications where applicable.</p> <p><b><u>REVIEWER'S ASSESSMENT:</u></b>  Accept this risk mitigation response.</p>
<a href="#">8d</a>	<p><b><u>STATE'S RISK RESPONSE:</u></b>  Per Michael Hall, not all Technical Requirements Assumptions were accepted. These assumptions were processed during the BAFO process, and the remaining items are being addressed through contract. Summary in Exhibit 1 below.</p> <p><b><u>REVIEWER'S ASSESSMENT:</u></b>  Accept this risk mitigation response.</p>

## Exhibit 1: Technical Requirements Assumption Risk Mitigation

ITEM #	REFERENCE (Section, Page, Paragraph)	DESCRIPTION	RATIONALE	MH - Resolution with eQ
4.	1.3.2	System Availability	Scheduled maintenance downtime is not accounted towards overall system uptime specific to SLAs	We agreed that scheduled downtime (outside of normal business hours) would not be counted in SLA measurement
5.	1.5	Integration	HIE data will not be considered as a key data source in the immediate phase	Accepted
6.	1.6	Scalability and Extensibility	The scalability and SLAs are based on approximately 180K lives with anticipated 10% growth per year.	Accepted for VCCI needs. Addition lives associated with implementing other programs would be dealt with in the associated contract amendment
7.	1.10	System Administration and Support	The State is amenable to vendor hosting the solution for the life cycle of the contract	Accepted that the system would initially be hosted as an option and that it could be moved to a State hosting in the future
8.	1.9	Health and Human Services Enterprise (HSE) Platform Alignment	The State is amenable to a SaaS technology stack provided by the vendor	Accepted
9.	1.3	Service Level Requirements (SLRs) and Performance	All the data sources are available in a timely manner from MMIS and other entities	Accepted, it was agreed that this would be an ASCII file possibly comma delimited
10.	1.3	Service Level Requirements (SLRs) and Performance	All the historical data will be converted and provided by the State for migration without requiring any addition data validation from the vendor.	eQ accepted that they will be doing ETL for the data migration and associated data validation
11.	1	Architecture and Policy Requirement	Vendor will be responsible for CMS MITA 3.0 compliance on care management system only.	Accepted

12.	1.5	Integration	The number of integrations with external registries are limited to 5.	Accepted as we anticipate only 3 registries at most will be needed for VCCI
13.	1.5	Integration	The data formats of all the various sources will be machine readable in a consumable format	Accepted, as above ASCII files at the minimum, could be HL7 or XML, several formats as identified in their Clinical Integration Framework
14.	1.5	Integration	The data formats of all the various sources will be machine readable in a consumable format.	Ditto (see 13)
15.	1.5	Integration	The State will finalize all the various data formats within the first month of the contract. Any change to the data formats will be subject to change management process.	Accepted this will occur as part of the associated JAD sessions



**MMIS Care Management Project**

KEY:

**STATEMENT OF: Use of Funds (Expenses), Source of Funds (Revenue), Cash Flow, and Change in Net Operating Cost**

Click on the links to the left to go to that data

<b>SUMMARY:</b>		<b>NET DECREASE/(INCREASE) IN OP. COSTS:</b>	<a href="#">\$1,598,779</a>
Total Project Cost Over 7 Years:	<a href="#">\$32,167,885</a>	<b>CASH FLOW ANALYSIS:</b>	<a href="#">Click Here</a>
Total Funding:	<a href="#">\$32,167,885</a>	Total Funding CMS:	\$23,568,827
Potential Revenue Recovery:	<a href="#">\$0</a>	Total Funding State of VT:	\$8,599,059
Funding Excess/(Shortage):	\$0		

USE OF FUNDS - START														DDI	M&O	Optional	
Description	Billing Milestone	Unit Price	# of Units	Total	MMIS Funded	Implementation		Implementation		Ops and Maint		Ops and Maint		TOTAL			
						Year 1 (FY16)	Year 2 (FY17)	Year 3 (FY18)	Year 4 (FY19)	Year 5 (FY20)	Year 6 (FY21)	Year 7 (FY22)					
<b>VENDOR OUT OF POCKET EXPENSES</b>																	
<b>SOFTWARE AND SERVICES</b>																	
<b>SOFTWARE</b>																	
				\$0													
eQHealth eQSuite™ Licensing			1		0%	100%	\$215,000	\$215,000	\$215,000	\$215,000	\$215,000	\$215,000	\$215,000	\$1,505,000			
Healthwise							\$158,000	\$158,000	\$158,000	\$158,000	\$158,000	\$158,000	\$158,000	\$1,106,000			
Interqual Interface development							\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0			
FirstDatabank							\$26,000	\$26,000	\$26,000	\$26,000	\$26,000	\$26,000	\$26,000	\$182,000			
Geocoding							\$10,000	\$10,000	\$10,000	\$10,000	\$10,000	\$10,000	\$10,000	\$70,000			
Coding Libraries (CPT, ICD9-10 APDRG etc.)							\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$35,000			
in-Rule (BRMS)							\$1,500	\$1,500	\$1,500	\$1,500	\$1,500	\$1,500	\$1,500	\$10,500			
Mirth Match							\$24,000	\$24,000	\$24,000	\$24,000	\$24,000	\$24,000	\$24,000	\$168,000			
HEDIS							\$83,250	\$83,250	\$83,250	\$83,250	\$83,250	\$83,250	\$83,250	\$582,750			
John Hopkins ACG (Predictive Modeling)							\$120,000	\$120,000	\$120,000	\$120,000	\$120,000	\$120,000	\$120,000	\$840,000			
<b>SOFTWARE TOTAL</b>				\$0			\$642,750	\$642,750	\$642,750	\$642,750	\$642,750	\$642,750	\$642,750	\$4,499,250			\$4,499,250
<b>SERVICES</b>																	
<b>IMPLEMENTATION SERVICES</b>																	
<b>IMPLEMENTATION SERVICES</b>																	
Solution Implementation		\$11,935,058	1	\$11,935,058	0%	100%	\$5,967,529	\$5,967,529	\$0	\$0	\$0	\$0	\$0	\$11,935,058			
Travel		\$0	6	\$0	0%	100%	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0			
<b>TOTAL: IMPLEMENTATION SERVICES</b>							\$5,967,529	\$5,967,529	\$0	\$0	\$0	\$0	\$0	\$11,935,058			\$11,935,058
<b>3rd PARTY VENDOR INTEGRATION</b>																	
		\$0	1	\$0	0%	100%	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0			
		\$0	1	\$0	0%	100%	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0			
<b>TOTAL: 3rd PARTY VENDOR INTEGRATION (Estimated Fees)</b>							\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0			
<b>SERVICES TOTAL</b>							\$5,967,529	\$5,967,529	\$0	\$0	\$0	\$0	\$0	\$11,935,058			
<b>SOFTWARE AND SERVICES TOTAL</b>							\$6,610,279	\$6,610,279	\$642,750	\$642,750	\$642,750	\$642,750	\$642,750	\$16,434,308			
<b>HARDWARE</b>																	
Hardware Costs (if applicable) (Hardware for mailing/fulfillment center)					0%	100%	\$30,000	\$0	\$0	\$0	\$0	\$0	\$0	\$0			
<b>HARDWARE TOTAL</b>							\$30,000	\$0	\$0	\$0	\$0	\$0	\$0	\$30,000			\$30,000
<b>MAINTENANCE AND OPERATIONS SUPPORT</b>																	
Application Maintenance and Operations Support					0%	100%	\$1,205,100	\$1,468,227	\$1,697,403	\$1,697,403	\$1,695,568	\$1,695,568	\$1,695,788	\$11,155,057			\$11,155,057
Hosting and DR Support (Until Full Deployment)					0%	0%	\$22,800	\$22,800	\$0	\$0	\$0	\$0	\$0	\$45,600			\$45,600
Hosting after full deployment					0%	100%	\$0	\$0	\$40,000	\$40,000	\$40,000	\$40,000	\$40,000	\$200,000			\$200,000
DR after full deployment					0%	100%	\$0	\$0	\$9,500	\$9,500	\$9,500	\$9,500	\$9,500	\$47,500			\$47,500
Change Orders (DDI)					0%	100%	\$230,665	\$0	\$0	\$0	\$0	\$0	\$0	\$230,665			\$230,665
Change Orders (M&O)					0%	100%	\$230,665	\$230,665	\$94,347	\$94,347	\$96,182	\$96,182	\$95,962	\$938,350			\$938,350
<b>MAINTENANCE AND OPERATIONS SUPPORT TOTAL</b>							\$1,689,230	\$1,721,692	\$1,841,250	\$1,841,250	\$1,841,250	\$1,841,250	\$1,841,250	\$12,617,172			
<b>TOTAL VENDOR OUT OF POCKET EXPENSES</b>							\$8,329,509	\$8,331,971	\$2,484,000	\$2,484,000	\$2,484,000	\$2,484,000	\$2,484,000	\$29,081,480			
<b>AHS INTERNAL COSTS</b>																	

Staffing Costs: 2																		
DII Project Management Oversight	Included in DII Fee Below	\$0	1	\$0	0%	100%	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
External Project Management Services	Not anticipated	\$0	5	\$0	0%	100%	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Security Assessment	Not anticipated	\$0	1	\$0	0%	100%	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Travel		\$0	1	\$0	0%	100%	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Other ()		\$0	1	\$0	0%	100%	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Contingency		\$0	1	\$0	0%	100%	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>AHS INTERNAL COSTS TOTAL</b>							\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0

Summary of Costs by DDI and M&O, in order to reconcile costs with how costs are funded by CMS; Includes "optional" costs proposed by Vendor that are not approved/accounted for in CMS budget																				
<b>DDI</b>																			\$12,195,723	\$12,195,723
<b>M&amp;O</b>																			\$16,885,757	\$16,885,757
<b>TOTAL BY DDI, M&amp;O, Unaccounted</b>																			\$29,081,480	\$29,081,480

See numbers in columns above to understand how the

ADD IN COSTS AT PROGRAM LEVEL NOT INITIALLY ALLOCATED TO PROJECT (these costs are allocated at 8.46%): 3																				
Staffing:																				
Technical Staff (.5 during DDI, .25 during M&O; \$36 for 2,000 hours annual)		\$36	2,000				\$36,000	\$36,000	\$18,000	\$18,000	\$18,000	\$18,000	\$18,000	\$18,000	\$18,000	\$18,000	\$18,000	\$18,000	\$162,000	\$162,000
Business Staff (7.5 during DDI, .25 during M&O; \$36 for 2,000 hours annual)		\$36	2,000				\$540,000	\$540,000	\$18,000	\$18,000	\$18,000	\$18,000	\$18,000	\$18,000	\$18,000	\$18,000	\$18,000	\$18,000	\$1,170,000	\$1,170,000
IV&V							\$437,305	\$222,015	\$158,155										\$817,476	\$817,476
<b>TOTAL PROGRAM COSTS ALLOCATED TO PROJECT:</b>							\$1,013,305	\$798,015	\$194,155	\$36,000	\$36,000	\$36,000	\$36,000	\$36,000	\$36,000	\$36,000	\$36,000	\$36,000	\$2,149,476	\$2,149,476

<b>PROJECT SUB TOTAL COSTS</b>							\$9,342,814	\$9,129,986	\$2,678,155	\$2,520,000	\$2,520,000	\$2,520,000	\$2,520,000	\$2,520,000	\$2,520,000	\$2,520,000	\$2,520,000	\$2,520,000	\$2,520,000	\$31,230,956
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<b>3% Charge for DII PMO/EA Services 4</b>							\$280,284	\$273,900	\$80,345	\$75,600	\$75,600	\$75,600	\$75,600	\$75,600	\$75,600	\$75,600	\$75,600	\$75,600	\$75,600	\$75,600	\$936,929
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<b>PROJECT TOTAL COSTS</b>							\$9,623,099	\$9,403,886	\$2,758,500	\$2,595,600	\$2,595,600	\$2,595,600	\$2,595,600	\$2,595,600	\$2,595,600	\$2,595,600	\$2,595,600	\$2,595,600	\$2,595,600	\$2,595,600	\$32,167,885
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**USE OF FUNDS - END**

**SOURCE OF FUNDS (PAYMENT SCHEDULE BASED ON DELIVERABLES) - START**

Revenue Source:							Year 1 (FY16)	Year 2 (FY17)	Year 3 (FY18)	Year 4 (FY19)	Year 5 (FY20)	Year 6 (FY21)	Year 7 (FY22)	TOTAL
CMS APD Funding at 90% (DDI)							\$5,670,000	\$5,670,000	\$0	\$0	\$0	\$0	\$0	\$11,340,000
State General Fund at 10% (DDI)							\$630,000	\$630,000	\$0	\$0	\$0	\$0	\$0	\$1,260,000
CMS APD Funding at 60% (M&O)				Operating Costs			\$1,440,000	\$1,440,000	\$1,440,000	\$1,440,000	\$1,440,000	\$1,440,000	\$1,440,000	\$10,080,000
State General Fund at 40% (M&O)				Operating Costs			\$960,000	\$960,000	\$960,000	\$960,000	\$960,000	\$960,000	\$960,000	\$6,720,000
Additional CMS APD Funding at 90% to be committed to by Feds				Per Joe Liscinsky			\$830,789	\$633,497	\$0	\$0	\$0	\$0	\$0	\$1,464,287
Additional CMS APD Funding at 60% to be committed to by Feds				Per Joe Liscinsky			\$0	\$0	\$215,100	\$117,360	\$117,360	\$117,360	\$117,360	\$684,540
Additional General Fund at 10%, yet to be committed to by State				Per Joe Liscinsky			\$92,310	\$70,389	\$0	\$0	\$0	\$0	\$0	\$162,699
Additional General Fund at 40%, yet to be committed to by State				Per Joe Liscinsky			\$0	\$0	\$143,400	\$78,240	\$78,240	\$78,240	\$78,240	\$456,360
<b>TOTAL:</b>							\$9,623,099	\$9,403,886	\$2,758,500	\$2,595,600	\$2,595,600	\$2,595,600	\$2,595,600	\$32,167,885

**SOURCE OF FUNDS - END**

<b>Total Funding CMS:</b>							\$13,610,789	\$13,413,497	\$12,995,100	\$12,897,360	\$12,897,360	\$12,897,360	\$12,897,360	\$52,599,059
<b>Total Funding State of VT:</b>							\$1,682,310	\$1,660,389	\$1,103,400	\$1,038,240	\$1,038,240	\$1,038,240	\$1,038,240	\$8,599,059

**CASH FLOW - START**

	Year 1 (FY16)	Year 2 (FY17)	Year 3 (FY18)	Year 4 (FY19)	Year 5 (FY20)	Year 6 (FY21)	Year 7 (FY22)	TOTAL
Use	\$9,623,099	\$9,403,886	\$2,758,500	\$2,595,600	\$2,595,600	\$2,595,600	\$2,595,600	\$32,167,885
Source	\$9,623,099	\$9,403,886	\$2,758,500	\$2,595,600	\$2,595,600	\$2,595,600	\$2,595,600	\$32,167,885
Net Cash by Fiscal Year:	\$0	(\$0)	\$0	\$0	\$0	\$0	\$0	\$0
<b>Cash Flow:</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

Potential Revenue Recovery:

	Year 1 (FY16)	Year 2 (FY17)	Year 3 (FY18)	Year 4 (FY19)	Year 5 (FY20)	Year 6 (FY21)	Year 7 (FY22)	TOTAL
Net Cash by Fiscal Year:	\$0	(\$0)	\$0	\$0	\$0	\$0	\$0	\$0
<b>Cash Flow:</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

**CASH FLOW - END**

**NET CHANGE IN OPERATING COSTS - START**


	Year 1 (FY16)	Year 2 (FY17)	Year 3 (FY18)	Year 4 (FY19)	Year 5 (FY20)	Year 6 (FY21)	Year 7 (FY22)	TOTAL
<i>Proposed Operating Costs:</i>								
M&O	\$2,101,315	\$2,364,442	\$2,484,000	\$2,484,000	\$2,484,000	\$2,484,000	\$2,484,000	\$16,885,757
<b>Total: Proposed Operating Costs:</b>	<b>\$2,101,315</b>	<b>\$2,364,442</b>	<b>\$2,484,000</b>	<b>\$2,484,000</b>	<b>\$2,484,000</b>	<b>\$2,484,000</b>	<b>\$2,484,000</b>	<b>\$16,885,757</b>
<i>Current Operating Costs:</i>								
APS Contract	\$2,640,648	\$2,640,648	\$2,640,648	\$2,640,648	\$2,640,648	\$2,640,648	\$2,640,648	\$18,484,536
<b>Total: Current Operating Costs:</b>	<b>\$2,640,648</b>	<b>\$2,640,648</b>	<b>\$2,640,648</b>	<b>\$2,640,648</b>	<b>\$2,640,648</b>	<b>\$2,640,648</b>	<b>\$2,640,648</b>	<b>\$18,484,536</b>
<b>Net Operating Cost Decrease/(Increase)</b>	<b>\$539,333</b>	<b>\$276,206</b>	<b>\$156,648</b>	<b>\$156,648</b>	<b>\$156,648</b>	<b>\$156,648</b>	<b>\$156,648</b>	<b>\$1,598,779</b>

**NET CHANGE IN OPERATING COSTS - END**












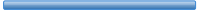







**NOTES / ASSUMPTIONS:**

- ① Includes base system maintenance and upgrades
- ② See ③ below

- 3 Tech staff at .5 FTE during DDI, .25 FTE during M&O; Business staff at 7.5 FTE during DDI, .25 FTE during M&O; a. Per Joe Liscinsky and Donna Amiot: The amount allocated for the Care Management Solution DDI (\$12.6) is approximately 16.5% of the total amount allocated for all MMIS Program DDI cc allocated for all MMIS Program DDI costs. Based on this, 16.5% of the IV&V costs should be allocated to Care Management.
- 4 EPMOFee is 3% of Cost; Is there a cap?

ID	Task Name	Duration	Start	Finish	Feb 1, '15		
					S	S	M
1	<b>DVHA - Enterprise Care Management Solution</b> 	<b>485 days?</b>	<b>Mon 2/2/15</b>	<b>Mon 12/12/16</b>			
2	<b>Workstream-I : FR 1 &amp; 2</b>	<b>305 days</b>	<b>Mon 2/2/15</b>	<b>Mon 4/4/16</b>			
3	<b>Immediate</b>	<b>120 days</b>	<b>Mon 2/2/15</b>	<b>Mon 7/20/15</b>			
4	<b>FR 1: Document Management</b>	<b>120 days</b>	<b>Mon 2/2/15</b>	<b>Mon 7/20/15</b>			
5	Letter Templates Design	120 days	Mon 2/2/15	Mon 7/20/15			
6	Front-end Author	1 day	Mon 2/2/15	Tue 2/3/15			
7	Scan, Upload & Member Attribution	1 day	Mon 2/2/15	Tue 2/3/15			
8	FR 1: Member, Authorized Representative and Community Provider/Partner Portal	1 day	Mon 2/2/15	Tue 2/3/15			
9	<b>FR 1: Workflow Management</b>	<b>90 days</b>	<b>Mon 2/2/15</b>	<b>Mon 6/8/15</b>			
10	Auto-save	90 days	Mon 2/2/15	Mon 6/8/15			
11	Document Approval	1 day?	Mon 2/2/15	Tue 2/3/15			
12	<b>FR 1: Alerts and Notifications</b>	<b>120 days</b>	<b>Mon 2/2/15</b>	<b>Mon 7/20/15</b>			
13	Define Library of External Integration Alerts	120 days	Mon 2/2/15	Mon 7/20/15			
14	Create Alerts Subscription Service	1 day?	Mon 2/2/15	Tue 2/3/15			
15	Alert Dispatch & Acknowledgement	1 day?	Mon 2/2/15	Tue 2/3/15			
16	Alert Authoring	1 day?	Mon 2/2/15	Tue 2/3/15			
17	<b>FR 1: General</b>	<b>30 days</b>	<b>Mon 2/2/15</b>	<b>Mon 3/16/15</b>			
18	Guideline Integration	30 days	Mon 2/2/15	Mon 3/16/15			
19	Print Formatting	1 day?	Mon 2/2/15	Tue 2/3/15			
20	Spellcheck Integration	1 day?	Mon 2/2/15	Tue 2/3/15			
21	Security Integration	1 day?	Mon 2/2/15	Tue 2/3/15			
22	<b>FR 1: Centralized Mailing</b>	<b>30 days</b>	<b>Mon 4/6/15</b>	<b>Mon 5/18/15</b>			
23	Establish P&P	30 days	Mon 4/6/15	Mon 5/18/15			

Project: State of Vermont - Ent  
Date: Thu 9/18/14

Task		Inactive Summary		External Tasks	
Split		Manual Task		External Milestone	
Milestone		Duration-only		Deadline	
Summary		Manual Summary Rollup		Progress	
Project Summary		Manual Summary		Manual Progress	
Inactive Task		Start-only			
Inactive Milestone		Finish-only			












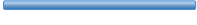







ID	Task Name	Duration	Start	Finish	Feb 1, '15			
					S	S	M	
24	Receive State Approved Letterheads and Envelops	1 day?	Mon 4/6/15	Tue 4/7/15				
25	Configure the environment	1 day?	Mon 4/6/15	Tue 4/7/15				
26	<b>FR 2: Setup Criteria</b>	<b>90 days</b>	<b>Mon 2/2/15</b>	<b>Mon 6/8/15</b>				
27	Criteria Library & Definitions	90 days	Mon 2/2/15	Mon 6/8/15				
28	Front-end Author	1 day?	Mon 2/2/15	Tue 2/3/15				
29	<b>FR 2: Setup Eligibility Rules</b>	<b>90 days</b>	<b>Mon 2/2/15</b>	<b>Mon 6/8/15</b>				
30	Eligibility Library and Definitions	90 days	Mon 2/2/15	Mon 6/8/15				
31	Front-end Author	1 day?	Mon 2/2/15	Tue 2/3/15				
32	<b>FR 2: Risk Stratification and Eligibility Determination</b>	<b>90 days</b>	<b>Mon 2/2/15</b>	<b>Mon 6/8/15</b>				
33	Data Sources Integration (Claims,Pharmacy, Labs, Member)	90 days	Mon 2/2/15	Mon 6/8/15				
34	eligibility determinations Criteria	1 day?	Mon 2/2/15	Tue 2/3/15				
35	program identification Criteria	1 day?	Mon 2/2/15	Tue 2/3/15				
36	Configure Risk Stratification Criteria	1 day?	Mon 2/2/15	Tue 2/3/15				
37	ineligibility documentation process	1 day?	Mon 2/2/15	Tue 2/3/15				
38	Eligibility Redetermination Process	1 day?	Mon 2/2/15	Tue 2/3/15				
39	<b>Future</b>	<b>180 days</b>	<b>Mon 7/27/15</b>	<b>Mon 4/4/16</b>				
40	<b>FR 1:Document Management</b>	<b>90 days</b>	<b>Mon 7/27/15</b>	<b>Mon 11/30/15</b>				
41	OCR	90 days	Mon 7/27/15	Mon 11/30/15				
42	<b>FR 1: Member, Authorized Representative and Community Provider/Partner Portal</b>	<b>30 days</b>	<b>Mon 7/27/15</b>	<b>Mon 9/7/15</b>				
43	Form entry with Branching	30 days	Mon 7/27/15	Mon 9/7/15				
44	Security Integration	1 day?	Mon 7/27/15	Tue 7/28/15				

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Task		Inactive Summary		External Tasks	
Split		Manual Task		External Milestone	
Milestone		Duration-only		Deadline	
Summary		Manual Summary Rollup		Progress	
Project Summary		Manual Summary		Manual Progress	
Inactive Task		Start-only			
Inactive Milestone		Finish-only			

ID	Task Name	Duration	Start	Finish	Feb 1, '15			
					S	S	M	
45	<b>FR 1: Workflow Management</b>	<b>150 days</b>	<b>Mon 7/27/15</b>	<b>Mon 2/22/16</b>				
46	Approval and Electronic Send	150 days	Mon 7/27/15	Mon 2/22/16				
47	<b>FR 1: Alerts and Notifications</b>	<b>60 days</b>	<b>Mon 7/27/15</b>	<b>Mon 10/19/15</b>				
48	external alerts and notifications	60 days	Mon 7/27/15	Mon 10/19/15				
49	electronic mailing (e-mailing) of alerts and notifications	1 day?	Mon 7/27/15	Tue 7/28/15				
50	automated notifications (hardcopy, electronic and phone)	1 day?	Mon 7/27/15	Tue 7/28/15				
51	<b>FR 1: General</b>	<b>180 days</b>	<b>Mon 7/27/15</b>	<b>Mon 4/4/16</b>				
52	auto notify	180 days	Mon 7/27/15	Mon 4/4/16				
53	member address validation	1 day?	Mon 7/27/15	Tue 7/28/15				
54	user role/access level data sharing	1 day?	Mon 7/27/15	Tue 7/28/15				
55	user interface compliance management	1 day?	Mon 7/27/15	Tue 7/28/15				
56	document imaging indexing	1 day?	Mon 7/27/15	Tue 7/28/15				
57	auto dial	1 day?	Mon 7/27/15	Tue 7/28/15				
58	member association	1 day?	Mon 7/27/15	Tue 7/28/15				
59	Decision Support Tools	1 day?	Mon 7/27/15	Tue 7/28/15				
60	External System Integration	1 day?	Mon 7/27/15	Tue 7/28/15				
61	Security Integration	1 day?	Mon 7/27/15	Tue 7/28/15				
62	System Audit Framework (Data & Activity)	1 day?	Mon 7/27/15	Tue 7/28/15				
63	<b>FR 1: Centralized Mailing</b>	<b>60 days</b>	<b>Mon 7/27/15</b>	<b>Mon 10/19/15</b>				
64	Establish Centralized Mailing Operations	60 days	Mon 7/27/15	Mon 10/19/15				
65	<b>FR 2: Setup Criteria</b>	<b>60 days</b>	<b>Mon 7/27/15</b>	<b>Mon 10/19/15</b>				
66	Establish Criteria Definitions	60 days	Mon 7/27/15	Mon 10/19/15				
67	<b>FR 2: Setup Eligibility Rules</b>	<b>1 day?</b>	<b>Mon 7/27/15</b>	<b>Tue 7/28/15</b>				

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Task		Inactive Summary		External Tasks	
Split		Manual Task		External Milestone	
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Project Summary		Manual Summary		Manual Progress	
Inactive Task		Start-only			
Inactive Milestone		Finish-only			

ID	Task Name	Duration	Start	Finish	Feb 1, '15			
					S	S	M	
68	<b>FR 2: Risk Stratification and Eligibility Determination</b>	<b>60 days</b>	<b>Mon 7/27/15</b>	<b>Mon 10/19/15</b>				
69	Electronic Referral Acceptance Interface	60 days	Mon 7/27/15	Mon 10/19/15				
70	eligibility determinations	1 day?	Mon 7/27/15	Tue 7/28/15				
71	program identification	1 day?	Mon 7/27/15	Tue 7/28/15				
72	ineligibility documentation process	1 day?	Mon 7/27/15	Tue 7/28/15				
73	Redetermination Process	1 day?	Mon 7/27/15	Tue 7/28/15				
74	<b>Workstream-II: FR 3, 4, 5 &amp; 6</b>	<b>445 days</b>	<b>Mon 2/2/15</b>	<b>Mon 10/17/16</b>				
75	<b>Immediate</b>	<b>120 days</b>	<b>Mon 2/2/15</b>	<b>Mon 7/20/15</b>				
76	<b>FR 3: Conduct Outreach</b>	<b>30 days</b>	<b>Mon 2/2/15</b>	<b>Mon 3/16/15</b>				
77	conduct outreach	30 days	Mon 2/2/15	Mon 3/16/15				
78	outreach type	1 day?	Mon 2/2/15	Tue 2/3/15				
79	outreach outcome	1 day?	Mon 2/2/15	Tue 2/3/15				
80	member contact information	1 day?	Mon 2/2/15	Tue 2/3/15				
81	member outreach decision	1 day?	Mon 2/2/15	Tue 2/3/15				
82	<b>FR 3: Assign Case Manager</b>	<b>30 days</b>	<b>Mon 2/2/15</b>	<b>Mon 3/16/15</b>				
83	store case manager profiles	30 days	Mon 2/2/15	Mon 3/16/15				
84	edit case manager profiles	1 day?	Mon 2/2/15	Tue 2/3/15				
85	case assignment	1 day?	Mon 2/2/15	Tue 2/3/15				
86	case management acknowledgement	1 day?	Mon 2/2/15	Tue 2/3/15				
87	case management reassignment	1 day?	Mon 2/2/15	Tue 2/3/15				
88	<b>FR 3: Assign Additional Staff to Case</b>	<b>60 days</b>	<b>Mon 2/2/15</b>	<b>Mon 4/27/15</b>				
89	case management user history	60 days	Mon 2/2/15	Mon 4/27/15				
90	case management reassignment reason	1 day?	Mon 2/2/15	Tue 2/3/15				

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Inactive Task		Start-only			
Inactive Milestone		Finish-only			



ID	Task Name	Duration	Start	Finish	Feb 1, '15			
					S	S	M	T
91	case manager reassignment notification	1 day?	Mon 2/2/15	Tue 2/3/15				
92	new case manager acknowledgement	1 day?	Mon 2/2/15	Tue 2/3/15				
93	<b>FR 3: General</b>	<b>45 days</b>	<b>Mon 2/2/15</b>	<b>Mon 4/6/15</b>				
94	supervisory management workflow	45 days	Mon 2/2/15	Mon 4/6/15				
95	<b>FR 4: Member's Profile Summary</b>	<b>30 days</b>	<b>Mon 2/2/15</b>	<b>Mon 3/16/15</b>				
96	Member Dashboard	30 days	Mon 2/2/15	Mon 3/16/15				
97	Member Case Summary Report	1 day?	Mon 2/2/15	Tue 2/3/15				
98	Medication Reconciliation	1 day?	Mon 2/2/15	Tue 2/3/15				
99	<b>FR 4: Perform Screening and Assessments</b>	<b>45 days</b>	<b>Mon 2/2/15</b>	<b>Mon 4/6/15</b>				
100	Security Integration	45 days	Mon 2/2/15	Mon 4/6/15				
101	Form Prepopulation	1 day?	Mon 2/2/15	Tue 2/3/15				
102	Assessment Branching	1 day?	Mon 2/2/15	Tue 2/3/15				
103	Auto Save	1 day?	Mon 2/2/15	Tue 2/3/15				
104	General Data Entry Form Useability	1 day?	Mon 2/2/15	Tue 2/3/15				
105	alerts for incomplete assessments	1 day?	Mon 2/2/15	Tue 2/3/15				
106	National Standards Validation Process	1 day?	Mon 2/2/15	Tue 2/3/15				
107	Form Wizard	1 day?	Mon 2/2/15	Tue 2/3/15				
108	<b>FR 5: Create Plan of Care</b>	<b>45 days</b>	<b>Mon 2/2/15</b>	<b>Mon 4/6/15</b>				
109	prepopulate POC	45 days	Mon 2/2/15	Mon 4/6/15				
110	Assessments to POC Mapping	1 day?	Mon 2/2/15	Tue 2/3/15				
111	POC Modification Capabilities	1 day?	Mon 2/2/15	Tue 2/3/15				
112	Issue-Goal-Intervention (IGI) Library	1 day?	Mon 2/2/15	Tue 2/3/15				
113	Security Integration	1 day?	Mon 2/2/15	Tue 2/3/15				
114	Target Date Mapping	1 day?	Mon 2/2/15	Tue 2/3/15				

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Split		Manual Task		External Milestone	
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Project Summary		Manual Summary		Manual Progress	
Inactive Task		Start-only			
Inactive Milestone		Finish-only			

ID	Task Name	Duration	Start	Finish	Feb 1, '15			
					S	S	M	T
115	POC Outcome Mapping	1 day?	Mon 2/2/15	Tue 2/3/15				
116	POC Printing and electronic distribution	1 day?	Mon 2/2/15	Tue 2/3/15				
117	Authorized Services History	1 day?	Mon 2/2/15	Tue 2/3/15				
118	<b>FR 5:Develop Action Plans</b>	<b>45 days</b>	<b>Mon 2/2/15</b>	<b>Mon 4/6/15</b>				
119	Display Action Plan (POC - Interventions)	45 days	Mon 2/2/15	Mon 4/6/15				
120	Action Customization At Member Level	1 day?	Mon 2/2/15	Tue 2/3/15				
121	IGI Mapping	1 day?	Mon 2/2/15	Tue 2/3/15				
122	Actions Editing	1 day?	Mon 2/2/15	Tue 2/3/15				
123	Action Plan Printing & Electronic Distribution	1 day?	Mon 2/2/15	Tue 2/3/15				
124	<b>FR 5:Provider Education Materials</b>	<b>30 days</b>	<b>Mon 2/2/15</b>	<b>Mon 3/16/15</b>				
125	Healthwise Education Material Integration	30 days	Mon 2/2/15	Mon 3/16/15				
126	Multi-language Functionality	1 day?	Mon 2/2/15	Tue 2/3/15				
127	Printing & Electronic Distribution	1 day?	Mon 2/2/15	Tue 2/3/15				
128	Member Association	1 day?	Mon 2/2/15	Tue 2/3/15				
129	<b>FR 6: Case Documentation</b>	<b>90 days</b>	<b>Mon 2/2/15</b>	<b>Mon 6/8/15</b>				
130	IGI User Management (Target Dates, Hide Functionality etc)	90 days	Mon 2/2/15	Mon 6/8/15				
131	IGI Prioritization Capabilities	1 day?	Mon 2/2/15	Tue 2/3/15				
132	Data Entry Useability Concepts	1 day?	Mon 2/2/15	Tue 2/3/15				
133	Member Association	1 day?	Mon 2/2/15	Tue 2/3/15				
134	Audit & Activity Framework	1 day?	Mon 2/2/15	Tue 2/3/15				
135	Member Demographics Editing	1 day?	Mon 2/2/15	Tue 2/3/15				
136	Member Contact Preference Management	1 day?	Mon 2/2/15	Tue 2/3/15				
137	Supervisory Workflow	1 day?	Mon 2/2/15	Tue 2/3/15				

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Split		Manual Task		External Milestone	
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Project Summary		Manual Summary		Manual Progress	
Inactive Task		Start-only			
Inactive Milestone		Finish-only			

ID	Task Name	Duration	Start	Finish	Feb 1, '15			
					S	S	M	T
138	Claims Integrations (ICD9 & 10)	1 day?	Mon 2/2/15	Tue 2/3/15				
139	<b>FR 6: Scheduling</b>	<b>120 days</b>	<b>Mon 2/2/15</b>	<b>Mon 7/20/15</b>				
140	Scheduling Integration	120 days	Mon 2/2/15	Mon 7/20/15				
141	provide a contact information directory	1 day?	Mon 2/2/15	Tue 2/3/15				
142	Document Attachments	1 day?	Mon 2/2/15	Tue 2/3/15				
143	Scheduling Privacy	1 day?	Mon 2/2/15	Tue 2/3/15				
144	Email Integration	1 day?	Mon 2/2/15	Tue 2/3/15				
145	<b>FR 6: Document Case Disposition</b>	<b>15 days</b>	<b>Mon 2/2/15</b>	<b>Mon 2/23/15</b>				
146	document case disposition status	15 days	Mon 2/2/15	Mon 2/23/15				
147	<b>FR 6: Transition</b>	<b>90 days</b>	<b>Mon 2/2/15</b>	<b>Mon 6/8/15</b>				
148	Referral Entry	90 days	Mon 2/2/15	Mon 6/8/15				
149	allow for printing and referral	1 day?	Mon 2/2/15	Tue 2/3/15				
150	Referral Acknowledgement	1 day?	Mon 2/2/15	Tue 2/3/15				
151	allow community provider to attach files	1 day?	Mon 2/2/15	Tue 2/3/15				
152	Referral History	1 day?	Mon 2/2/15	Tue 2/3/15				
153	Referral Search	1 day?	Mon 2/2/15	Tue 2/3/15				
154	Referral Withdrawal	1 day?	Mon 2/2/15	Tue 2/3/15				
155	<b>FR 6: Close Program Enrollment</b>	<b>75 days</b>	<b>Mon 2/2/15</b>	<b>Mon 5/18/15</b>				
156	Plan of Care Status	45 days	Mon 3/16/15	Mon 5/18/15				
157	Program Closure	1 day?	Mon 2/2/15	Tue 2/3/15				
158	Batch Problem Management	1 day?	Mon 2/2/15	Tue 2/3/15				
159	Batch Goal Management	1 day?	Mon 2/2/15	Tue 2/3/15				
160	Automated Closure Rules	1 day?	Mon 2/2/15	Tue 2/3/15				
161	Alerts for Follow Ups	1 day?	Mon 2/2/15	Tue 2/3/15				

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Project Summary		Manual Summary		Manual Progress	
Inactive Task		Start-only			
Inactive Milestone		Finish-only			

ID	Task Name	Duration	Start	Finish	Feb 1, '15			
					S	S	M	T
162	<b>FR 6: Care Coordination</b>	<b>30 days</b>	<b>Mon 2/2/15</b>	<b>Mon 3/16/15</b>				
163	Security Integration	30 days	Mon 2/2/15	Mon 3/16/15				
164	<b>FR 6: General</b>	<b>30 days</b>	<b>Mon 2/2/15</b>	<b>Mon 3/16/15</b>				
165	Care Management Data Search	20 days	Mon 2/2/15	Mon 3/2/15				
166	Rx Drug Gaps	30 days	Mon 2/2/15	Mon 3/16/15				
167	<b>Future</b>	<b>320 days</b>	<b>Mon 7/27/15</b>	<b>Mon 10/17/16</b>				
168	<b>FR 3: Conduct Outreach</b>	<b>120 days</b>	<b>Mon 7/27/15</b>	<b>Mon 1/11/16</b>				
169	auto route member info to user	120 days	Mon 7/27/15	Mon 1/11/16				
170	notify user of need for outreach	1 day?	Mon 7/27/15	Tue 7/28/15				
171	alerts/notify user on predetermined time intervals if the user has not taken action	1 day?	Mon 7/27/15	Tue 7/28/15				
172	escalate the case if user has not acknowledged case and taken action	1 day?	Mon 7/27/15	Tue 7/28/15				
173	allow user to acknowledge outreach assignment	1 day?	Mon 7/27/15	Tue 7/28/15				
174	track time before outreach assignment is acknowledged	1 day?	Mon 7/27/15	Tue 7/28/15				
175	allow users to send electronic communication if email is available	1 day?	Mon 7/27/15	Tue 7/28/15				
176	record all electronic communication and associate it with members case	1 day?	Mon 7/27/15	Tue 7/28/15				
177	allow user to close a program specific case and auto notify	1 day?	Mon 7/27/15	Tue 7/28/15				
178	<b>FR 3: Assign Case Manager</b>	<b>210 days</b>	<b>Mon 7/27/15</b>	<b>Mon 5/16/16</b>				
179	Workflow and Routing	210 days	Mon 7/27/15	Mon 5/16/16				
180	Alerts and Reminders	1 day?	Mon 7/27/15	Tue 7/28/15				
181	Case Escalation process	1 day?	Mon 7/27/15	Tue 7/28/15				
182	Case manager schedule intergration	1 day?	Mon 7/27/15	Tue 7/28/15				

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Inactive Task		Start-only			
Inactive Milestone		Finish-only			

ID	Task Name	Duration	Start	Finish	Feb 1, '15			
					S	S	M	
183	<b>FR 3: Assign Additional Staff to Case</b>	<b>90 days</b>	<b>Mon 7/27/15</b>	<b>Mon 11/30/15</b>				
184	Additional Staff Assignment	90 days	Mon 7/27/15	Mon 11/30/15				
185	Program History	1 day?	Mon 7/27/15	Tue 7/28/15				
186	Case Manager Search	1 day?	Mon 7/27/15	Tue 7/28/15				
187	<b>FR 3: General</b>	<b>60 days</b>	<b>Mon 7/27/15</b>	<b>Mon 10/19/15</b>				
188	New Member Case Establishment	60 days	Mon 7/27/15	Mon 10/19/15				
189	<b>FR 4: Member's Profile Summary</b>	<b>180 days</b>	<b>Mon 7/27/15</b>	<b>Mon 4/4/16</b>				
190	PBM Integration	180 days	Mon 7/27/15	Mon 4/4/16				
191	Program History	1 day?	Mon 7/27/15	Tue 7/28/15				
192	<b>FR 4: Perform Screening and Assessments</b>	<b>90 days</b>	<b>Mon 7/27/15</b>	<b>Mon 11/30/15</b>				
193	Assessment Scheduling	90 days	Mon 7/27/15	Mon 11/30/15				
194	Security Integration	1 day?	Mon 7/27/15	Tue 7/28/15				
195	<b>FR 5: Create Plan of Care</b>	<b>180 days</b>	<b>Mon 7/27/15</b>	<b>Mon 4/4/16</b>				
196	Assessments to Services Mapping	180 days	Mon 7/27/15	Mon 4/4/16				
197	POC Copy and Edit All Stakeholders	1 day?	Mon 7/27/15	Tue 7/28/15				
198	Security Integration	1 day?	Mon 7/27/15	Tue 7/28/15				
199	POC Notifications	1 day?	Mon 7/27/15	Tue 7/28/15				
200	Member Service History for All Stakeholder Portals	1 day?	Mon 7/27/15	Tue 7/28/15				
201	HCBS Services Library	1 day?	Mon 7/27/15	Tue 7/28/15				
202	POC Signature	1 day?	Mon 7/27/15	Tue 7/28/15				
203	<b>FR 5: Develop Action Plans</b>	<b>120 days</b>	<b>Mon 7/27/15</b>	<b>Mon 1/11/16</b>				
204	Action Plan Editing By All Stakeholders	120 days	Mon 7/27/15	Mon 1/11/16				
205	Multi-languagage Functionality	1 day?	Mon 7/27/15	Tue 7/28/15				
206	<b>FR 5: Provider Education Materials</b>	<b>120 days</b>	<b>Mon 7/27/15</b>	<b>Mon 1/11/16</b>				

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	Inactive Milestone		Finish-only			

ID	Task Name	Duration	Start	Finish	Feb 1, '15			
					S	S	M	
207	State Education Material Integration	120 days	Mon 7/27/15	Mon 1/11/16				
208	Program to Material Mapping	1 day?	Mon 7/27/15	Tue 7/28/15				
209	Electronic Distribution	1 day?	Mon 7/27/15	Tue 7/28/15				
210	Batch Print & Mail	1 day?	Mon 7/27/15	Tue 7/28/15				
211	Integration to Member Portal	1 day?	Mon 7/27/15	Tue 7/28/15				
212	<b>FR 6: Case Documentation</b>	<b>210 days</b>	<b>Mon 7/27/15</b>	<b>Mon 5/16/16</b>				
213	Neworn to Mother Association Utility	210 days	Mon 7/27/15	Mon 5/16/16				
214	Services Rendered Analysis & Compliance	1 day?	Mon 7/27/15	Tue 7/28/15				
215	Member Case History Management	1 day?	Mon 7/27/15	Tue 7/28/15				
216	Critical Incident Reporting & Management	1 day?	Mon 7/27/15	Tue 7/28/15				
217	Family Association for Care Management	1 day?	Mon 7/27/15	Tue 7/28/15				
218	<b>FR 6: Scheduling</b>	<b>320 days</b>	<b>Mon 7/27/15</b>	<b>Mon 10/17/16</b>				
219	Scheduling Integration Phase 2	320 days	Mon 7/27/15	Mon 10/17/16				
220	Map Integration	1 day?	Mon 7/27/15	Tue 7/28/15				
221	<b>FR 6: Document Case Disposition</b>	1 day?	Mon 7/27/15	Tue 7/28/15				
222	<b>FR 6: Transition</b>	<b>120 days</b>	<b>Mon 7/27/15</b>	<b>Mon 1/11/16</b>				
223	Referral Acknowledgement	120 days	Mon 7/27/15	Mon 1/11/16				
224	Provider Partner Search	1 day?	Mon 7/27/15	Tue 7/28/15				
225	Batching and Mailing of Referrals	1 day?	Mon 7/27/15	Tue 7/28/15				
226	Referral Electronic Dispatch	1 day?	Mon 7/27/15	Tue 7/28/15				
227	<b>FR 6: Close Program Enrollment</b>	<b>90 days</b>	<b>Mon 7/27/15</b>	<b>Mon 11/30/15</b>				
228	Appointment Alerts	90 days	Mon 7/27/15	Mon 11/30/15				
229	Batch Disceased Status	1 day?	Mon 7/27/15	Tue 7/28/15				
230	<b>FR 6: Care Coordination</b>	<b>240 days</b>	<b>Mon 7/27/15</b>	<b>Mon 6/27/16</b>				

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	Inactive Task		Start-only			
	Inactive Milestone		Finish-only			

ID	Task Name	Duration	Start	Finish	Feb 1, '15			
					S	S	M	
231	Health Team Framework	240 days	Mon 7/27/15	Mon 6/27/16				
232	Stakeholder Assignment	1 day?	Mon 7/27/15	Tue 7/28/15				
233	Primary Assignment Contact Information	1 day?	Mon 7/27/15	Tue 7/28/15				
234	Concurrent Review Process	1 day?	Mon 7/27/15	Tue 7/28/15				
235	<b>FR 6: General</b>	<b>60 days</b>	<b>Mon 7/27/15</b>	<b>Mon 10/19/15</b>				
236	Security Integration	60 days	Mon 7/27/15	Mon 10/19/15				
237	<b>Workstream-III: 7 &amp; 8</b>	<b>485 days</b>	<b>Mon 2/2/15</b>	<b>Mon 12/12/16</b>				
238	<b>Immediate</b>	<b>120 days</b>	<b>Mon 2/2/15</b>	<b>Mon 7/20/15</b>				
239	<b>FR 7: Manage Population Health Outreach</b>	<b>120 days</b>	<b>Mon 2/2/15</b>	<b>Mon 7/20/15</b>				
240	Reporting	120 days	Mon 2/2/15	Mon 7/20/15				
241	User Profiles & Geocoding	1 day	Mon 2/2/15	Tue 2/3/15				
242	Assignment Management	1 day?	Mon 2/2/15	Tue 2/3/15				
243	Provider Demographics	1 day?	Mon 2/2/15	Tue 2/3/15				
244	Sessions Notes	1 day?	Mon 2/2/15	Tue 2/3/15				
245	Appointment Scheduling	1 day?	Mon 2/2/15	Tue 2/3/15				
246	Action Item Management	1 day?	Mon 2/2/15	Tue 2/3/15				
247	Healthwise Integration	1 day?	Mon 2/2/15	Tue 2/3/15				
248	Printing & Electronic Distribution	1 day?	Mon 2/2/15	Tue 2/3/15				
249	Program Performance Management	1 day?	Mon 2/2/15	Tue 2/3/15				
250	Business Analytics based on MMIS Source Data	1 day?	Mon 2/2/15	Tue 2/3/15				
251	Population Health Campaign management	1 day?	Mon 2/2/15	Tue 2/3/15				
252	Utilization Census Integrations	1 day?	Mon 2/2/15	Tue 2/3/15				
253	<b>FR 8: Manage Registry</b>	<b>90 days</b>	<b>Mon 2/2/15</b>	<b>Mon 6/8/15</b>				
254	Performance Measure Tracking	90 days	Mon 2/2/15	Mon 6/8/15				

Project: State of Vermont - Ent Date: Thu 9/18/14	Task		Inactive Summary		External Tasks	
	Split		Manual Task		External Milestone	
	Milestone		Duration-only		Deadline	
	Summary		Manual Summary Rollup		Progress	
	Project Summary		Manual Summary		Manual Progress	
	Inactive Task		Start-only			
	Inactive Milestone		Finish-only			

ID	Task Name	Duration	Start	Finish	Feb 1, '15			
					S	S	M	T
255	Clinical Gap Registry	1 day?	Mon 2/2/15	Tue 2/3/15				
256	<b>FR 9: Referral Management</b>	<b>120 days</b>	<b>Mon 2/2/15</b>	<b>Mon 7/20/15</b>				
257	Document Attachments to Referrals	120 days	Mon 2/2/15	Mon 7/20/15				
258	Referral Notifications & Acknowledgements	1 day?	Mon 2/2/15	Tue 2/3/15				
259	Referral Types & Workflow	1 day?	Mon 2/2/15	Tue 2/3/15				
260	<b>FR 9: Prior Authorization</b>	1 day	Mon 2/2/15	Tue 2/3/15				
261	<b>Future</b>	<b>360 days</b>	<b>Mon 7/27/15</b>	<b>Mon 12/12/16</b>				
262	<b>FR 7: Manage Population Health Outreach</b>	<b>1 day</b>	<b>Mon 7/27/15</b>	<b>Tue 7/28/15</b>				
263	Batch and Mail	1 day?	Mon 7/27/15	Tue 7/28/15				
264	External Data Source Integration	1 day?	Mon 7/27/15	Tue 7/28/15				
265	Attendance Registry	1 day?	Mon 7/27/15	Tue 7/28/15				
266	<b>FR 8: Manage Registry</b>	<b>360 days</b>	<b>Mon 7/27/15</b>	<b>Mon 12/12/16</b>				
267	Inbound External Registry Integration	360 days	Mon 7/27/15	Mon 12/12/16				
268	Outbound External Registry Integration	1 day?	Mon 7/27/15	Tue 7/28/15				
269	HCBS Registry Integartion from MMIS and 2-1-1	1 day?	Mon 7/27/15	Tue 7/28/15				
270	<b>FR 9: Referral Management</b>	<b>280 days</b>	<b>Mon 7/27/15</b>	<b>Mon 8/22/16</b>				
271	Comprehensive Electronic Referral Workflow & Acknowledgement	280 days	Mon 7/27/15	Mon 8/22/16				
272	Member Eligibility on Referrals	1 day?	Mon 7/27/15	Tue 7/28/15				
273	Ineligible Registry & Notifications	1 day?	Mon 7/27/15	Tue 7/28/15				
274	Referral Search & Routing	1 day?	Mon 7/27/15	Tue 7/28/15				
275	<b>FR 9: Prior Authorization</b>	<b>320 days</b>	<b>Mon 7/27/15</b>	<b>Mon 10/17/16</b>				
276	Prior-Auth MMIS Integration	320 days	Mon 7/27/15	Mon 10/17/16				
277	Prior-auth Functionality	1 day?	Mon 7/27/15	Tue 7/28/15				

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Task		Inactive Summary		External Tasks	
Split		Manual Task		External Milestone	
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Inactive Task		Start-only			
Inactive Milestone		Finish-only			



ID	Task Name	Duration	Start	Finish	Feb 1, '15			
					S	S	M	T
278	Prior-Auth Notifications	1 day?	Mon 7/27/15	Tue 7/28/15				
279	<b>Workstream-IV: 9, 10 &amp; 11</b>	<b>405 days</b>	<b>Mon 2/2/15</b>	<b>Mon 8/22/16</b>				
280	<b>Immediate</b>	<b>125 days</b>	<b>Mon 2/2/15</b>	<b>Mon 7/27/15</b>				
281	<b>FR 10: Reporting</b>	<b>125 days</b>	<b>Mon 2/2/15</b>	<b>Mon 7/27/15</b>				
282	Reporting Export Formats	125 days	Mon 2/2/15	Mon 7/27/15				
283	Security Integration	1 day?	Mon 2/2/15	Tue 2/3/15				
284	Reports Favorites\Bookmarks	1 day?	Mon 2/2/15	Tue 2/3/15				
285	Report Archival	1 day?	Mon 2/2/15	Tue 2/3/15				
286	Report Graphical Data Representation	1 day?	Mon 2/2/15	Tue 2/3/15				
287	Data Type Integration	1 day?	Mon 2/2/15	Tue 2/3/15				
288	Report Configuration	1 day?	Mon 2/2/15	Tue 2/3/15				
289	Parameterized Reports	1 day?	Mon 2/2/15	Tue 2/3/15				
290	Report Scheduling, Printing & Distribution	1 day?	Mon 2/2/15	Tue 2/3/15				
291	HEDIS Integration	1 day?	Mon 2/2/15	Tue 2/3/15				
292	Gaps-in-Care Reports	1 day?	Mon 2/2/15	Tue 2/3/15				
293	Performance & Outcomes Reports	1 day?	Mon 2/2/15	Tue 2/3/15				
294	Clinical Reports	1 day?	Mon 2/2/15	Tue 2/3/15				
295	Cost & Quality Reports	1 day?	Mon 2/2/15	Tue 2/3/15				
296	Encounter Reports	1 day?	Mon 2/2/15	Tue 2/3/15				
297	OLAP Cubes for Reporting	1 day?	Mon 2/2/15	Tue 2/3/15				
298	Reports Library & Description	1 day?	Mon 2/2/15	Tue 2/3/15				
299	Secure Electronic Dispatch of Reports	1 day?	Mon 2/2/15	Tue 2/3/15				
300	Ad-hoc Data Mining & Export	1 day?	Mon 2/2/15	Tue 2/3/15				
301	Report Auditing	1 day?	Mon 2/2/15	Tue 2/3/15				

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	Inactive Task		Start-only			
	Inactive Milestone		Finish-only			



















ID	Task Name	Duration	Start	Finish	Feb 1, '15			
					S	S	M	T
302	Productivity Reports	1 day?	Mon 2/2/15	Tue 2/3/15				
303	Predictive Modeling Reports	1 day?	Mon 2/2/15	Tue 2/3/15				
304	Ad-hoc Analysis Engine	1 day?	Mon 2/2/15	Tue 2/3/15				
305	High-Risk Pregnancy Reports & Data Capture	1 day?	Mon 2/2/15	Tue 2/3/15				
306	Dashboard Reports	1 day?	Mon 2/2/15	Tue 2/3/15				
307	Geocoding & Mapping of Member Parmeters for Reports	1 day?	Mon 2/2/15	Tue 2/3/15				
308	Federal & State Reports	1 day?	Mon 2/2/15	Tue 2/3/15				
309	<b>FR 11: Consent Management</b>	<b>120 days</b>	<b>Mon 2/2/15</b>	<b>Mon 7/20/15</b>				
310	Consent Acknowledgement & Notifications	120 days	Mon 2/2/15	Mon 7/20/15				
311	Security Integratiins	1 day?	Mon 2/2/15	Tue 2/3/15				
312	Member Demographics & Summary	1 day?	Mon 2/2/15	Tue 2/3/15				
313	Third Party Consent	1 day?	Mon 2/2/15	Tue 2/3/15				
314	Consent Types	1 day?	Mon 2/2/15	Tue 2/3/15				
315	Consent Form Printing & Distribution	1 day?	Mon 2/2/15	Tue 2/3/15				
316	<b>Future</b>	<b>280 days</b>	<b>Mon 7/27/15</b>	<b>Mon 8/22/16</b>				
317	<b>FR 10: Reporting</b>	<b>210 days</b>	<b>Mon 7/27/15</b>	<b>Mon 5/16/16</b>				
318	External Data Set Integration	210 days	Mon 7/27/15	Mon 5/16/16				
319	Ad-hoc Reporting and Exporting Phase 2	1 day?	Mon 7/27/15	Tue 7/28/15				
320	Biometrics Reports	1 day?	Mon 7/27/15	Tue 7/28/15				
321	Survey Form Builder	1 day?	Mon 7/27/15	Tue 7/28/15				
322	Survey Scheduling	1 day?	Mon 7/27/15	Tue 7/28/15				
323	Survey Analysis & Reporting	1 day?	Mon 7/27/15	Tue 7/28/15				
324	Geocoding & Mapping Phase 2	1 day?	Mon 7/27/15	Tue 7/28/15				

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Inactive Task		Start-only			
Inactive Milestone		Finish-only			

ID	Task Name	Duration	Start	Finish	Feb 1, '15			
					S	S	M	T
325	<b>FR 11: Consent Managemetrn</b>	<b>280 days</b>	<b>Mon 7/27/15</b>	<b>Mon 8/22/16</b>				
326	Auto-population of Member Demograhics	280 days	Mon 7/27/15	Mon 8/22/16				
327	Consent Notifications	1 day?	Mon 7/27/15	Tue 7/28/15				
328	Consent Audting	1 day?	Mon 7/27/15	Tue 7/28/15				
329	Consent Search	1 day?	Mon 7/27/15	Tue 7/28/15				
330	Consent Printing and Distribution	1 day?	Mon 7/27/15	Tue 7/28/15				
331	Consent Configurations	1 day?	Mon 7/27/15	Tue 7/28/15				

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Split		Manual Task		External Milestone	
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Project Summary		Manual Summary		Manual Progress	
Inactive Task		Start-only			
Inactive Milestone		Finish-only	