TECHNICAL RESPONSE PACKET
710-24-0005

RESPONSE SIGNATURE PAGE

Type or Print the following information.

PROSPECTIVE CONTRACTOR'S INFORMATION					
Company:	Performant Recovery, Inc. d/b/a/ Performant Healthcare Solutions				
Address:	900 South Pine Island Road, Suite 150				
City:	Plantation	State:	FL	Zip Code:	33324
Business Designation:	☐ Individual ☐ Sole Proprietorship ☐ Public Service Corp ☐ Partnership ☒ Corporation ☐ Nonprofit				
Minority and Women Owned Designation*:	☒ Not Applicable ☐ American Indian ☐ Service Disabled Veteran ☐ African American ☐ Hispanic American ☐ Women-Owned				
	☐ Asian American ☐ Pacific Islander American				
	AR Certification #: _____ * See *Minority and Women-Owned Business Policy*				

PROSPECTIVE CONTRACTOR CONTACT INFORMATION *Provide contact information to be used for solicitation related matters.*			
Contact Person:	Mike Feid	Title:	Sr. VP, Eligibility & Recovery Services
Phone:	(224) 407-1592	Alternate Phone:	954-839-3397
Email:	mfeid@performantcorp.com		

CONFIRMATION OF REDACTED COPY

☒ YES, a redacted copy of submission documents is enclosed.

☐ NO, a redacted copy of submission documents is not enclosed. I understand a full copy of non-redacted submission documents will be released if requested.

Note: If a redacted copy of the submission documents is not provided with Prospective Contractor's response packet, and neither box is checked, a copy of the non-redacted documents, with the exception of financial data (other than pricing), will be released in response to any request made under the Arkansas Freedom of Information Act (FOIA). See Solicitation Terms and Conditions for additional information.

ILLEGAL IMMIGRANT CONFIRMATION

By signing and submitting a response to this *Solicitation*, a Prospective Contractor agrees and certifies that they do not employ or contract with illegal immigrants and **shall not** employ or contract with illegal immigrants during the term of a contract awarded as a result of this solicitation.

ISRAEL BOYCOTT RESTRICTION CONFIRMATION

By checking the box below, a Prospective Contractor agrees and certifies that they do not boycott Israel and **shall not** boycott Israel during the term of a contract awarded as a result of this solicitation.

☒ Prospective Contractor does not and **shall not** boycott Israel.

An official authorized to bind the Prospective Contractor to a resultant contract shall sign below.

The signature below signifies agreement that any exception that conflicts with a Requirement of this *Solicitation* **may cause the Prospective Contractor's response to be rejected.**

Authorized Signature: DocuSigned by: Simeon Kohl E21F12A151B5421... **Title:** CEO

Printed/Typed Name: Simeon Kohl **Date:** 2/14/24

SECTIONS 1 – 4: VENDOR AGREEMENT AND COMPLIANCE

- *Any requested exceptions to items in this section which are NON-mandatory **must** be declared below or as an attachment to this page. Vendor **must** clearly explain the requested exception, and should label the request to reference the specific solicitation item number to which the exception applies.*
- *Exceptions to Requirements **shall** cause the vendor's proposal to be disqualified.*

Performant Recovery, Inc. d/b/a/ Performant Healthcare Solutions has no exceptions.

By signature below, vendor agrees to and **shall** fully comply with all Requirements as shown in this section of the bid solicitation.

Authorized Signature: DocuSigned by: Simeon Kohl E21F12A151B5421...

Use Ink Only.

Printed/Typed Name: Simeon Kohl **Date:** 2/14/24

State of Arkansas
DEPARTMENT OF HUMAN SERVICES
700 South Main Street
P.O. Box 1437 / Slot W345
Little Rock, AR 72203

ADDENDUM 1

TO: All Addressed Vendors
FROM: Office of Procurement
DATE: January 3, 2024
SUBJECT: Medicaid Third Party Liability (710-24-0005)

The following change(s) to the above referenced RFP have been made as designated below:

_____Change of specification(s)
_____ Additional specification(s)
_____ Change of bid opening date and time
_____ Cancellation of bid
___X___ Other

OTHER

- The extended deadline for receipt of written question is January 10, 2024, at 3PM, CST.

The specifications by virtue of this addendum become a permanent addition to the above referenced RFP. Failure to return this signed addendum may result in rejection of your proposal.

If you have any questions, please contact: Arnetia Dean, DHS.OP.Solicitations@dhs.arkansas.gov or via phone at 501-683-5969.

DocuSigned by:
Simeon Kolul
E21F12A151B5421...

Vendor Signature

2/16/2024 | 1:15 PM EST
Date

Performant Recovery
Company

State of Arkansas
DEPARTMENT OF HUMAN SERVICES
700 South Main Street
P.O. Box 1437 / Slot W345
Little Rock, AR 72203

ADDENDUM 2

TO: All Addressed Vendors
FROM: Office of Procurement
DATE: January 19, 2024
SUBJECT: Medicaid Third Party Liability (710-24-0005)

The following change(s) to the above referenced RFP have been made as designated below:

_____Change of specification(s)
_____ Additional specification(s)
_____ Change of bid opening date and time
_____ Cancellation of bid
___X___ Other

OTHER

- Section 2.2.C – remove and replace with the following:
  The Contractor shall have at least five (5) years cumulative experience working on similar contracts for at least three (3) other state Medicaid programs. If the Contractor proposes to use subcontractors, the Contractor's proposed subcontractors shall have the experience working on similar projects with other State Medicaid programs. For verification purposes, the Contractor must accurately complete and sign Attachment I - Client History Form.

- Section 3.2.A Cost Score – add the following:
  Consideration will only be given to those that bid all line items.

- Section 2.4.1.B – add the following:
  Major carriers should include at a minimum licensed AR Life & Health Insurance Carriers with COA to operate in Arkansas and have an annual amount of $70 million in premiums or more.

- <u>Section 2.4.14.F.1 remove and replace with the following:</u>
  1. The Contractor shall provide during the applicable phase (e.g., initiation, design, testing, training, UAT) of the project as and maintain throughout the project, system documentation that at a minimum includes:
  a. A description of each component, their purpose, including basic functions and the business areas supported
  b. User stories/use cases
  c. Screen layouts, report layouts, and other output definitions, including examples and content definitions
  d. Physical database design
  e. A module system diagram, including all components, identifying all business process diagrams, data flows, systems functions, and their associated data storage
  f. Configurations
  g. Job streams within each module, identifying programs, inputs and outputs, control, job stream flow, operating procedures, and error and recovery procedures.
  h. A network schematic showing all network components and technical security control
  i. Listing of the edits and audits applied to each input item and the corresponding error messages.
  j. As applicable, listing and description of all control reports
  k. Interface Control Documents
  l. Narrative descriptions of each of the reports and an explanation of their use must be presented.
  m. Definition of all fields in reports, including a detailed explanation of all report item calculations.
  n. Operations Procedure Manual
  o. Data Dictionary

- 2.4.2.C – remove and replace with the following:

The Contractor must obtain files from all health insurance carriers as required by DHS and conduct a data match with the Arkansas Department of Human Services Medicaid eligibility file from the MMIS Contractor to identify and add, or update, third-party information on the TPL Master Resource File. The data match shall be performed on a schedule consistent with the same frequency in which the Contractor receives files from each carrier.

- Section 3.2.A – remove and replace with the following:

When pricing is opened for scoring, the maximum amount of cost points will be given to the proposal with the lowest grand total as shown on the Official Bid Price Sheet. Consideration will only be given to those who bid all line items. (See Grand Total Score for maximum points possible for cost score.)

- Section 3 - add the following:

Oral Presentation/Demonstration Score:

A. The three Prospective Contractors with the top Technical proposal scores after the completion of the technical proposal evaluation, may at the sole discretion of DHS be contacted to schedule an oral presentation/demonstration, if requested.
B. Should DHS opt to schedule any oral presentation/demonstration, the buyer will create a second set of score sheets by copying the Excel workbook (including the scores entered) and titling each of the score sheets in that workbook as the “Post-Demonstration” score sheets.
C. Should DHS opt to schedule any oral presentation/demonstration, after each oral presentation/demonstration is complete, the Evaluation Committee members will have the opportunity to discuss the oral presentation/demonstration and revise their individual scores on the Post-Demonstration Consensus Score Sheet based on the information provided during the oral presentation/demonstration.
D. The final individual scores of the evaluators on the Post-Demonstration Consensus Score Sheets will be averaged to determine the final Technical score for each proposal.

- Attachment C Performance Based Contracting, Cost Avoidance and Third Party Liability Identification, Item C – remove and replace with the following:
  The Contractor must obtain files from all health insurance carriers as required by DHS and conduct a data match with the Arkansas Department of Human Services Medicaid eligibility file from the MMIS Contractor to identify and add, or update, third-party information on the TPL Master Resource File. The data match shall be performed on a schedule consistent with the same frequency in which the Contractor receives files from each carrier.

The specifications by virtue of this addendum become a permanent addition to the above referenced RFP. Failure to return this signed addendum may result in rejection of your proposal.

If you have any questions, please contact: Arnetia Dean, DHS.OP.Solicitations@dhs.arkansas.gov or at 501-683-5969.

DocuSigned by:
Simeon Kohl
E21F12A151B5421...

2/16/2024 | 1:15 PM EST

Vendor Signature — Date

Performant Recovery

Company

State of Arkansas
DEPARTMENT OF HUMAN SERVICES
700 South Main Street
P.O. Box 1437 / Slot W345
Little Rock, AR 72203

ADDENDUM 3

TO: All Addressed Vendors
FROM: Office of Procurement
DATE: January 29, 2024
SUBJECT: Medicaid Third Party Liability (710-24-0005)

The following change(s) to the above referenced RFP have been made as designated below:

_____Change of specification(s)
_____ Additional specification(s)
____X_ Change of bid opening date and time
_____ Cancellation of bid
_____ Other

CHANGE OF BID SUBMISSION DEADLINE & BID OPENING DATE AND TIME

- Bid submission deadline: February 20, 2024, at 1:00 p.m.
- Bid opening date and time: February 20, 2024, at 2:00p.m.

The specifications by virtue of this addendum become a permanent addition to the above referenced RFP. Failure to return this signed addendum may result in rejection of your proposal.

If you have any questions, please contact: Arnetia Dean DHS.OP.Solicitations@dhs.arkansas.gov; 501-683-5969.

DocuSigned by:
Simeon Kohl
E21F12A151B5421...

Vendor Signature

2/16/2024 | 1:15 PM EST

Date

Performant Recovery

Company

Attachment Number _____

Action Number _____

CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM

Failure to complete all of the following information may result in a delay in obtaining a contract, lease, purchase agreement, or grant award with any Arkansas State Agency.

SUBCONTRACTOR: **SUBCONTRACTOR NAME:**

☐ **Yes** ☑ **No** Performant Healthcare Solutions

TAXPAYER ID NAME: Performant Recovery, Inc.

IS THIS FOR: **Goods?** ☐ **Services?** ☑ **Both?** ☐

YOUR LAST NAME: Kohl **FIRST NAME** Simeon **M.I.:**

ADDRESS: 900 South Pine Island Road, Suite 150

CITY: Plantation **STATE:** FL **ZIP CODE:** 33324 **COUNTRY:** USA

AS A CONDITION OF OBTAINING, EXTENDING, AMENDING, OR RENEWING A CONTRACT, LEASE, PURCHASE AGREEMENT, OR GRANT AWARD WITH ANY ARKANSAS STATE AGENCY, THE FOLLOWING INFORMATION MUST BE DISCLOSED:

FOR INDIVIDUALS*

Indicate below if: you, your spouse or the brother, sister, parent, or child of you or your spouse *is* a current or former: member of the General Assembly, Constitutional Officer, State Board or Commission Member, or State Employee:

Position Held	Mark (√)		Name of Position of Job Held [senator, representative, name of board/ commission, data entry, etc.]	For How Long?		What is the person(s) name and how are they related to you? [i.e., Jane Q. Public, spouse, John Q. Public, Jr., child, etc.]	
	Current	Former		From MM/YY	To MM/YY	Person's Name(s)	Relation
General Assembly							
Constitutional Officer							
State Board or Commission Member							
State Employee							

☐ **None of the above applies**

FOR AN ENTITY (BUSINESS)*

Indicate below if any of the following persons, current or former, hold any position of control or hold any ownership interest of 10% or greater in the entity: member of the General Assembly, Constitutional Officer, State Board or Commission Member, State Employee, or the spouse, brother, sister, parent, or child of a member of the General Assembly, Constitutional Officer, State Board or Commission Member, or State Employee. Position of control means the power to direct the purchasing policies or influence the management of the entity.

Position Held	Mark (√)		Name of Position of Job Held [senator, representative, name of board/commission, data entry, etc.]	For How Long?		What is the person(s) name and what is his/her % of ownership interest and/or what is his/her position of control?		
	Current	Former		From MM/YY	To MM/YY	Person's Name(s)	Ownership Interest (%)	Position of Control
General Assembly								
Constitutional Officer								
State Board or Commission Member								
State Employee								

☑ **None of the above applies**

Attachment Number _____

Action Number _____

Contract and Grant Disclosure and Certification Form

Failure to make any disclosure required by Governor's Executive Order 98-04, or any violation of any rule, regulation, or policy adopted pursuant to that Order, shall be a material breach of the terms of this contract. Any contractor, whether an individual or entity, who fails to make the required disclosure or who violates any rule, regulation, or policy shall be subject to all legal remedies available to the agency.

As an additional condition of obtaining, extending, amending, or renewing a contract with a *state agency* I agree as follows:

1. Prior to entering into any agreement with any subcontractor, prior or subsequent to the contract date, I will require the subcontractor to complete a **CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM**. Subcontractor shall mean any person or entity with whom I enter an agreement whereby I assign or otherwise delegate to the person or entity, for consideration, all, or any part, of the performance required of me under the terms of my contract with the state agency.

2. I will include the following language as a part of any agreement with a subcontractor:

   Failure to make any disclosure required by Governor's Executive Order 98-04, or any violation of any rule, regulation, or policy adopted pursuant to that Order, shall be a material breach of the terms of this subcontract. The party who fails to make the required disclosure or who violates any rule, regulation, or policy shall be subject to all legal remedies available to the contractor.

3. No later than ten (10) days after entering into any agreement with a subcontractor, whether prior or subsequent to the contract date, I will mail a copy of the **CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM** completed by the subcontractor and a statement containing the dollar amount of the subcontract to the state agency.

I certify under penalty of perjury, to the best of my knowledge and belief, all of the above information is true and correct and that I agree to the subcontractor disclosure conditions stated herein.

Signature DocuSigned by: Simeon Kold Title CEO Date 2/12/24

Vendor Contact Person Mike Feid Title Sr. VP, Eligibility & Recovery Services Phone No. (224) 407-1592

Agency use only

Agency Number 0710 Agency Name Department of Human Services Agency Contact Person _____ Contact Phone No. _____ Contract or Grant No. _____

PERFORMANT	EQUAL EMPLOYMENT OPPORTUNITY & AFFIRMATIVE ACTION POLICY	
DOCUMENT ID: **PFMT-HR-PO-013**	EFFECTIVE DATE: **SEPTEMBER 20, 2023**	EXECUTIVE AUTHORITY: **CHIEF PEOPLE OFFICER**

A. PURPOSE

The purpose of this policy is to establish Performant Financial Corporation's (Performant or Company) requirements for providing Equal Employment Opportunity (EEO) and for taking affirmative action in both external and internal employment decisions affecting qualified applicants and employees.

The goal of this policy is to ensure compliance with the laws enforced by the Equal Employment Opportunity Commission (EEOC) which are applicable to Performant's business practices.

B. SCOPE

This policy applies to all Performant employees, contingent workers, officers, and board members; and those of its subsidiaries (hereafter referred to as Performant Team Members).

C. RESPONSIBILITIES

1. The Chief People Officer is responsible for maintaining this policy and to effect changes, as necessary.
2. Human Resource Managers and Generalists are responsible for interpreting and assisting with the application of the policy.
3. Human Resources and all members of management are responsible for:
    - Developing and implementing Affirmative Action programs.
    - Developing, auditing, and using reporting systems to measure the effectiveness of such programs.
    - Serving as liaisons for the Company on EEO and affirmative action issues.
    - Ensuring compliance with all corporate procedures and applicable laws which support this policy.
    - Promoting EEO and affirmative action practices in accordance with this policy as they perform their job duties.
    - Identifying potential problem areas and assisting in the support and implementation of solutions to those issues as they arise.
4. Employees are encouraged to bring to management any questions or concerns about the Company's Equal Employment Opportunity Policy or Affirmative Action Programs.

D. DEFINITIONS

1. **EEO** means Equal Employment Opportunity as defined by the Department of Labor are the laws prohibiting the specific types of job discrimination in certain workplaces.
2. **Affirmative Action** means steps aimed to increase opportunities in the workplace (or education) focused on demographics who have historically had low representation in certain job groups.
3. **Retaliation** means adverse action against an employee for engaging in protected activity.

E. POLICY

Performant is an equal opportunity employer. It is the policy of Performant to provide equal opportunity and take affirmative action in both external and internal employment decisions affecting qualified applicants and employees. This policy is strictly upheld and applied during all phases of the employment relationship, including, but not limited to, recruiting, hiring practices, discipline, promotion, demotion, transfer, lay-offs, termination, rates of pay, benefits, and selection for training.

1. **Discrimination and Harassment**

   The Company does not unlawfully discriminate against qualified applicants or employees with respect to any terms or conditions of employment based on race, color, national origin, ancestry, gender, gender identity, sex, sexual orientation, pregnancy, status as a parent, marital status, age, religion, physical or mental disability, medical history or genetic information, medical condition, citizenship status, military service, political belief or affiliation, or any other consideration made unlawful by federal, state, or local laws. In addition, the Company does not unlawfully discriminate based on the perception that anyone has any of the above characteristics or is associated with a person who has or is perceived as having any of the above characteristics.

   It is not considered harassment of any sort for an employee's management to enforce the Company's job performance, behavioral, attendance or conduct standards in a fair, equitable and consistent manner.

   The Company is committed to providing a work environment that is free from all forms of illegal discrimination and harassment. In keeping with this commitment, the Company maintains a strict policy prohibiting all forms of conduct that can be considered harassing, coercive, or disruptive, including sexual harassment. The Company will not tolerate unlawful harassment or discrimination of its employees, contingent workers, service providers, or clients.

   The Company will not tolerate unlawful harassment or discrimination by anyone in the workplace or in a work-related situation; this includes Company supervisors, coworkers, and non-employees. In keeping with this policy, the Company prohibits unlawful harassment in any form, including visual, verbal, or physical conduct.

2. **Required Postings and Notifications**

   Equal Employment opportunity notices are posted on appropriate employee bulletin boards as required by law. The notices summarize the rights of employees to equal opportunity in employment and list the names and addresses of the various government agencies that may be contacted in the event that any person believes he or she has been discriminated against.

3. **Americans with Disabilities Act (ADA)**

   It is the policy of the Company to comply with all relevant and applicable provisions of the Americans with Disabilities Act (ADA) and any equivalent applicable state or local laws. The Company does not discriminate against any qualified employee or job

applicant with respect to any terms, privileges, or conditions of employment, because of a person's physical or mental disability.

4. **Protection from Retaliation**

   Employees are protected by law from retaliation for opposing unlawful discriminatory practices, for having reported harassment or discrimination to their employer, for having assisted another employee in reporting harassment or discrimination, for filing a complaint with the DFEH (California), Oregon Bureau of Labor and Industries "BOLI" in Oregon, or other state equivalent jurisdiction, or EEOC, or for otherwise participating in any proceeding conducted by any of these agencies. Retaliation will not be tolerated. Retaliation against any employee, independent contractor or consultant may result in disciplinary action, up to and including termination.

   a. The Employee Handbook (i.e., Commitment to Diversity section) should be referred to for additional information.

F. EXCEPTIONS

Exceptions to this policy, if any, require advance written approval of the Chief People Office or designee.

G. POLICY ENFORCEMENT & MANAGEMENT RIGHTS

Anyone who fails to comply with this policy may be subject to disciplinary action up to and including termination.

Management reserves the right to use its discretion in applying this policy under special circumstances and the right to amend this policy at any time with or without notice.

H. APPROVERS

EXECUTIVE APPROVAL	POLICY/CONTENT OWNER
Melissa Christ Chief People Officer	Linda Bogesdorfer Manager, HR Compliance & Benefits
DocuSigned by: Melissa Christ 9/20/2023 | 7:54 AM PDT 31D6D55D380E40E... Signature Date	DocuSigned by: Melissa Christ 9/20/2023 | 7:54 AM PDT 31D6D55D380E40E... Signature Date

I. REVISION HISTORY

Version #	Description	Reviewed By	Approved By	Date
1.0	Initial Release	B. Calvin	B. Calvin	05/30/08
1.2	Upon review of the policy, adjustments were made to make the policy up to date with current practices	B. Calvin	B. Calvin	10/15/08
1.3	Upon review of the policy, adjustments were made to make the policy up to date with current practices and responsible persons.	L. Bogesdorfer	J. Snyder	06/01/14
1.4	Upon review of the policy, adjustments were made to make the policy up-to-date and adapt to new company policy template.	L. Bogesdorfer	J. Snyder H. Leach	12/31/19
1.5	Annual review: adjustments made to make the policy up to date with current practices and responsibilities, corrections to structure and formatting.	L. Benavidez L. Valenzuela D. Christie J. Snyder	H. Leach	04/13/21
1.6	Annual review: adjustments made to change to Chief People Officer	L. Bogesdorfer B. Honeycutt M. Kase-Elliott	M. Christ	11/28/22
2.0	Annual Review	B. Honeycutt	M. Christ	09/20/23

PROPOSED SUBCONTRACTORS FORM

• ***Do not*** *include additional information relating to subcontractors on this form or as an attachment to this form.*

PROSPECTIVE CONTRACTOR PROPOSES TO USE THE FOLLOWING SUBCONTRACTOR(S) TO PROVIDE SERVICES.

Type or Print the following information

Subcontractor's Company Name	Street Address	City, State, ZIP
Carelon Subrogation	N17 W24222 Riverwood Drive #300	Waukesha, WI 53188

☐ PROSPECTIVE CONTRACTOR DOES NOT PROPOSE TO USE SUBCONTRACTORS TO PERFORM SERVICES.

Department of Transformation and Shared Services
Governor Sarah Huckabee Sanders
Secretary Joseph Wood
Director Edward Armstrong

CERTIFICATION FOR BOYCOTT AND ILLEGAL IMMIGRANT RESTRICTIONS

Pursuant to Arkansas law, a vendor must submit the below certifications prior to entering into a contract with a public entity for an amount as designated by the applicable laws.

1. **Israel Boycott Restriction:** For contracts valued at $1,000 or greater.
   A public entity shall not enter into a contract with a company unless the contract includes a written certification that the person or company is not currently engaged in a boycott of Israel. If at any time after signing this certification the contractor decides to engage in a boycott of Israel, the contractor must notify the contracting public entity in writing.
   See Arkansas Code Annotated § 25-1-503.

2. **Illegal Immigrant Restriction:** For contracts exceeding $25,000.
   No state agency may enter into or renew a public contract for services with a contractor who employs or contracts with an illegal immigrant. A contractor shall certify that it does not employ, or contract with, illegal immigrants.
   See Arkansas Code Annotated § 19-11-105.

3. **Energy, Fossil Fuel, Firearms, and Ammunition Industries Boycott Restriction:**
   For contracts valued at, or exceeding, $75,000.
   A public entity shall not enter into a contract with a company unless the contract includes a written certification that the person or company is not currently engaged in, and agrees for the duration of the contract not to engage in, a boycott of an Energy, Fossil Fuel, Firearms, or Ammunition Industry. If a company does boycott any of these industries, *see* Arkansas Code Annotated § 25-1-1102.

By signing this form, the contractor agrees and certifies that it does not, and shall not for the remaining aggregate term of the contract, participate in the activities checked below:

☑ Do not boycott Israel.

☑ Do not employ illegal immigrants.

☑ Do not boycott Energy, Fossil Fuel, Firearms, or Ammunition Industries.

Contract Number & Description	710-24-0005 Medicaid Third Party Liability
Name of Public Entity	Arkansas Department of Human Services
Name of Vendor/Contractor	Performant Recovery, Inc. d/b/a Performant Healthcare Solut
AASIS Vendor Number	20240213122749184

DocuSigned by:
Simeon Kohl
E21F12A151B5421...
Contractor Signature

2/14/24
Date

Attachment I
Revised Client History Form
Medicaid Third Party Liability
RFP # 710-24-0005

Attachment I

Medicaid Third Party Liability Client History Form

Instructions: This form is intended to help the State gain a more complete understanding of each Respondent's experience. This form **must** be completed completely and accurately.

The State reserves the right to verify the accuracy of these answers by contacting any of the listed clients, and all applicable clients **must** be listed. Omission of a client will constitute a failure to complete this form.

For purposes of this form, the "client" is not an individual but the entity which held the contract. By way of explanation, in the Contract resulting from this RFP, Arkansas DHS will be the client. For each listed client, Respondents may (but are not required) provide the contact information for a person at the client entity who is knowledgeable of the named project. If the State contacts clients listed on this form, the State reserves the right to contact the listed individual or another person at the listed client.

The boxes below each prompt will expand if necessary. The form **must** be signed (please see the final page) by the same signatory who signed the Response Signature Page.

1. Please list at least three (3) clients (federal, district, state, county, American territory, tribe, or Canadian province) where you (the prime contractor only) **served as the prime contractor** for the administration and implementation of state Medicaid programs in the past five (5) years. For each client, please specify the organization/agency/division, not just the state or political subdivision. Please briefly describe the scope of the contract. If there are no contracts which meet this definition, please state "none."

This information was redacted

2. Please list at least three (3) clients (federal, district, state, county, American territory, tribe, or Canadian province) where a proposed subcontractor **served as the prime contractor** for the administration and implementation of state Medicaid programs in the past five (5) years. For each client, please specify the organization/agency/division, not just the state or political subdivision. Please briefly describe the scope of the contract. If there are no contracts which meet this definition, please state "none."

This information was redacted

Authorized Signature: DocuSigned by: Simeon Kohl F21512A151B5421... **Title:** CEO

Use Ink Only.

Printed/Typed Name: Simeon Kohl **Date:** 2/14/24

Arkansas Secretary of State
John Thurston

State Capitol Building ♦ Little Rock, Arkansas 72201-1094 ♦ 501-682-3409

Certificate of Good Standing

I, John Thurston, Secretary of State of the State of Arkansas, and as such, keeper of the records of domestic and foreign corporations, do hereby certify that the records of this office show

PERFORMANT RECOVERY, INC.

formed under the laws of the state of California, and authorized to transact business in the State of Arkansas as a Foreign For Profit Corporation, was granted a Application for Certificate of Authority by this office January 13, 1997.

Our records reflect that said entity, having complied with all statutory requirements in the State of Arkansas, is qualified to transact business in this State.

In Testimony Whereof, I have hereunto set my hand and affixed my official Seal. Done at my office in the City of Little Rock, this 2nd day of February 2024.

John Thurston
Secretary of State

Online Certificate Authorization Code: fe2f423cfbabec5
To verify the Authorization Code, visit sos.arkansas.gov

SECTION E.2.D. COST AVOIDANCE AND THIRD-PARTY LIABILITY IDENTIFICATION

Liberty Mutual Surety

February 8, 2024

Ashleigh L. McClenney
Field Product Line Underwriting Consultant

Arkansas Department of Human Services
Attn: Office of Procurement
700 Main Street
Little Rock, AR 72201

3011 Sutton Gate Dr, Suite 300
Suwanne, GA 30024
Office: 205-909-9050
Ashleigh.Mcclenney@libertymutual.com

Subject: Solicitation Number: 710-24-0005, Medicaid Third Party Liability

To Whom This May Concern:

Please allow this bondability and/or bid letter to confirm that Ohio Casualty Insurance Company a Division of Liberty Mutual Insurance Company, is currently handling the bond needs of Performant Recovery, Inc. Currently, Ohio Casualty Insurance Company is an A.M. Best "A" rated company (Excellent).

Please be advised that Performant Recovery, Inc. is in good standing with the surety. Given the company's financial strength and credit worthiness, we are willing to entertain the Medicaid Third Party Liability Program in the amount of $16,000,000.

Should Performant Recovery, Inc., be a successful bidder, the surety will favorably consider the performance bond in the full amount of the annual contract amount, provided, Performant Recovery, Inc., accepts an award of the contract and makes an application to us on or about the time the work is to commence and we are satisfied with the prevailing underwriting conditions, including but not limited to acceptable contract terms and job specifications, approved annual bond form, and adding our annual contract language to the contract: **"Bonds may be renewable annually, for both the initial term and the renewal terms, provided that neither non-renewal nor cancellation by the surety, nor failure, nor inability of the Vendor to file a replacement bond shall not constitute a loss or claim recoverable under the bond"**

This letter is not an assumption of liability. We have issued this letter only as a bonding reference requested by our client.

We recommend Performant Recovery, Inc., to you. Should you require any additional information, please feel free to contact our office.

Sincerely,

Ashleigh L. Mc Clenney

Ashleigh L. McClenney
Field Product Line Underwriting Consultant
Liberty Mutual Surety

RECOVERY STRATEGY

SBU/CEE:	Carelon	Peter Haytaian	**DATE:**	Wednesday, June 28, 2023
DEPARTMENT:	Carelon Insights	Jeffrey Plante	**UPDATED BY:**	Robyn Markelz
PLAN OWNER:	Subrogation	AARON BROWDER		
BUSINESS UNIT:	Subrogation		**UNIT OWNER:**	AARON BROWDER

ACD, IVR Unavailable

If ACD is down the only impact would be to reporting – first process identified is IVR. Recovery Strategy will need to be focused on managing incoming call volume.

Initial Response

Business Unit Recovery Team or internal telecommunications expert will contact Elevance Health's Technical Help Desk at 1- 888-268-4368 to inform them of critical situation.

Business Unit Recovery Team will make assessment of duration based on information known at the time and update associates

SEE: Resource Forms - BU Recovery Team tab

Depending on incident, there may be a need to activate Conference Call

SEE: Resource Forms - BU Command Center tab

Update associates on situation and expected duration

< 2 Hours

Business Unit Recovery Team or internal telecommunications expert will contact Elevance Health's Technical Help Desk at 1- 888-268-4368 for update

Business Unit Recovery Team determines Action Plan based on expected duration via conference call

Contact the Virtual Command Center (1-888-653-6672) informing Network Operations Center –a.k.a. Corporate Incident Response Team (CIRT) of critical situation with expected duration and instructions, to coordinate incident response and update the Associate National Emergency Information Number 1-800-422-2085

Management team updates associates

Business Unit Recovery Team or internal telecommunications expert contact Elevance Health's Technical Help Desk at 1- 888-268-4368 to activate en-route announcement

Action Plan is developed based on current situation

2 to 4 Hours

Business Unit Recovery Team or internal telecommunications expert will contact Elevance Health's Technical Help Desk at 1- 888-268-4368 for update and if necessary, have them reroute calls to go directly into call center

Business Unit Recovery Team determines Action Plan based on expected duration and impact to caller via conference call

Impact to caller : no self service, potential ring no answer, recording advising of technical difficulties

Communicate to associates the above and expected duration

SEE: Resource Forms - Staff tab

4 Hours to 1 Day

Continue as above

1 to 2 Days

Continue as above

Key stakeholders are updated if appropriate

SEE: Resource Forms - Customer tab
SEE: Resource Forms - Regulatory tab

3 to 5 Days

Continue as above

6 to 10 Days

Continue as above

11 to 15 Days

Continue as above

Applications Unavailable

An incident has occurred that is impacting application access / availability and other technology services. Your Recovery Strategy will need to be focused on communication with internal and external stakeholders, tracking backlog and having associates perform any work that would not require application access. Documenting all alternative work procedures that could be executed in an IT absent work environment is critical.

Initial Response

Business Unit Recovery Team will contact Elevance Health's Technical Help Desk at 1- 888-268-4368 to inform them of critical situation.

Business Unit Recovery Team all associates that situation is being looked into.

SEE: Resource Forms - BU Recovery Team tab
SEE: Resource Forms - Staff List tab

Implement IT absent alternate procedures.

See: Alternate-Procedure-document-name contained in My Attachments section
Enter communication mode because NO IT absent alternate procedures exist

< 2 Hours

Business Unit Recovery Team identifies non system type of work that can be assigned to associates to perform -- Any work that would not require mainframe access.

Instruct associates accordingly

2 to 4 Hours

Business Unit Recovery Team Contact Elevance Health's Technical Help Desk at 1- 888-268-4368 for status update

Contact the Virtual Command Center (1-888-653-6672) informing Corporate Incident Response Team (CIRT) of critical situation with expected duration and instructions, to coordinate response
Business Unit Recovery Team begin to evaluate the appropriateness of sending associates home.

4 Hours to 1 Day

If needed activate send home associates plan

1 to 2 Days

Business Unit Recovery Team hold conference call to determine status and expected duration from Elevance Health's Technical Help Desk at 1- 888-268-4368

SEE: Resource Forms - BU Command Center tab

Determine work or no work status of associates

Contact the Virtual Command Center (1-888-653-6672) informing Technical Operations Center –a.k.a. Corporate Incident Response Team (CIRT) to update the Associate National Emergency Information Number 1-800-422-2085

Evaluate appropriateness of contacting key internal and external stakeholders to inform them of situation including outsource vendors

SEE: Resource Forms - Customer tab
SEE: Resource Forms - Regulatory tab

3 to 5 Days

Continue as above

6 to 10 Days

Business Unit Recovery Team hold conference call to determine status and expected duration from Elevance Health's Technical Help Desk at 1- 888-268-4368

SEE: Resource Forms - BU Command Center tab

Business Unit Recovery Team Coordinate with site Emergency Response Leader and Corporate Incident Response Team

Business Unit Recovery Team will verify that work site is ready

Business Unit Recovery Team Notify associates to return to work

SEE: Resource Forms - Staff List tab

11 to 15 Days

Continue as above

Facility Unavailable

An incident has occurred that has forced a work site to be unavailable. Your Recovery Strategy will need to define how to temporarily shift and manage work at an interim or alternate site or by shifting to work at home where possible. You should also consider the possibility of staff commuting to another Elevance Health work location. All while working towards a transition back to a permanent work location.

Action Summary

Activate work at home response

Shift work to alternate facility

Initial Response

If associate safety is involved, respond according to existing Associate Safety Program

Contact the Virtual Command Center (1-888-653-6672) informing Technical Operations Center (a.k.a. Corporate Incident Response Team (CIRT) of critical situation with expected duration and instructions, to coordinate incident response and update the Associate National Emergency Information Number 1-800-422-2085

Business Unit Recovery Team will make assessment of duration based on information known at the time

Depending on incident, there may be a need to activate Conference Call

SEE: Resource Forms - BU Recovery Team tab

SEE: Resource Forms - BU Command Center tab

Corporate Incident Response Team (CIRT) assesses availability of Elevance Health recovery resources or buildings if necessary

< 2 Hours

Business Unit Recovery Team will develop talk points for CIRT and impacted site discuss actions and prepare associate message update

Business Unit Recovery Team Leaders contact associates to give situation update

SEE: Resource Forms - Staff List tab

Contact the Virtual Command Center (1-888-653-6672) informing Technical Operations Center –a.k.a. Corporate Incident Response Team (CIRT) of critical situation with expected duration and instructions, to coordinate incident response and update the Associate National Emergency Information Number 1-800-422-2085

2 to 4 Hours

Business Unit Recovery Team will make assessment of duration based on information known at the time, modify action plan as required and communicate with CIRT and associates as required

SEE: Resource Forms - BU Recovery Team tab

SEE: Resource Forms - BU Command Center tab

4 Hours to 1 Day

Business Unit Recovery Team gets update on event from Technical Operations Center (a.k.a. Corporate Incident Response Team (CIRT) . Phone number via Virtual Command Center – 1-888-643-6672

Business Unit Recovery Team activates call tree beginning with work from home associates to provide for another facility update. If need be, determine which associates would be available to travel to other sites

SEE: Resource Forms - Staff List tab

Business Unit Recovery Team determines availability of interim site workstations, determine resource deployment strategy based on skill set and availability to travel and leverage work at home associates

Business Unit Recovery Team matches Skill Sets with business needs

SEE: Resource Forms - Staff List tab

SEE: CPC 1.08 Gap Analysis tab

1 to 2 Days

Activate standard Conference Call. Business Unit Recovery Team will make assessment of duration based on information known at the time, modify action plan as required and communicate with CIRT and associates as required

SEE: Resource Forms - BU Recovery Team tab

SEE: Resource Forms - BU Command Center tab

Business Unit Recovery Team Determines ongoing resource Gap and develop plan for an overtime strategy at all operating sites

Evaluate level of backlog and timing of critical due dates

Identify interim worksite locations that can accept additional volume and associates

SEE: CPC 1.08 Gap Analysis tab

Determine interim worksite capacity/Plan

Begin activation of resource deployment strategy and track where people are assigned

Develop overtime strategy for work from home associates

SEE: Resource Forms - Staff List tab

Assess and communicate workflow process changes to internal stakeholders

Assess training needs of interim worksite staff

If appropriate - Arrange transportation/lodging

Develop alternate work schedules if needed and determine if request for an alternate site is necessary

Attempt to recover any essential materials as appropriate from facility. E.g. critical documents

Communicate/update with internal and external stakeholders if appropriate

SEE: Resource Forms - Customer tab

SEE: Resource Forms - Regulatory tab

3 to 5 Days

Business Unit Recovery Team activate standard Conference Call

Business Unit Recovery Team determine facility /resource Gaps

Notify CIRT of need for alternate site and communicate requirements

SEE: CPC 1.08 – Statistics tab

Deploy assigned staff to alternate work sites and keep track of where they are assigned
Evaluate level of backlog and timing of critical due dates

Assess and communicate process changes to internal stakeholders

Communicate/update with internal and external stakeholders if appropriate
SEE: Resource Forms - Customer tab

6 to 10 Days

Business Unit Recovery Team review daily actual production versus projected and determine ongoing resource Gap

Assess availability of associates recently leaving the department or retiring

Assess and communicate workflow process changes to internal stakeholders
SEE: Resource Forms - Customer tab

Prepare to utilize an alternate site provided by CIRT when made available if necessary

Communicate/update with internal and external stakeholders if appropriate
SEE: Resource Forms - Customer tab

11 to 15 Days

Continue as above

Key Supplier Unavailable

There has been an incident in which a vendor or key supplier has become unavailable. Your Recovery Strategy will need to focus on understanding the severity of impact and determining:
- Which business process is affected?
- Can vendor services be performed in-house?
- Can services be provided by an alternate vendor?

If there is no alternate vendor, is there an "alternate process" in the event the Key Supplier is unavailable?

Initial Response

Business Unit Recovery Team will make assessment of duration based on information known at the time.

Business Unit Recovery Team or Manager assigned will contact vendor.
SEE: Resource Forms - Vendor tab

Depending on incident, there may be a need to activate Conference Call
SEE: Resource Forms - BU Command Center tab
SEE: Resource Forms - BU Recovery Team tab

< 2 Hours

Business Unit Recovery Team will continue to make assessment of duration. Try to make contact with Vendor for status.

Business Unit Recovery Team will begin to activate associate call tree beginning with work from home associates and communicate impact.
SEE: Resource Forms - Staff List tab
SEE: Resource Forms - Vendor tab

2 to 4 Hours

Continue as above

4 Hours to 1 Day

Call associates or send communication to staff for update of status

SEE: Resource Forms - Staff List tab

Business Unit Recovery Team determines business needs/required resources to recover and begin developing work activation plan.

Develop preliminary "available resource" list to activate associates to work.

Determine resource shortages based on phone contacts

Begin to match skill sets with business needs

Develop strategy to fill resource gap to address staff required to recover

SEE: CPC 1.08 Gap Analysis tab

Contact managers and Senior Management regarding situation and expected duration

Communicate/update with internal and external stakeholders if appropriate

SEE: Resource Forms - Customer tab

SEE: Resource Forms - Regulatory tab

1 to 2 Days

Conduct Conference Call to provide update and discuss recovery plan.

SEE: Resource Forms – BU Command Center tab

Business Unit Recovery Team or Manager assigned contact vendor on status update.

SEE: Resource Forms - Vendor tab

Contact managers and Senior Management regarding situation and expected duration

Business Unit Recovery Team will reevaluate situation to determine business needs and work re-distribution.

Determine ongoing resource Gap

SEE: Resource Forms - Staff List tab

Determine overtime strategy at home site and interim sites required to recover from vendor production loss

Develop backlog reduction program using overtime, interim site capability or any other appropriate method

Evaluate level of backlog and timing of critical due dates

3 to 5 Days

Continue to perform tasks listed above

Business Unit Recovery Team determine whether temporary or permanent staff is required

Contact Human Resources, Sourcing or Temp Agency as required to initiate hiring

Business Unit Recovery Team determines training needs and that most recent training material, policy, procedures and job aids are available on-line

Develop and deploy training plan

Evaluate associate resources to determine available trainers

Evaluate level of backlog and timing of critical due dates

Determine training needs as required by actions to fill staffing gap.

SEE: Resource Forms - Process Documentation tab

Review inventory updates as they become available and adjust work force as needed

6 to 10 Days

Continue as above

Business Unit Recovery Team determines availability of associates who have recently left the department or have retired

Determine any deviation from standard procedures that will need to be implemented (depending on available resources, some processing procedures may need to be changed)

Access and communicate workflow process changes to internal stakeholders

Review inventory updates as they become available and adjust work force as needed

11 to 15 Days

Continue as above

Network Connection Unavailable

An incident has occurred that prevents connection to the network. Depending on location of local servers, no access is available beyond the limited capabilities of the individual PC. Your Recovery Strategy will need to be focused on communication with internal and external stakeholders, tracking backlog, having associates perform any work that would not require network access, having associates perform any work using an alternate procedure that does not require network access, and/or focused on routing critical processes to other locations.

o Can your impacted associates connect via another Pulse Secure connection?
o Do your associates know how to connect via another Pulse Secure connection?
o Are there any other potential access capabilities (Citrix or PingID)?
o Can your associates go to an Elevance Health facility to work?
o Can work be shifted to other locations (onshore or offshore)?
o Is there an "alternate process" in the event the network connection is unavailable?

Action Summary

Activate work at home response

Shift work to alternate facility

Initial Response

Business Unit Recovery Team will contact Elevance Health's Technical Help Desk at 1- 888-268-4368 to inform them of critical situation

Business Unit Recovery Team updates in house associates and work from home associates that situation is being looked into

SEE: Resource Forms - BU Recovery Team tab

SEE: Resource Forms - Staff List tab

Implement IT absent alternate procedures.

See: Alternate-Procedure-document-name contained in My Attachments section

Enter communication mode because NO IT absent alternate procedures exist

< 2 Hours

Business Unit Recovery Team identifies non system type of work that can be assigned to associates to perform -- Any work that would not require mainframe and possible local access depending on location of servers

Instruct associates accordingly

2 to 4 Hours

Business Unit Recovery Team contact Elevance Health's Technical Help Desk at 1- 888-268-4368 for status update

Contact the Virtual Command Center (1-888-653-6672) informing Technical Operations Center –a.k.a. Corporate Incident Response Team (CIRT) of critical situation with expected duration and instructions, to coordinate incident response and update the Associate National Emergency Information Number 1-800-422-2085

Business Unit Recovery Team begin to evaluate the appropriateness of sending associates home

Assign work as appropriate to home site associates

Give associates update of situation

SEE: Resource Forms - Staff List tab

4 Hours to 1 Day

Business Unit Recovery Team contact Elevance Health's Technical Help Desk at 1- 888-268-4368 for status update

Assess interim site workstation availability

SEE: CPC 1.08 Gap Analysis tab

If associates were sent home, activate associate call tree beginning with work from home associates

Business Unit Recovery Team Determine resource deployment strategy based on skill set and availability to travel

Develop alternative work distribution plan using phone or Fax to sites and work at home associates
Evaluate level of backlog and timing of critical due dates
Develop overtime plan for work at home associates
SEE: Resource Forms - Staff List tab

1 to 2 Days

Business Unit Recovery Team hold standard conference call to plan actions based of status and expected duration from Elevance Health's Technical Help Desk at 1- 888-268-4368
Determine work or no work status of associates
Determine ongoing resource Gap
Determine interim worksite and work from home capacity
Determine overtime strategy at all operating locations
SEE: CPC 1.08 Gap Analysis tab
SEE: Resource Forms - Staff List tab

Assess and communicate workflow process changes to internal stakeholders

Evaluate appropriateness of contacting key internal and external stakeholders to inform them of situation including outsource vendors
SEE: Resource Forms - Customer tab
SEE: Resource Forms - Regulatory tab
Assess training needs of interim worksite staff
Business Unit Recovery Team Arrange transportation/lodging
Develop alternate work schedules if needed
SEE: Resource Forms - Staff List tab
Evaluate level of backlog and timing of critical due dates

Notify CIRT of need for alternate site or data connection and communicate requirements

3 to 5 Days

Business Unit Recovery Team hold standard conference call to plan daily actions based on status and expected duration from Elevance Health's Technical Help Desk at 1- 888-268-4368
Determine ongoing resource Gap
Evaluate level of backlog and timing of critical due dates
Evaluate level of backlog and timing of critical due dates

Assess and communicate workflow process changes to internal stakeholders
SEE: Resource Forms - Staff List tab

6 to 10 Days

Business Unit Recovery Team hold standard conference call to plan daily actions based on status and expected duration from Elevance Health's Technical Help Desk at 1- 888-268-4368
Determine ongoing resource Gap
Review daily actual production versus projected
Assess availability of associates recently leaving the department or retiring
SEE: Resource Forms - Staff List tab

Communicate and coordinate with dependent internal stakeholders
SEE: Resource Forms - Customer tab

Assess and communicate workflow process changes to internal stakeholders

11 to 15 Days

Continue as above

No Inbound Calls

An incident has occurred that results in no inbound calls being received at the site. Recovery Strategy will need to be focused on routing critical volume to other locations.

Initial Response

Business Unit Recovery Team or internal telecommunications expert will contact Elevance Health's Technical Help Desk at 1- 888-268-4368 to inform them of critical situation.

Business Unit Recovery Team will make assessment of duration based on information known at the time and update associates

SEE: Resource Forms - BU Recovery Team tab

Depending on incident, there may be a need to activate Conference Call

SEE: Resource Forms - BU Command Center tab

Update associates on situation and expected duration

Calls will be routed to Kentucky and Indiana. Work at Home associate can continue to take calls.

< 2 Hours

Business Unit Recovery Team or internal telecommunications expert will contact Elevance Health's Technical Help Desk at 1- 888-268-4368 for update

Business Unit Recovery Team determines Action Plan based on expected duration via conference call
Contact the Virtual Command Center (1-888-653-6672) informing Technical Operations Center – a.k.a. Corporate Incident Response Team (CIRT) of critical situation with expected duration and instructions
Management team updates associates

Business Unit Recovery Team or internal telecommunications expert contact Elevance Health's Technical Help Desk at 1- 888-268-4368 to activate en-route announcement

Action Plan is developed based on current situation

2 to 4 Hours

Business Unit Recovery Team or internal telecommunications expert will contact Elevance Health's Technical Help Desk at 1- 888-268-4368 for update

Business Unit Recovery Team determines Action Plan based on expected duration via conference call

Alternate work (Correspondence and queue work, or training) is provided for call takers not able to take incoming calls

Business Unit Recovery Team engage Work Force Management contacts to redirect call volume as appropriate

SEE: CPC 1.08 Gap Analysis tab

4 Hours to 1 Day

Business Unit Recovery Team works with Work Force Management to monitor situation and adjust routing as required

Business Unit Recovery Team reassess situation via conference call and initiates discussion regarding associate work schedule adjustments (i.e. staggering of hours, partial staffing, sending home of associates etc.)

SEE: Resource Forms - BU Recovery Team tab

SEE: Resource Forms - Staff List tab

Alternate work is provided for call takers (Correspondence and queue work, or training)

Associates are all updated at every opportunity

SEE: Resource Forms - Staff List tab

1 to 2 Days

Business Unit Recovery Team works with Work Force Management to monitor situation and adjusts routing as required

Contact the Virtual Command Center (1-888-653-6672) informing Technical Operations Center –a.k.a. Corporate Incident Response Team (CIRT) of critical situation with expected duration and instructions, to coordinate incident response and update the Associate National Emergency Information Number 1-800-422-2085

Business Unit Recovery Team reassess situation via conference call and initiates discussion regarding associate work schedule and reassignments to interim site

Business Unit Team develops backlog reduction strategy

11 to 15 Days

Continue as above

No Outbound Calls

Incident impacts out going calls only, CSR's will still be able to receive calls. Recovery Strategy involves using outer available means for outbound communication.

Initial Response

Business Unit Recovery Team or internal telecommunications expert will contact Elevance Health's Technical Help Desk at 1- 888-268-4368 to inform them of critical situation.

Business Unit Recovery Team will make assessment of duration based on information known at the time and update associates

SEE: Resource Forms - BU Recovery Team tab

Depending on incident, there may be a need to activate Conference Call

SEE: Resource Forms - BU Command Center tab

Calls wil be routed to Kentucky and Indiana. Work at Home associate can continue to take calls.

< 2 Hours

Business Unit Recovery Team continues conference calls as needed

Business Unit Recovery Team or internal telecommunications expert will contact Elevance Health's Technical Help Desk at 1-888-268-4368 for update

Action Plan is developed based on call-back volume

Associates are notified by Management Team via e-mail and or walk around

SEE: Resource Forms - Staff List tab

2 to 4 Hours

Continue as above

Key stakeholders are updated if appropriate via e-mail

SEE: Resource Forms - Customer tab

SEE: Resource Forms - Regulatory tab

4 Hours to 1 Day

Business Unit Recovery Team develops backlog reduction plan to be used when outbound calls are operational

SEE: Resource Forms - BU Recovery Team tab

1 to 2 Days

Continue as above until fix is in place and outbound calls are operational

Initiate backlog reduction plan and track progress

Key stakeholders are updated when appropriate via e-mail

SEE: Resource Forms - Customer tab

SEE: Resource Forms - Regulatory tab

3 to 5 Days

Continue as above

6 to 10 Days

Continue as above

11 to 15 Days

Continue as above

People Unavailable

There has been an incident that has resulted in a loss of associates able to work. Your Recovery Strategy will need to focus on understanding the severity of impact and determining if there is an opportunity to shift work to other sites / locations that have available associates or to a vendor. It should also include steps for permanent and temporary hiring and training.

o Can your resources work from an Elevance Health facility?

o Can your vendor take on additional work?

o Is there an "alternate process" in the event of a people unavailable situation?

Action Summary

Shift work to cross-trained back-up staff

Hire temporary staff or permanent staff, as necessary

Initial Response

If associate safety is involved, respond according to existing Associate Safety Program

Contact the Virtual Command Center (1-888-653-6672) informing Corporate Incident Response Team (CIRT) of critical situation with expected duration and instructions, to coordinate incident response and update the National Associate Emergency Information Number 1-800-422-2085

Management Team along with Business Unit Recovery Team will make assessment of duration based on information known at the time

Depending on incident, there may be a need to activate Conference Call.

Conference #: 1-866-308-0254; pin: 317-650-2430; pin: 8264. Conference call may be activated/monitored by anyone.

SEE: Resource Forms – BU Recovery Team tab

SEE: Resource Forms - BU Command Center tab

< 2 Hours

Business Unit Recovery Team will continue to make assessment of duration

Business Unit Recovery Team will begin to activate associate call tree beginning with work from home associates to understand impact

SEE: Resource Forms - Staff List tab

SEE: Resource Forms - Staff List tab

Business Unit Recovery Team will begin to activate associate call tree beginning with work from home associates to understand impact

Management Team and Business Unit Recovery Team will continue to make assessment of duration

2 to 4 Hours

Continue as above

4 Hours to 1 Day

Call associates to again verify associates that can come to work. *Note: step is required because associate status availability can change.

SEE: Resource Forms - Staff List tab

Business Unit Recovery Team determines business needs/required resources to recover and begin developing work activation plan.

Develop preliminary “available resource” list to activate associates to work.
Determine resource shortages based on phone contacts
Begin to match skill sets with business needs

SEE: Resource Forms - Staff List tab

Develop strategy to fill resource gap to address staff required to recover

Contact managers and Senior Management regarding situation and expected duration

Communicate/update with internal and external stakeholders if appropriate

SEE: Resource Forms - Customer tab

SEE: Resource Forms - Regulatory tab

1 to 2 Days

Conduct Conference Call to provide update and discuss recovery plan

SEE: Resource Forms - BU Command Center tab

Business Unit Recovery Team will call associates to again verify associates that can come to work
Determine ongoing resource Gap

SEE: Resource Forms - Staff List tab

Evaluate level of backlog and timing of critical due dates

Identify interim worksite locations, including W@H that can accept additional volume
Determine interim worksite capacity

SEE: CPC 1.08 Gap Analysis tab

Determine training needs as required by actions to fill staffing gap

SEE: Resource Forms - Process Documentation tab

Determine overtime strategy at home site, W@H and interim sites required to recover

3 to 5 Days

Continue to perform tasks listed above
Business Unit Recovery Team determine whether temporary or permanent staff is required

Contact Human Resources, Sourcing or Temp Agency as required to initiate hiring - Contact numbers for HR and other sourcing or temporary help agencies

SEE: Resource Forms - Customer tab

Business Unit Recovery Team develop and deploy training plan
Determine training needs as required by actions to fill staffing gap

SEE: Resource Forms - Process Documentation tab

Review backload / workload and adjust available work force as needed

6 to 10 Days

Continue as above

Business Unit Recovery Team determines availability of associates who have recently left the department or retired

Determine any deviation from standard procedures that will need to be implemented (depending on available resources, some processing procedures may need to be changed)

Assess and communicate workflow process changes to internal stakeholders

Review backload / workload and adjust available work force as needed

Develop training plan for new hires and /or replacements as required

Determine training needs as required by actions to fill staffing gap

SEE: Resource Forms - Process Documentation tab

Evaluate associate resources to determine available trainers

Determine availability of associates recently left department or retired

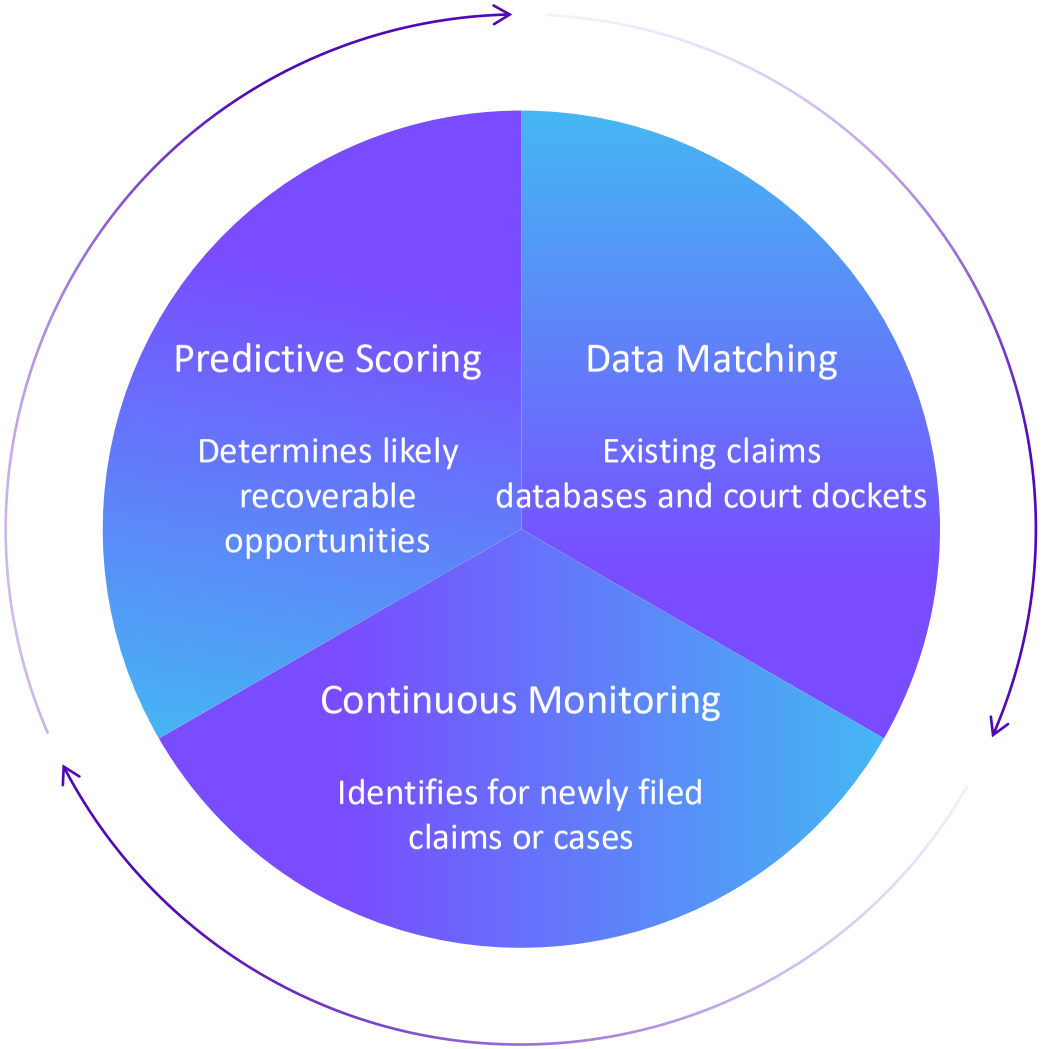
11 to 15 Days

Continue as above

How we do it- Data Analytics

Members can be alarmed by traditional investigation methods, but the Carelon Subrogation solution is virtually invisible.

Member responses can be unreliable, so we provide limited member touch points for added savings and less abrasion.



How we do it – Detection, Technology, & Tools

Using advance techniques and tools, Carelon Subrogation is able to identify cases where the member provides little or no assistance

Analytical Claim Scoring
Identifies most likely TPL opportunities using claims data and trends

Clearinghouse Database Matching
Identifies cases for members using a clearinghouse of property/casualty claims (used by 95% of P&C carriers)

State/Federal Litigation Matching
Matches member data to court databases on the state and federal levels to identify cases where a suit has been filed

Identification Toolbox
Continuously expanding our identification toolbox with the addition of new states for Police Report Matching and WC Database Matching

How we do it - Detailed process & timeline

Identify and recover claims from auto accidents, work-related incidents, slip-and-falls, medical malpractice, and/or product liability actions with third party liability

Day 1 - 30 → Day 180 +

Event & Claim

Detection

Claims Screening
- Claims are screened for trauma-related diagnosis codes.

Questionnaires
- Screened claims accumulating $750 in paid claims prompt system-generated questionnaires to be mailed to members to investigate for potential third-party liability.

Third Party Data Sources
- As a 2nd or 3rd pass, claims that meet certain criteria are also compared to other third-party sources:
  - ISO
  - 2nd Pass WC Data Matching
  - Crash Report Data Matching
  - Mass Torts (Devices and Rx) National Litigation Docket Matching

Leads
- Leads are received from insurers, attorneys, members via our website or toll-free number.

Investigation

Investigation
- Case facts gathered via police and injury reports, medical record review, liability insurance companies, attorneys, members and other sources.
- Inquiries are sent to liability/med-pay carriers to identify where both Elevance and that carrier have paid for the same services.

Notice
- Once a potential case is identified, notice of the plan's rights is sent to all involved parties.

Case Management

Case Management
- Lien amounts are updated based on review of additional paid claims.
- Communications with involved parties are maintained throughout the life of the case to monitor the status of settlement, trial, etc.
- Outside counsel is retained, if necessary.

Settlement & Recovery

Settlement
- Settlements are negotiated by the adjustor, manager, in-house or outside counsel to obtain highest possible recovery.
- Litigated cases are handled by law firms that specialize in subrogation/ERISA.

Recovery
- Amount of recovery will depend on:
  - Plan language
  - State laws
  - Policy limits of responsible parties and other factors.
  - Subrogation services are provided on a contingency fee basis only – a percentage of the subrogation recovery. We are paid only when we recover.

Audit & Reporting

Financial Operations
- The net recovery amount is credited to the appropriate health plan or client (various methods).

Audit
- Audits are conducted throughout and after the subrogation process to monitor results and take corrective actions if necessary.

Reporting
- Provide clients with detailed reports of subrogation activity including recoveries, fees and cases in progress.

How we do it- Customer Service/IVR

Carelon Subrogation Greeting:

"Thank you for calling Carelon Subrogation."

Contact Information:

Carelon Subrogation
Subrogation Department
PO Box 659940
San Antonio, TX 78265-9939

Information Regarding Carelon Subrogation:

Carelon Subrogation provides Subrogation services on behalf of your health plan and recovers money for any medical claims that were paid due to an accident, injury or illness. If you received this letter from us, we are contacting you to confirm if another party may be responsible for the claims paid by your health plan. Some examples of other parties may be auto insurance, workers compensation insurance, liability insurance, or medical malpractice insurance.

Carelon Subrogation Closed Message after 7:00p.m. CST

Thank you for contacting the subrogation department. At this time, our offices are closed. If you are calling to respond to a letter, you may do so online at www.careloninsights.com/payment-integrity/other-party-liability/full-service-subrogation or please call back during our normal business hours, Monday through Friday, from 7:30 a.m. until 7:00 p.m. CST. Thank you and have a good day.

INFORMATION FOR EVALUATION

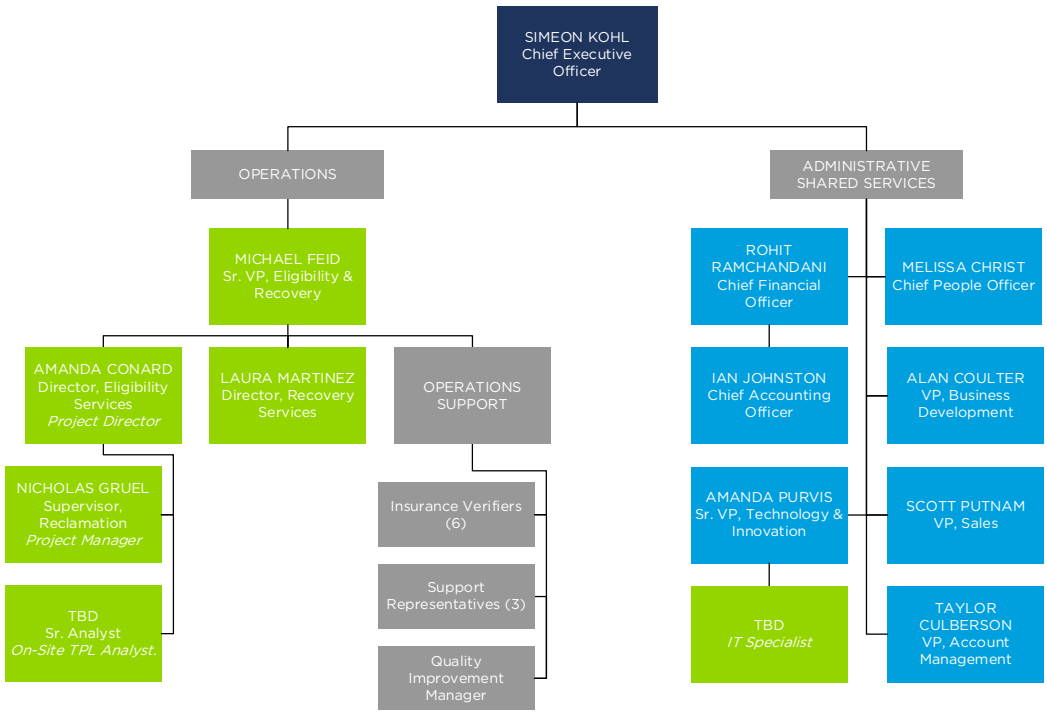
- *Provide a response to each item/question in this section. Prospective Contractor may expand the space under each item/question to provide a complete response.*
- ***Do not** include additional information if not pertinent to the itemized request.*

	Maximum RAW Score Available
E.1 ADMINISTRATION	
A. Provide a staffing plan and associated organization chart detailing the number of personnel, level, roles, and responsibilities, and team reporting relationships. STAFFING PLAN OVERVIEW Performant's approach to staffing the AR HHS program is designed to accelerate the period for initiating Third-Party Liability (TPL) programs under the new contract. The plan is based on our established experience staffing and running high-volume TPL operations Performant is currently staffed by nearly 1000 employees. Approximately 810 employees dedicated to serving health plans. This demonstrates Performant's capabilities to immediately staff implementation of an awarded contract and our ability to grow and develop staff to support the operation and expansion of Cost Avoidance, Third Party Liability Identification and Recovery Services for AR HHS. Performant has an exceptional track record in implementing large-scale TPL programs for government entities like the Centers for Medicare & Medicaid Services (CMS), as well as national and regional commercial payors. The keystone of our success is a deep understanding of the clients we serve, combined with a steadfast commitment to close collaboration with our various stakeholders. Indeed, whether it be through policy interpretation, regulatory compliance, or navigating the intricacies of a multi-stakeholder program, it is imperative that Performant have a thorough understanding of a program's goals, challenges, and key constituents. In line with this client-centric philosophy, Performant has partnered with Matt Salo of Salo Health Strategies to provide Medicaid-specific thought leadership to our team. Matt has significant knowledge of state Medicaid programs, and he uniquely understands the combination of policy, political, and operational challenges that programs must balance while managing a successful cost-containment program. Performant intends to leverage Matt's wealth of knowledge, experience, and strategic guidance both to support our initial implementation, and to ensure long-term program success by keeping us abreast of the ever-evolving Medicaid landscape, while also assisting Performant in building close working relationships with the key stakeholders within the State of New York's Medicaid program. All personnel who will be assigned to this contract will have the requisite experience and certifications as applicable to the job role. And, due to Performant's high-scale and mature operations for payment integrity programs, we have strategically instituted flexible staffing models that afford the opportunity to reassign these experienced resources without diminishing service on our existing contracts. Top candidates from this rich reservoir of talent will be cross trained to assist in performing AR HHS TPL operations should they be needed to help support increased workload given our wealth of experience and staffing acumen, Performant is equipped to fully support our clients no matter the circumstances. Performant will assign AR HHS a dedicated Program Implementation Manager to shepherd implementation. The Implementation Manager will provide AR HHS with a dedicated point of	5 points

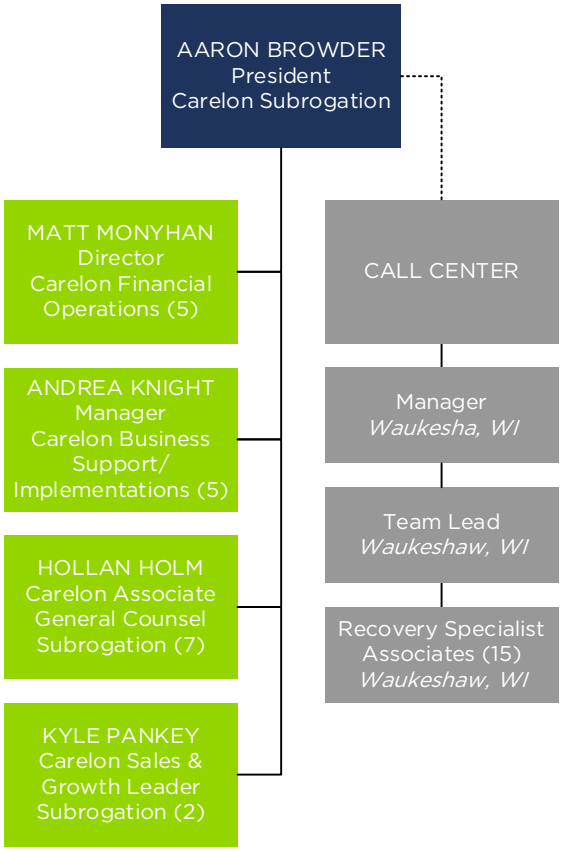
contact throughout the implementation process and assume responsibility for coordinating the appropriate work streams within Performant and managing project milestones. Performant also assigns to each client a dedicated account manager who will participate throughout the implementation phase of a program and will continue as the dedicated managerial point of contact for all program operations. The account manager is responsible for reporting recovery targets and performance, monitoring service level agreements (SLAs), assuring timely reporting, and facilitating all intercompany work processes. This person will be supplemented with operational managers assigned to each program. Additionally, the account manager will routinely ensure the health plan has direct access to Performant's executive leadership, operational managers, data analytics leads, medical directors, and other personnel as appropriate to the scope of services awarded. In short, Performant's account manager is authorized to ensure the plan is finding Performant to be a top-rated vendor, delivering quality and valuable services to the delight of our client's teams.

STAFFING ASSIGNMENTS & RESPONSIBILITIES

PERFORMANT HEALTHCARE SOLUTIONS ORG CHART



CARELON SUBROGATION ORG CHART



Our proposed project organization (please see org chart) demonstrates Performant's understanding of how the organization should be structured to perform all work requirements identified in the RFP. Our organizational chart clearly delineates position titles and the functions to be performed by each team, including key and non-key personnel. We have also provided an explanation of the corresponding qualifications and experience of the team members performing each function's respective responsibilities. We have scrutinized and vetted the pool of talent available to staff this project and selected these individuals for their outstanding qualifications and direct relevance to AR HHS' requirements and overall project needs, as well as their demonstrated ability to manage and execute all aspects of the statement of work (SOW).

Through our initial kickoff meeting and ongoing program management process updates with AR HHS, the Performant team will assess staffing needs as they relate to AR HHS's programmatic goals to proactively ensure the availability of trained personnel before any possible lapses in activity occur.

STAFF RECRUITMENT & ONBOARDING CAPABILITIES

The following sections detail Performant's plan to successfully recruit, train, and retain personnel to staff AR HHS' TPL contract and is based on our experience modeling staffing levels for similar large scale federal, state, and commercial contracts.

RECRUITING

Performant has established an effective recruitment model to facilitate the ongoing staffing of high-quality professionals experienced in medical coverage, coding, payment, and billing guidance. Performant employs numerous strategies to attract and recruit new talent, including:

- An optimal mix of methods such as employee referrals, recruiters with expertise in the desired field, our professional network through participation in industry groups and associations, and digital recruiting.

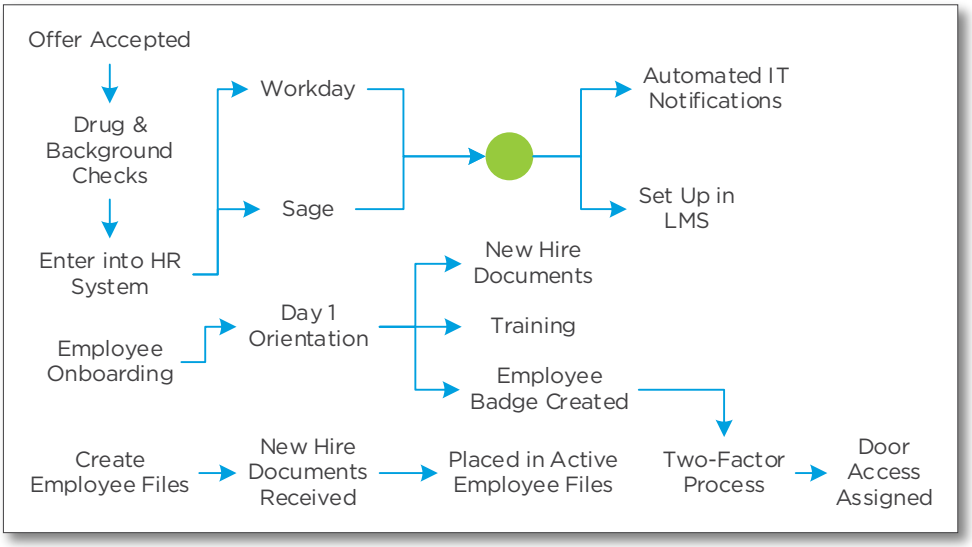
- Access to numerous college and university graduates and training programs with the medical disciplines to meet the minimum SOW requirements.

These recruiting resources will also enable Performant to staff for project growth with knowledgeable and experienced team members.

NEW EMPLOYEE ONBOARDING PROCESS

Figure 1: Employee New Hire & Onboarding Process outlines the onboarding process for new hires beginning with an HR orientation, which includes a general introduction to the company, safety orientation, company policies/employee handbook, benefit highlights, completion of core compliance training, all required employment related documents, and employee badge assignment (building access, identification, and two-factor Personal Identity Verification (PIV) card).

Figure 1: Employee New Hire & Onboarding Process



Some of our key compliance training courses include Code of Conduct, Conflict of Interest/Ethics and Whistleblower, Anti-Harassment, Information Security, Drug-Free Workplace, and Wage and Hour, in addition to client-specific training. If a new hire requires any clearances, HR will also initiate applicable processes at this time. After new hires complete HR orientation, they will begin applicable departmental and client-specific training delivered by appointed SMEs. New hires requiring clearances must complete required documents and processes prior to receiving any access to applicable systems/data.

EMPLOYEE RETENTION

Performant retains talent through numerous means such as attractive benefits packages, continuing education, opportunities for advancement, providing a work environment that promotes excellence, and incentive rewards for top performance. Performant strives to provide meaningful incentives for our employees based upon their position, rewarding performance achievement in alignment with client and business objectives, compliance with legal, regulatory, and client requirements, health plan experience, and in accordance with Performant's values.

During the COVID-19 Public Health Emergency (PHE), Performant did not furlough or otherwise separate with any of our professional workforce. Instead, Performant invested in auditor training, including the provision of courses that granted auditors Continuing Professional Education (CPE) credits. This sort of commitment to our teams resulted in high retention and strong "word-of-mouth" recruiting pipelines.

EXPANSION CAPABILITIES Performant's infrastructure is designed to effortlessly expand to meet the needs of both new clients and the expansion of programs with our existing partners. Performant's program leadership discusses and plans program expansion requirements in weekly production and operations meetings.	
B. Describe your company and all proposed subcontractors including key personnel that will be performing services under any resulting contract from this project. PERFORMANT HEALTHCARE SOLUTIONS Founded in 1976, Performant is a leading provider of technology-enabled eligibility, recovery, audit, and analytics services in the United States. With nearly 50 years of experience, innovation, and leadership, we help contain costs for commercial and government clients by preventing, identifying, and recovering improper payments. These clients operate in complex, regulated environments, and outsource their recovery needs to reduce losses on millions of dollars of improper healthcare payments. Over the past decade, Performant has delivered approximately $7 billion in healthcare savings to our clients through our data mining, complex/clinical review, eligibility, and recovery services. Performant offers broad experience in the commercial and government-sponsored healthcare markets, managing both prospective (pre-payment) and retrospective (post-payment) solutions. In the commercial market, we provide audit and recovery services to some of the largest national commercial payers in the U.S., regional payers, and Blue Cross Blue Shield plans. Performant reviews more than 45,000 medical records and data mines tens of thousands of claims monthly on behalf of these entities. Additionally, we provide MSP services to the second largest MA plan in the industry, third-party liability (TPL) and audit solutions to 53 Medicaid managed care organizations (MCOs) in 29 states and are the primary TPL vendor for the second largest MCO group in the country. Performant also has an extensive footprint with the Centers for Medicare & Medicaid Services (CMS), including Recovery Audit Contractor (RAC) Region 1 that was re-awarded to Performant in 2021 for an 8.5-year contract, RAC Region 2 contract awarded in 2022 for an 8.5-year contract, RAC Region 5 (sole national auditor for DMEPOS, home health, and hospice claims), and the Medicare Secondary Payer Commercial Repayment Center (MSP CRC) contract, which was re-awarded in 2022 for a 6-year contract. Through these contracts, Performant identifies and prevents improper payments through the deployment of advanced technology, automated and manual intervention, and extensive outreach efforts. In January of 2022, the U.S. Department of Health and Human Services, Office of the Inspector General (HHS OIG) awarded Performant the indefinite delivery, indefinite quantity (IDIQ) contract. Under this national contract, Performant will provide medical review and consultative services associated with the oversight activities of the OIG, primarily assessing services and claims for Medicare fee-for-service (FFS) payments for Part A and Part B. Performant is HITRUST v9.2 certified. All data held and stored by Performant is protected by data-sharing and security controls. We have been certified with multiple Authorities to Operate (ATO) by CMS. These ATOs distinguish Performant as an organization that not only complies with Health Insurance Portability and Accountability Act (HIPAA) and Federal Information Security Management Act (FISMA) standards, but also signifies compliance with all laws, regulations, and controls. With more than 1,000 employees working across 50 states, Performant offers innovative solutions and a team of industry experts who enable health plans to meet their cost containment objectives. Our extensive suite of payment integrity services fall under three categories: Claim Audit Services, Federal and State Eligibility Services, and Specialty	5 points

Recovery Services. **Figure 2** provides additional high-level detail concerning key events in Performant's history.

Figure 2: Performant Key Events

To support national-scale cost containment efforts, Performant offers a wide range of complex/clinical review audits and data mining services for all lines of business (LOBs), including commercial, Medicaid, and Medicare. Performant has been recognized by CMS for our leading audit accuracy rate among RACs and by the American Hospital Association (AHA) for our high provider satisfaction scores. Areas of audit expertise include inpatient, outpatient, specialty care, post-acute home care, coordination of benefits (COB), TPL, MSP, contract compliance, provider billing, and specialty recovery. Our team of highly trained audit professionals includes certified coding specialists and supervisors with an average 16 years of experience. Coders apply AHA International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) Coding Guidelines and

Coding Clinics, as well as American Medical Association (AMA) Current Procedural Terminology (CPT) Coding Guidelines and Coding Assistant information. Appropriate skills and certifications allow for proper and accurate review of medical records and coding regulations. Coding specialists are required to keep their coding certifications current, and Performant conducts semiannual validations to ensure compliance.

Performant's team also includes currently licensed registered nurses (RNs) with an average 18 years of experience. These nurses serve in different roles, including clinical audit, review and response to discussion periods, quality assurance (QA), and appeals support. Our nurses represent a wide variety of specialty areas with experience in the nursing and/or auditing field; and they will provide audit feedback to assist in refining queries and helping to increase findings. Nurses are also required to keep their certifications current, and Performant conducts semiannual validations to ensure compliance.

All audit staff operate under medical supervision and bring deep experience in the claim payment integrity cycle, from analysis through appeals, to each engagement. Working closely with health plans, Performant helps ensure the success of their provider audit programs.

Performant provides administrative, management and analytics, and operations functions from the following office locations:

Office Type—Function	Location
Corporate Headquarters—Administrative	900 South Pine Island Road, Suite 150 Plantation, FL 33324
Healthcare Management & Analytics	17080 S Harlan Road Lathrop, CA 95330
Operations—Healthcare Audit and Recovery, Recovery, and Business Process Outsourcing (BPO)	2763 Southwest Boulevard San Angelo, TX 76904
Mailing	4309 Hacienda Drive Suite 110 Pleasanton, CA 94588

Performant is currently staffed by nearly 1000 employees. Approximately 810 employees dedicated to serving health plans.

CARELON SUBROGATION

Carelon Subrogation offers a comprehensive, proven approach to recover funds from liable third parties through our end-to-end subrogation services. We have provided dependable and high-value subrogation services for more than 30 years. Our internal, dedicated subrogation team is comprised of associates who are highly skilled in investigation, negotiations, and settlements and exercise a deepened understanding of litigation. The average tenure of our associates is over 10 years, unlike other companies with high turnover rates, which ensures personnel consistency through each case and throughout our contractual commitments. These experienced professionals aggressively pursue third-party liability claims to ensure the appropriate party assumes responsibility for paying medical bills. We maximize recoveries through a combination of sophisticated discovery techniques, our highly successful non-responder program, and internal and external legal support to negotiate the settlement and obtain appropriate reimbursement.

Carelon Subrogation can receive subrogation responses or information through a variety of channels including mail, fax, email, web-portal, or through toll-free calls to our dedicated

customer service team.

- Web Portal: The Carelon Subrogation webpage provides options for both questionnaire responses and new case referrals. Both paths have easy-to-follow questions that allow for completion of required information in a fast and convenient method.
- Customer Service: Carelon Subrogation has a dedicated intake team available from 7:30am to 6pm CST. These trained and resourceful associates assist all caller types (member, insurance company, member representative) and are there to assist at various points throughout the case life cycle.
- Email/Fax/Mail: All incoming correspondence, regardless of submission method, is vetted by trained associates to determine appropriate next actions. All incoming correspondence are retained within our content repository system.

E.2 COST AVOIDANCE AND THIRD-PARTY LIABILITY IDENTIFICATION

A. How do you handle coordination of benefits in your current operations and how would you adapt your current operations to meet contract requirements — 5 points

Performant utilizes a multifaceted approach to maximizing TPL identifications while maintaining a high level of data quality. Since no single source of TPL information exists for Medicaid, Performant searches for potential primary coverage through the following means (descending by reliability):

1. In-house eligibility data assets
2. Client- "referred" COB information
3. Data mining and analytics
4. Data partner relationships
5. Call center reports

To provide the best TPL solution possible, Performant utilizes a business partner-type approach with our clients to optimize each success-influencing function systematically:

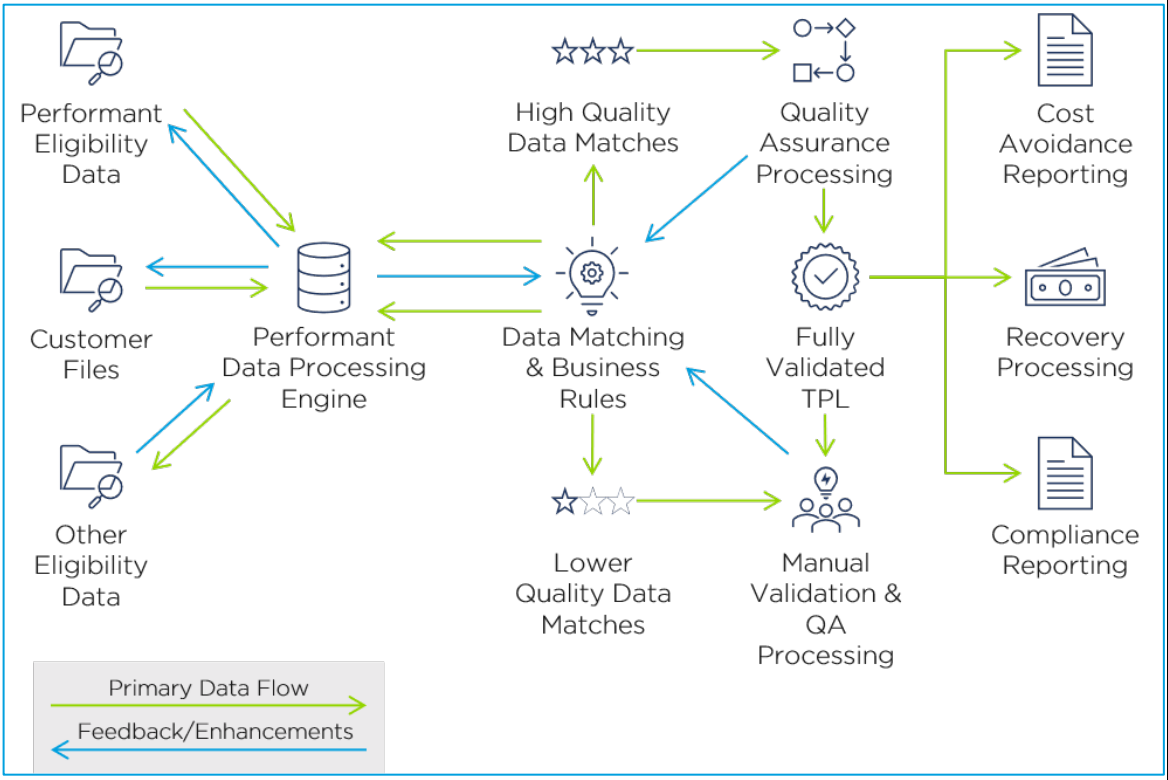
(1) Identify Primary TPL Coverage—As described in detail below, Performant casts a wide net to find as many TPL leads as possible. However, by following a multitiered approach descending by data quality, Performant conserves resources on more reliable data and dives deeper into more questionable sources, maximizing the pool of potential primary coverage.

(2) Validate and Cost Avoid Whenever Possible—Unlike many vendors that seek to maximize profitability through automation or loose accuracy tolerances, Performant employs the technology and people needed to provide fully validated TPL information back to our clients. By "fully validated", we mean Performant provides the information our payer clients' need to bill the primary carrier and get paid properly the first time. During implementation, Performant's onboarding team will work with AR HHS' business partners to understand how your systems use TPL information, as well as how providers interact with that information. This translates into business requirements for Performant's TPL file delivery to AR HHS, which is designed to work with any existing import automation. In the returned data, Performant will include the elements (all validated) that AR HHS would require for accurate cost avoidance and to ensure that providers receive accurate payment (e.g., member/subscriber demographics, carrier information, policy numbers, group names/numbers, coverage dates, etc.). When this step is handled properly, it results in a win-win for both payers and providers; payers avoid erroneous expenses as quickly and efficiently as possible, and providers get paid properly faster (and sometime at a higher rate than Medicaid rates).

(3) Offset from the Provider when Feasible—Nearly all payers agree that next to cost avoidance, offsetting claim payments from providers is the most efficient mechanism for performing post-payment recoveries. However, despite the effectiveness of this process, it can lead to significant network abrasion when not handled properly.

When addressing TPL payments, this is due to the number of complications in the primary billing process that can prevent providers from getting paid. Just because a primary TPL policy exists does not mean a particular claim will be covered by the primary payer. This can be for many reasons, some legitimate (e.g., non-covered service, out-of-network provider, etc.) and some not legitimate (e.g., timely filing). In either event, offsetting without the proper information can lead to providers being stripped of their original payment and then forced to refile the claim after the primary carrier denies it. To prevent this friction, Performant offers provider offset assistance where our operational teams work with the provider to notify them of the primary coverage and confirm the claim will be paid before initiating the offset. Though this extra step adds some time to the savings recognition process, Performant has found that the administrative savings and provider goodwill gained justify the delay. (4) Carrier Biling when Necessary — As a long-standing TPL/COB/Recovery vendor, Performant has established claiming capabilities with most primary insurance carriers operating nationwide today. While Performant always strives for automation and electronic processing, insurance carriers' ability to process secondary or "reclamation" claims largely depends on constraints within those payers' systems. In response to these potential limitations, Performant maintains collaborative relationships with each payer to learn their systems and processes, so we can design claiming schemas that maximize timeliness, accuracy, and value. Therefore, while true EDI claiming is in place with many large, national payers, Performant has many other means to deliver reclamation claims effectively. Performant's current operations are set up to take on new clients and seamless integrate them into our TPL processes. Performant understands that every client has different requirements that must be met. The role of Performant's Implementation Manager will be to ensure those requirements of AR HHS are documented and met as part of our implementation plan. Performant is confident in its ability to delivery on the requirements stated in this RFP.	
B. What routine systems/business processes are employed to test, update and validate Third Party Liability data Please refer to section E.2.A. for additional information on routine systems/business processes are employed to test, update and validate Third Party Liability data.	5 points

Figure 1: TPHI/TPL Identification Workflow



Important Note: Consistent with industry practice, Performant's standard TPL audit processes do not include regular member outreach. In our experience, relying on member-direct input for new TPL identifications is unreliable and has a negative qualitative return on investment (ROI) in terms of abrasion. However, Performant is able to integrate member outreach according to AR HHS preferences. If so, Performant will work with our AR HHS business partners to clearly define who, when, and how members should be contacted. This definition process will include development of scripting, letters, and other materials.

Performant leverages quality controls in its TPL and recovery process to ensure guidelines and standards are met for our clients. Each functional area has established policy and operating procedure that sets the basis for which control measures are placed with standards that achieve total quality control and productivity with little tolerance for variances and errors. The controls are monitored frequently through generated reporting and quality reviews.

B. Provide your list of proposed commercial insurance carriers or other databases used to match and include time frames for completing such matches. Describe the rationale for selection of these entities such as success rate and accuracy.

5 points

As a long-standing Medicaid TPL vendor, Performant has agreements in place with over five hundred Insurers including the majority of insurers in the State of Arkansas. Payers Performant intends to target include, but not limited to, Arkansas Blue Cross and Blue Shield, UnitedHealthcare, OptumRx, HMO Partners, Inc., Humana, Inc., CVS/Aetna, Caremark, Express Scripts, MedImpact, PRIME Therapeutics, and Cigna.

Performant's dedicated Payer Outreach Team is focused on the continued expansion of Performant's commercial insurer data assets and is capable of swiftly establishing new client's agreements with insurers as needed. Performant maintains relevant insurer coverage data for all of its Medicaid TPL clients.

Performant has trading partner agreements in place with most sources of commercial coverage that supply full eligibility rosters directly for data matching. Supplied either

weekly or monthly, these direct data feeds contain “global” coverage information from major payers for the entire 3-year Medicaid lookback period. In-house data assets like this allow for exceptionally high-quality data matching due to Performant’s ability to manipulate the data through multiple types of automated and manual data matching and validation. Performant provides validated data matches including the other commercial coverage policy and group information, the primacy determination, and any relevant or required comments back to its clients on a regular basis and in an established format as required by its clients. Performant does not intend to limit the number of payers being matched against for AR HHS and will upload new insurance segments following business rules approved by AR HHS.	
D. Describe the proposed data match criteria for the identification of valid matches. Please refer to section E.2.A. for a description of the proposed data match criteria for the identification of valid matches.	5 points
E. Describe your process for discovering and transmitting corrections. Performant leverages eligibility information from multiple third-party liability (TPL) sources to create a repository of other coverage information, comparing the Medicaid enrollment rosters against our robust data warehouse to identify payers that should be primary to Medicaid. Valuing client partnerships above profitability, we do not sacrifice savings and quality through deploying automation alone. Performant pursues claims other vendors miss with automation, performing outreach to verify minor discrepancies in member data that may have resulted in automatic denial. Performant’s proven reclamation programs are supported by our commitment to full transparency to Medicaid plans—providing billing and recovery details and why previous efforts failed to identify savings. Our flexible platform enables us to design custom programs for each Medicaid plan’s needs, while our extensive resources and dedicated account management ensure expedited and accurate program implementation. Our identification, cost avoidance, billing, and reclamation solutions ensure payment appropriateness and recover payments where Medicaid should have been the payer of last resort. Performant will establish all required links to data sources including Defense Enrollment Eligibility Reporting System (DEERS), Department of Human Services, and Social Security Administration to ensure the Master Resource file is populated correctly and in its entirety. Performant will ensure that all data match criteria is met, establish an automated means of transmitting data and updates to MMIS which will all be approved by AR HHS as part of our implementation. Performant will ensure that the insurance information remains current and accurate by conducting a reconciliation process at least monthly to re-verify insurance coverage information. The Contractor will send frequent monthly updates, as frequent as daily, but no longer than monthly (adds, changes, terminations) to MMIS.	5 points
F. Describe your reconciliation process. Performant will ensure that the insurance information remains current and accurate by conducting a reconciliation process at least monthly to re-verify insurance coverage information. The Contractor will send frequent monthly updates, as frequent as daily, but no longer than monthly (adds, changes, terminations) to MMIS. Performant has built its reconciliation process into the advanced eligibility matching as described in 2.D above.	5 points

Performant will work with AR HHS to define and meet all financial reporting requirements. As a demonstration of our experience, Performant here outlines a standard approach many clients appreciate in terms of our Financial reporting. This reporting is comprised of weekly, monthly, and quarterly reporting formats.

Weekly Lockbox Reporting:

For all provider payments made to the Performant-managed "lock box" Performant would propose to provide weekly reporting to AR HHS, corresponding to a weekly remittance of deposited and reconciled funds received and any refunds issued. Such weekly reporting normally includes:

- Claim-level tracking
- Date and Amount of payment received
- Date and Amount of any refund issues
- Outstanding balance

Monthly Financial Reporting:

Monthly financial reporting usually features 3 types of reports:

- Monthly Lockbox Reporting**:** Which provides a monthly compilation and reconciliation of the Weekly Lockbox Reporting.
- Monthly Activity Reporting**:** Tracking the overpayments and underpayment identified during the ensuing month.
- Monthly Inventory Aging Reconciliation**:** Tracking the outstanding aging on overpayment inventory, inclusive of any appeal overturns, cancelations, and refunds.

Quarterly Financial Reporting:

Performant usually provides a Quarterly Financial Report that aligns with Quarterly Business Reviews. Quarterly Financial would be proposed to include, at a minimum, following:

- Overpayments identified
- Overpayment collected – Amounts shall only be included if the amount has been collected by AR HHS
- Underpayments identified
- Underpayments paid back to provider – Amounts shall only be included if the amount has been paid back to the provider by AR HHS
- Overpayments adjusted – Amounts to be included if a hearing has been decided in the provider's favor
- Outstanding Overpayment Balance
- Outstanding Underpayment Balance
- Any additional data fields or additional reports requested by AR HHS.

G. Provide your proposed TPL Master Resource File review and verification process including:

1. Migrating TPL Master Resource data from the current TPL Master Resource File, maintained by the MMIS Contractor; and

   Performant will create and maintain a comprehensive TPL Master file taking into consideration all data sources and files. Performant will ensure that the insurance information remains current and accurate by conducting a reconciliation process at least monthly to re-verify insurance coverage information. The Contractor will send frequent monthly updates, as frequent as daily, but no longer than monthly (adds, changes, terminations) to MMIS.

   Please refer to section E.2.A. for additional information on Performant's proposed TPL Master Resource File review and verification process.

2. Providing a comprehensive revalidation of all data included on the current TPL Master Resource File.

   Please refer to section E.2.A. for information on Performant's proposed TPL Master Resource File review and verification process.

5 points

E.3 RECOVERIES (POST PAYMENT, CASUALTY, & TORT)

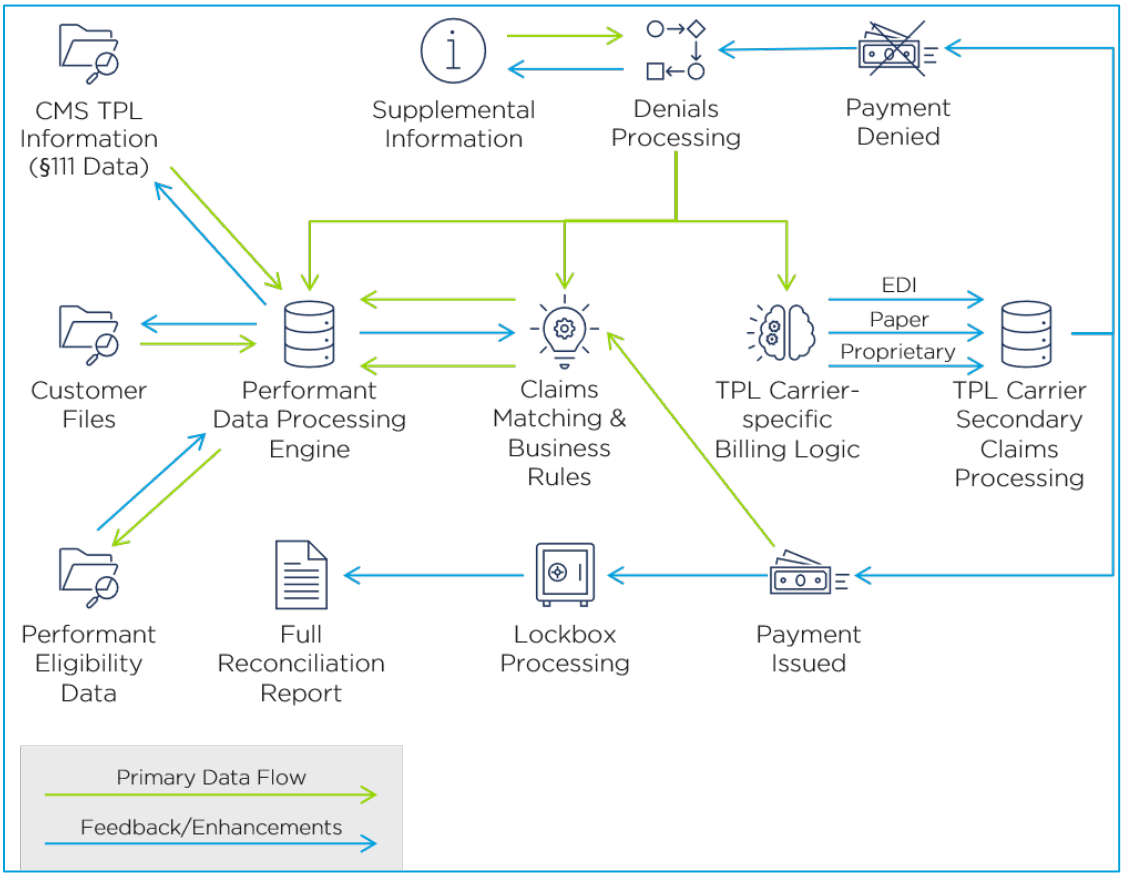
A. What percentage of Medicaid claims billed to Commercial Insurance Carriers actually get recovered? Industry recovery standards for post-payment carrier reclamation varies greatly based on numerous factors primarily dependent up the carrier being billed. The age of a claim, service type, billing method and eligibility accuracy are primary drivers. Given the spread of acceptable rates Performant set a minimum acceptance rate of 20%. Given Performant's strategic partnership approach with the payer community we achieve recovery rates up to and in the 30% range for our clients today.	5 points

B. Describe your process for pay and chase activities and how it will be accomplished?
 	
PERFORMANT HEALTHCARE SOLUTIONS RESPONSE
Please refer to section E.2.A for additional information on Performant's process for pay and chase activities and how it will be accomplished.
 	
DIRECT BILL APPROACH
 	
RECOVER PAYMENTS BY BILLING THE PRIMARY INSURANCE CARRIER
Direct or carrier-to-carrier billing has been the industry standard for post-payment reclamation from the beginning, and the process has many attractive benefits, such as ease of measurement (versus cost avoidance) and absence of provider friction. However, in Performant's experience, this collection mechanism is neither as efficient or effective as cost avoidance or provider-direct recovery. Performance believes carrier-to-carrier billing can be an effective savings method when others are not possible or feasible.
 	
As discussed above, Performant starts the carrier-to-carrier billing process with the highest quality COB policy information possible, and claims earmarked for carrier-based collections. Using this information, Performant initiates the direct billing process:
 	
• Claims matching and customer-specific business rules are applied
  ○ This highly customizable process allows Performant to include/exclude different coverage, claim, and carrier types to maximize billing accuracy and allow parallelization with other collection mechanisms, such as offsetting/disallowance
• Carrier-specific billing logic is applied
  ○ As discussed above, Performant has long-standing relationships is other insurance carriers, and we have detailed mappings of those carriers' reclamation claim handling processes and delivery requirements
• Claims are billed to primary carriers using the most effective means available
  ○ Regardless of delivery method, Performant's reclamation operations team follows up with payers to confirm billing bundles were received and are being processed
• Primary carries issue payment for billed claims
  ○ Performant's cash-handling team receives the payment and remittance advice in a dedicated customer P.O. Box
  ▪ Documents are imaged, indexed, and stored for later use
  ▪ EDI payments are automatically sent to the customer's designated bank account
  ▪ Physical payments (checks) are scanned, and funds are digitally transferred to the customer's designated bank account via ACH transaction
• Primary carriers deny payment for billed claims
  ○ Electronic and paper claim denials reports are received and processed by Performant's denial management team
  ○ Denials are investigated and assigned into categories based on actionability:
	5 points

- Non-actionable denials—situations in which the denial is appropriate and/or no action taken by Performant will yield collections (e.g., out-of-network provider, non-covered service, and patient responsibility (e.g., co-pays, deductibles, etc.)
- Actionable denials
  - Inappropriate denial/education needed—erroneous denials where outreach and/or education is needed for the primary payer to properly process the reclamation claim
  - Potentially inappropriate denial/research needed—denials that may or may not be appropriate, and additional action is needed by Performant to resolve the matter (e.g., member/policy information not found, additional and/or corrected information required, medical records needed for processing, etc.)

- Claim resolution
  - Performant applies customer-specific standards to have all claims resolved (paid or closed) in a timely manner

Figure 4: Bill/Carrier-to-Carrier Billing Workflow



Though Performant has a robust Carrier Billing process to recover overpayments, some still become a liability. Understanding why previous collection efforts were ineffective helps guide subsequent recovery actions and resolve the liability as efficiently as possible. A successful provider recovery effort begins by identifying the overpayment opportunity and barriers to provider cooperation to address avoidance behaviors directly.

C. How will subrogation activities be conducted, and updates maintained? Carelon Subrogation is committed to providing dependable and high-value cost-containment services to our accounts and members. Proprietary predictive analytics allow us to recover cases more quickly, delivering savings and ensuring the appropriate party assumes responsibility for paying medical bills to help reduce healthcare costs.	5 points

Carelon Subrogation utilizes advanced analytics and technologies to identify and process cases and integrates with national and local databases to locate additional prospective sources of recovery. Furthermore, we offer a comprehensive range of identification capabilities that include: • Database identification • Non-responder program • Referrals Carelon Subrogation's multi-faceted approach to case identification can be customized to reduce or even eliminate member involvement for a better member experience while maximizing recovery opportunities. When we identify a potential case, we give notice to all involved parties of our right to subrogation/reimbursement. This notification happens through a letter to the member, the member's attorney (if represented), and all involved insurance carriers. Inquiries are also sent to liability and med-pay (no-fault) carriers to identify if both the carrier and Carelon Subrogation has paid for the same services. Additionally, we will assign legal representation to protect our interest, if necessary. Legal assistance is provided within the context of the subrogation services described above. Carelon Subrogation uses a proprietary, and internally developed, case management system (CMS) as its tracking mechanism for all file-level communication. Our letter generation process is contained entirely within the CMS and is 100% digital. All incoming correspondences are imaged and contained within a content repository system that is linked to the CMS and all incoming and outgoing calls are user documented within the system. File notes, which contain time- and date-stamped records of all calls and correspondence, can be exported and published in PDF or Excel formats. Our retention period for all case information including correspondence, is generally seven (7) years, unless the benefit plan requires a longer period.	
D. Describe the process of communication and outreach to attorney's, insurance companies and other providers in relation to subrogation activities? Carelon Subrogation utilizes multiple sources of subrogation identification and strategic approaches to maximize recoveries. We offer flexibility and the option of sending member questionnaires for subrogation identification (we recommend sending at least one questionnaire). In addition to member responses, Carelon Subrogation can accept subrogation responses or information from other sources, such as the member's attorney or other representation (family members), referrals from insurance carriers, employer/group, providers, and client referrals. We also use various external databases and data sources for subrogation identification, and we integrate with other operational areas (Case Management, Member Services, etc.) that generate subrogation referrals. Once a potential case is identified, we notify all involved parties of our right to subrogation/reimbursement. This notification is completed through a letter to the member, the member's attorney (if represented), and all involved insurance carriers. We can customize our questionnaire content, frequency, and any other communication based on preferences needed. Carelon Subrogation offers internal legal support and a network of external legal resources with subrogation and workers' compensation expertise to ensure we have the best resources involved in the consultation, negotiation, and settlement process. Our dedicated account management team assists with inquiries and works with our client's internal teams to generate leads and referrals and can effectively manage any subrogation cases from investigation to recovery.	5 points
E. Describe your process for establishing, maintaining, and updating the accounts receivable file for claims identified and billed to third party resources.	5 points

Performant is accustomed to the maintenance of a Case file containing all of the information as required in this solicitation. Hence, the only anticipated software changes are required in current application to onboard AR HHS will be to adjust the case file to AR HHS's preferred format. Performant developed a customized application to pull case files at regular intervals and upon ad-hoc requests as well as posting pertinent details to the portal as desired/required by AR HHS. This application is designed to pull and package relevant documentation of the claim based on type of review (complex or automated) per AR HHS specifications in the SOW. These documents include medical records, documentation received during the rebuttal, copies of all letter correspondence to providers, activity logs, appeal requests, details related to adjustments submitted to AR HHS, letter issuance dates, overpayment/underpayment amounts, and audit closures/rescinds along with the New Issue documentation effective as of the claim selection date for audit and review date. Performant's system maintains a log of case file requests, including requestor, date of request, and date sent. Performant's investment in these custom applications brings additional value to AR HHS by ensuring AR HHS receives the most compliant and complete access to full program records in a fully traceable and accountable fashion.

Recovery Case Management:

- Performant will create a unique case for each Member, Carrier or Provider, encompassing related claims.
    - Each claim will be tracked at the claim(s) and or line level.
    - As claims are entered in to case management system, tracking of the claim lifecycle begins.
    - Each claim has the ability to be statused, based on the basis of each interaction taken on the claim.
    - Claim statuses are based on, but not limited to: (These statuses can be updated based on client request)
        - Letter/Billing Sent (paper or EDI)
        - Open/Active
        - Payment
        - Partial payment
        - Closed
        - Canceled
        - On Hold
        - Appeal (Multiple levels)
        - Appeal determination (multiple levels)
        - Rebuttal
        - Rebilling
- Performant will issue an initial billing or letter
    - As approved by AR HHS ("demand letter"), giving the provider notice of debt. The demand letter will introduce the Performant, explain the nature of the Performant's business relationship with the customer and will explain and document the providers obligation to repay the Customer for the claims sited in the letter.
- Performant will conduct the following activities to support the demand letter process
    - Submit electronic carrier billings
    - Print and mail demand letters
    - Make outreach phone calls to carriers and providers to ensure receipt of billings and/or demand letter.
        - All demands are recorded tracked and timestamped in our recovery system, with the ability to re-print, review and access at any time.
        - All contacts are documented in the recovery case management system either at the claim, or case level. This information is readily available in the case management system, under the Carrier/Providers history, recorded with a time stamp and date.

        - If/as needed, update vendor data to correct, addresses, add special mail handling instructions or re-issuance of demand letter.
        - Introduce vendor and explain nature of the business relationship to the customer.
        - Explain the process being engaged to recovery on the Carrier/Provider's debt and obligation to make payment to the customer.
- Performant will continue to follow up with Carrier/Providers after confirming receipt and the Provider's understanding of the demanded debt. The schedule and cadence of the phone follow-up combined with an escalating series of letters, as approved by the customer, Is Recovery Case Management.
- Through Recovery Case Management system, Performant will: seek to explain the nature of claim overpayment and document all outreach and interaction with Providers
    - Documentation of Inbound/outbound Phone calls
    - Documentation of Inbound/Outbound Emails
    - Documentation of Inbound/Outbound Facsimile transactions
    - Documentation of inbound/Outbound Correspondence to and from Carrier/Providers
- Continue to remind the carrier/provider of their financial obligation to repay the customer.
- Provider and additional information to document the debt as needed and as information on the case or claim become available.
- Conduct scheduled follow up calls through, Inventory management mechanisms in the case management system.
- Seek to identify the appropriate parties within the Carrier/Providers organization who are empowered to make determinations as to repayment of debt.
- Issue customer approved escalation letters.
- Negotiate and make payment arrangements
- If approved and as directed by AR HHS, negotiate settlement payment on debt.

Recovery Case Management: Payment Tracking

- Payment received, while in case management:
    - All payments processed will be applied to the appropriate claim or line
    - All payments are timestamped, and recorded in the direct history of case, and at the claim/line level.
    - Overall payments applied to the case balance, will be reduced as payments are applied to reflect the correct balance of the entire case daily.
- Claim Adjustments received, while in case management
    - All adjustment received will be processed and applied to the appropriate claim(s) or line
    - All adjustments are timestamped, and recorded in the direct history of case, and at the claim(s) or line.
    - Overall adjustments to the case balance, will be reduced as payments are applied to reflect the correct balance of the entire case daily.

Performant will staff lockbox operations to receive and apply payment in compliance with all applicable requirements of state and federal laws and regulations. Establishment of a dedicated account and PO Box to receive Provider payments via check or ACH with dedicated staffing of a secure operations area for opening, processing and scanning of checks and any payment related correspondence. All payments received will be loaded and tracked in the recovery case management system, against the identified claim. Documented research, including follow-up outreach to the Provider along with appropriately documented posting of Provider payments toward claims placed with Performant by customer will be accessible.

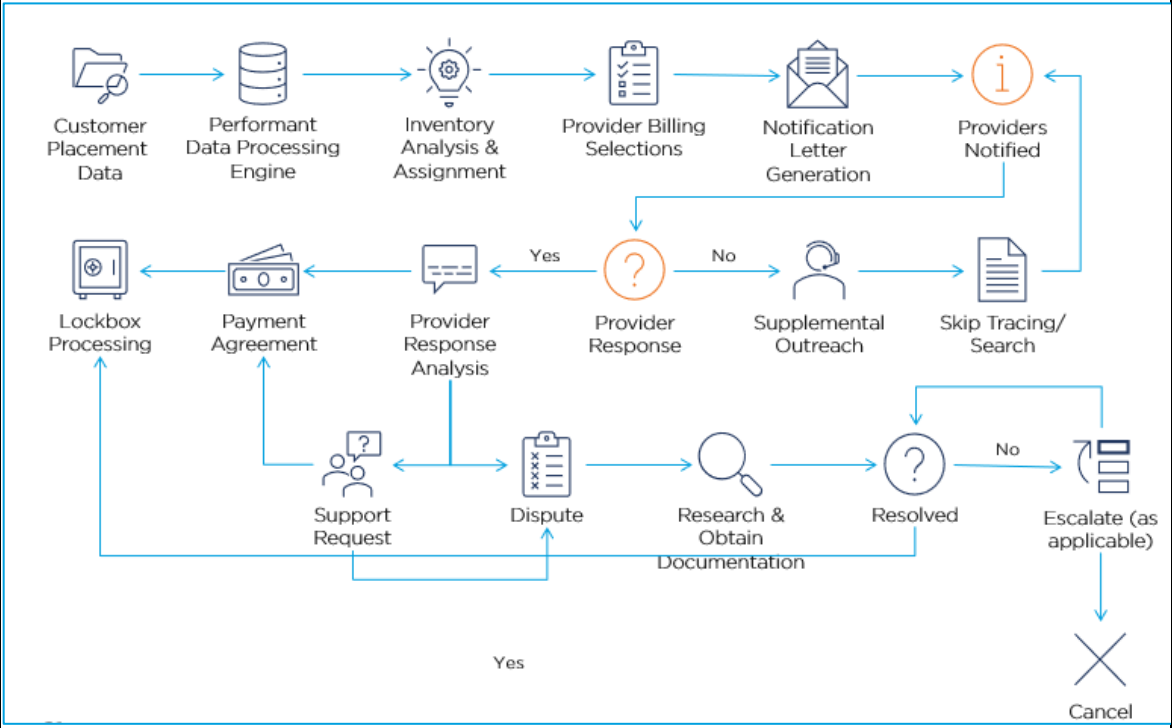
In circumstances where the Provider payment cannot be reconciled to specific debts, Performant will provide the received provider payment details and any Provider correspondence or documentation. Performant will perform additional research to obtain sufficient documentation of the payment such that the Customer can apply the payments against specific or outstanding debts.	

F. Describe your process for closing out claims for which no response was received.
 	
Follow-up and Denial Handling
Performant takes every step to streamline recovery dollars back to our clients in a timely and professional manner. Pursuable inventory is monitored and measured so that follow-ups are made appropriately and escalating any disputes to resolve payment on claims. Disputes or denials are addressed swiftly through systematic prioritization and dedicated staff which are both monitored to completion.
 	
• Primary carriers deny payment for billed claims
  ○ Electronic and paper claim denials reports are received and processed by Performant's denial management team
  ○ Denials are investigated and assigned into categories based on actionability:
  ▪ Non-actionable denials—situations in which the denial is appropriate and/or no action taken by Performant will yield collections (e.g., out-of-network provider, non-covered service, and patient responsibility (e.g., co-pays, deductibles, etc.)
  ▪ Actionable denials
  • Inappropriate denial/education needed—erroneous denials where outreach and/or education is needed for the primary payer to properly process the reclamation claim
  • Potentially inappropriate denial/research needed—denials that may or may not be appropriate, and additional action is needed by Performant to resolve the matter (e.g., member/policy information not found, additional and/or corrected information required, medical records needed for processing, etc.)
• Claim resolution
  ○ Performant applies customer-specific standards to have all claims resolved (paid or closed) in a timely manner
 	
Though Performant has a robust Carrier Billing process to recover overpayments, some still become a liability. Understanding why previous collection efforts were ineffective helps guide subsequent recovery actions and resolve the liability as efficiently as possible. A successful provider recovery effort begins by identifying the overpayment opportunity and barriers to provider cooperation to address avoidance behaviors directly.
 	
Deploying a specialized team of recovery professionals backed by a proprietary collection platform customized for aged provider recovery, Performant Healthcare Solutions offers Recovery Advantage—a specialized approach to aged provider recovery designed to maximize recoveries while limiting provider abrasion. Our dynamic recovery approach includes three targeted provider components—outreach, escalation, and dispute resolution.
 	
Performant's unique provider outreach approach includes a dedicated recovery agent assigned to each provider, which allows the agent to develop rapport with the provider and enhance communication efficiency. Our team of recovery professionals make targeted outbound calls and emails to providers with a 30-day service level agreement based on recovery industry best practices. To boost the success of our aged provider recovery efforts, Performant's provider escalation approach allows direct communication with provider executives (e.g., CFO and executive offices) after 60 days—a service not offered
	5 points

by most recovery agencies—utilizing letter campaigns to notify provider leadership of the outstanding obligation.

In addition to outreach and escalation approaches designed to reduce provider abrasion, Performant's aged provider recovery approach includes detailed procedures for provider dispute resolution, including alternative resolution of outstanding obligations. Our Compliance team ensures ongoing quality assurance and provider satisfaction by reviewing and responding to written provider disputes within 30 days. With confidence that recoveries can be increased without damaging provider relationships, Performant offers alternative paths for resolution for providers to overcome barriers such as non-responsiveness, merits arguments, and financial arguments. Providers in financial hardship are given the option of payment arrangements for up to six months, and, at the health plan's discretion, settlements can be offered to resolve otherwise written-off obligations.

Figure 3: Provider Recovery Workflow



CARELON RESPONSE

Please refer to our response in section E.3.C regarding our avenues of investigating a subrogation case. Once Carelon Subrogation has exhausted all cost-effective methods of investigation, we close our subrogation file.

G. Describe your process for conducting recoupment and disallowances.

5 points

PERFORMANT HEALTHCARE SOLUTIONS RESPONSE

For TPL services, any outstanding overpayment balances are communicated to the provider via letter. Recovery letters detail outstanding claims in need to recoupment, summary information as to the reviews conducted and detailed instructions for making payment. As detailed further below, Performant assigns inventory by Provider, rather than by Claim. Through this process, Performant's recovery agents gain knowledge of the provider's personnel and unique repayment processes. Performant's recovery agents maintain contact with the provider, ensuring mailing are received, recoupment processes are understood and that payment arrangements are documented and tracked.

Performant takes every step to streamline recovery dollars back to our clients in a timely and professional manner. Pursuable inventory is monitored and measured so that follow-ups are made appropriately and escalating any disputes to resolve payment on claims. Disputes or denials are addressed swiftly through systematic prioritization and dedicated staff which are both monitored to completion.

In addition to excluding claims which have been settled or negotiated, Performant will not audit claims that have already been audited by another entity. Performant has extensive experience establishing and maintaining specific systems for ensuring coordination and audit deconfliction with other agencies and contractors. For instance, in our CMS RAC contracts, Performant integrates with the RAC Data Warehouse (RACDW) as a primary mechanism in avoiding duplicate and redundant reviews and to ensure excluded or suppressed providers are not being actively audited. Additionally, Performant has established similar client-specific systems to ensure clean and traceable coordination of claim eligibility for audit. In so doing, Performant is deeply experienced in establishing Joint Operating Agreements with other Government agencies and their contractors, is facile in facilitating file exchanges of different format and scope and can unify this information into a comprehensive database for the tracking of audits.

The Customer Service team is committed to a one-call resolution whenever possible. Any written correspondence from providers, including mailed, emailed, and faxed documents, will be confirmed within one business day by either calling or sending email confirmation, and the response will be sent within 30 calendar days of receipt, per the SOW. Medical records and discussion requests receipts are confirmed on the provider portal. Any emails or letters received indicating displeasure with Performant will be forwarded to AR HHS. Team leaders are always available to handle escalated calls. Our Customer Service team uses Performant's workflow platform to aid this process. This is the same platform utilized by audit staff to track and document claims, allowing staff to view the entire history of each claim, finding rationale, provider information, letters, medical records, and customer service call logs at the click of a mouse. Availability of this information ensures staff thoroughly answer provider questions.

At this time, the customer service representative verifies HIPAA, and allows for multi-lingual communication based on the plan member's preferred language (including but not limited to, Spanish, Polish, Portuguese, Russian, and German.)

Performant staff are fully trained and knowledgeable about Arkansas Medicaid standards and protocols, the Recovery Audit program, and recovery processes.

Performant will provide enough properly functioning toll-free telephone numbers/line (in-state and out-of-state) for providers to call for services as described in this RFP. The toll-free customer service number will be included in all provider correspondence.

Specific features of our customer service center include:

- Standard business operating hours exceeding 8:00 a.m. to 5:00 p.m. central time zone
- Available to providers on all business days, including some of the federal holidays—President's Day, Columbus Day, and Veteran's Day
- Toll-free customer service number with voicemail during non-business hours
- Remote call monitoring and recording for training and compliance
- Comprehensive call reporting for all customer service calls

Customer Service Representatives (CSRs) facilitate all aspects of provider interactions in the TPL recovery workflows. CSRs conduct outbound calls to confirm Provider addresses and points of contact and to ensure that communications have been received, understood and that due dates are clearly communicated. CSRs also assist providers in registration to the Provider Portal to facilitate electronic communications if desired by the Provider. If necessitated by the

State, CSRs can also conduct additional outreach to follow-up with providers when medical record due dates are approaching.

Provider Address Customization allows providers to submit and customize addresses and other contact information. As shown in Figure 4, providers can provide information for two different contacts, including one for medical records requests and another for RRLs/demand letters.

Figure 4: Provider Address Customization Screenshot

Performant will maintain a log of communications between the provider and the Contractor for all reviews/audits.

Should Performant transition out of the contract, we agree to relinquish ownership of the toll-free telephone numbers upon contract termination, at which time AR HHS will take title to these numbers.

Performant can provide sufficient fax and electronic document capabilities with sufficient memory or buffers to handle multiple incoming and outgoing transmissions. Performant has a written backup plan to implement in the event of a fax system failure.

Performant's data intake process is flexible and can accommodate current and future file format required by AR HHS. CARELON RESPONSE Carelon Subrogation pursues provider refunds directly with the provider when duplicate payments or primary third-party resources are identified in a tort or workers compensation matter.	
H. Describe the criteria and considerations used when reviewing refund requests. PERFORMANT HEALTHCARE SOLUTIONS RESPONSE Performant reviews all recoveries for accuracy and ensures only applicable and accurate recoveries are posted and eligible for Performant fees to be applied. If a recovery is received that Performant cannot reconcile it will be investigated to against work completed to determine if the recover was sent in error. Any recover sent in error will be coordinate to be sent back to the party issuing the inaccurate payment. If a recovery made by Performant's effort is reviewed and subsequently determined to be incorrect Performant will coordinate the incorrect payment to be sent back to the party issuing the payment and pay back any fees paid on these claims to Performant by our clients. CARELON SUBROGATION RESPONSE Carelon Subrogation analysts will verify that the duplicate payment was received by a provider or whether a third-party resource is available to pay a claim prior to submitting a refund request to the provider in a tort or workers compensation matter.	5 points
I. Describe your methodology for identifying refunds owed to third party resources to correct recoveries or other overpayments. PERFORMANT HEALTHCARE SOLUTIONS RESPONSE Please refer to section E.2.A. for Performant's methodology for identifying refunds owed to third party resources to correct recoveries or other overpayments. CARELON SUBROGATION RESPONSE Carelon Subrogation will process refund requests when there is a documented overpayment by a third-party resource in resolution of a tort or workers compensation matter.	5 points

J. Describe your methodology for conducting patient account reviews and payment audit programs. Please refer to E.3.E. for Performant's methodology for conducting patient account reviews and payment audit programs.	5 points
K. Describe your methodology for conducting credit balance audits. Please refer to E.3.E. for Performant's methodology for conducting credit balance audits.	5 points
L. Describe your methodology for identifying Medicaid provider inpatient and outpatient overpayments. Please refer to E.3.E. for Performant's methodology for identifying Medicaid provider inpatient and outpatient overpayments.	5 points
M. Explain how you will avoid duplicate billing. PERFORMANT HEALTHCARE SOLUTIONS RESPONSE In addition to excluding claims which have been settled or negotiated through AR HHS, Performant will not audit claims that have already been audited by another entity. Performant has extensive experience establishing and maintaining specific systems for ensuring coordination and audit deconfliction with other agencies and contractors. For instance, in our CMS RAC contracts, Performant integrates with the RAC Data Warehouse (RACDW) as a primary mechanism in avoiding duplicate and redundant reviews and to ensure excluded or suppressed providers are not being actively audited. Additionally, Performant has established similar client-specific systems to ensure clean and traceable coordination of claim eligibility for audit. In so doing, Performant is deeply experienced in establishing Joint Operating Agreements with other Government agencies and their contractors, is facile in facilitating file exchanges of different format and scope and can unify this information into a comprehensive database for the tracking of audits. CARELON SUBROGATION RESPONSE Carelon Subrogation will coordinate with Performant/client to avoid situations in which a TPL claim is being pursued by both Subrogation and Coordination of Benefits processes**.**	5 points
N. Describe your process for identifying, tracking, and pursuing recovery of Medicaid funds from casualty and litigation related cases (including cases involved in mass tort and global settlement). See Carelon Subrogation's response to E.3.C. for general litigation-related case handling. In reference to mass torts, our identification and management process is dependent on the nature of a distinct mass tort or class action. For smaller mass torts, we utilize the same detection and pursuit processes that we use for a general, single event subrogation matter. On larger mass torts we utilize strategic partnerships with an outside counsel who specializes in mass tort identification and recovery. In many instances, there is a formulaic approach applied through a private lien resolution program or other aggregate based compensation methodology. Carelon Subrogation is currently involved in more than 35 mass tort litigations with the largest recoveries involving asbestos, pelvic mesh, defective hips, Essure, and RoundUp. We are also closely monitoring the mass tort environment to look for new opportunities (earlier investigation techniques, increasing in-house capabilities, and collaborative efforts with personal injury firms) as well as potential threats (bankruptcy technique being utilized by J&J in Talc) to consolidate liabilities and limit personal injury settlement amounts.	5 points
E.4 CALL CENTER	

A. Describe your ability to accommodate all calls, including those requiring the use of interpreter services for the hearing impaired and for callers that have limited English proficiency. Carelon Subrogation handles all calls and employs Spanish language fluent associates. Our member questionnaires contain the TTY line for the hearing impaired as well as enclosures for communications in other languages.	5 points
B. Describe the call center's technological capability to allow for monitoring and auditing of calls as well as documenting calls. Carelon Subrogation uses Verint 15.2 for call recording. This technology allows us to pull any call and review the interaction, including screen captures of what took place on the calls. All calls are documented within subrogation's care management system.	5 points
C. Provide a draft of your call center disaster recovery plan. Because of the confidential nature of our core business, our disaster recovery and continuity plan has been rigorously vetted to the highest standard. Carelon Subrogation has live agents staffed to handle all inquiries between 7:30am and 6:00pm CST with voicemail enacted for the hour following closure and return calls placed within 24 hours. We leverage the Call Management System that is part of our telecommunications platform to manage and analyze call patterns to determine peak call times and to manage staffing to meet contract requirements. As a result, we maintain a formal and comprehensive Business Continuity Plan that promotes minimal disruption of service if our Engagement Center experiences a disaster or temporary closure. Although such incidents are rare, it is vital to maintain a detailed plan so that all staff can quickly and decisively respond to any planned or unplanned incidents. For situations where service is disrupted due to power outage, natural disaster, or building evacuation, all incoming calls receive an inclement weather and/or technical difficulties alert message. We return to normal service when the power outage or building evacuation is over. Carelon Subrogation recognize that our ability to maintain service is critical to the success of our partnerships with our clients. We use a multi-level system and data redundancy to minimize interruptions to operations in case of system outages or disaster. Our fully developed disaster recovery and business continuity plan includes requirements, strategies, and actions necessary to rapidly recover business operations including real-time data replication of core applications, hot-site recovery, and redundant failover of systems and power. Carelon Subrogation fully tests our business continuity and disaster recovery plan annually. We will coordinate with our clients to ensure that our system experiences limited downtime, if any, when testing is conducted. We will send our clients a notice of completion following conclusion of disaster recovery testing. Please see the Excel attachment **Call Center Disaster Recovery Plan** for an outline of Carelon Subrogation's recovery strategy.	5 points
D. Describe your methodology for meeting or exceeding the minimum standards outlined in Section 2.4.5.D of the RFP. Carelon Subrogation is answering this question for Section 2.4.6.D of the RFP, as the section cited above does not exist in the RFP. • **The weekly average abandon rate must not exceed five percent (5%). A call shall be considered abandoned after the first 30 seconds when a caller chooses to disconnect after the introductory message and prior to being connected to a representative.**	5 points

Carelon Subrogation's call abandon rate is 5%. • **Hold time, when the caller is placed on hold by the representative to perform further research to assist the caller, must not exceed an average of 120 seconds per call over the course of the month.** Carelon Subrogation has the ability to monitor call hold times. • **All calls must be answered within three rings (a call pick-up system or IVR that places the call-in queue may be used) however queue times must not exceed 30 seconds on average.** Carelon Subrogation's service expectation is to answer calls within 90 seconds. Calls received outside of business hours must be returned within the next business day. • **Calls received outside of business hours must be returned the next business day.** See Carelon Subrogation's response to the above subpart.	
E.5 PLANS	
A. Describe how your Project Management Plan (PMP) meets all requirements in the scope of work as specified in Section 2.4.8.A of the RFP. PERFORMANT HEALTHCARE SOLUTIONS RESPONSE Performant will assign AR HHS a dedicated Program Implementation Manager to shepherd implementation. The Implementation Manager will provide AR HHS with a dedicated point of contact throughout the implementation process and assume responsibility for coordinating the appropriate work streams within Performant and managing project milestones. Performant also assigns to each client a dedicated account manager who will participate throughout the implementation phase of a program and will continue as the dedicated managerial point of contact for all program operations. The account manager is responsible for reporting recovery targets and performance, monitoring service level agreements (SLAs), assuring timely reporting, and facilitating all intercompany work processes. This person will be supplemented with operational managers assigned to each program. Additionally, the account manager will routinely ensure the health plan has direct access to Performant's executive leadership, operational managers, data analytics leads, medical directors, and other personnel as appropriate to the scope of services awarded. In short, Performant's account manager is authorized to ensure the plan is finding Performant to be a top-rated vendor, delivering quality and valuable services to the delight of our client's teams. CARELON SUBROGATION RESPONSE Carelon Subrogation does not pursue TPL outside of the Tort or Workers Compensation loss scenario. The reporting requirements listed at this Section pertains to non-casualty third party resources.	5 points
B. Describe your communication plan as specified in Section 2.4.8.B of the RFP. PERFORMANT HEALTHCARE SOLUTIONS RESPONSE Performant's communication approach is designed to promote clear, comprehensive, and effective communication with beneficiaries, providers, insurance carriers, attorneys, and DHS. Performant is capable of multiple means of communication, communication channels, communication flow within the organizational structure, escalation, guidelines for meetings, dissemination of knowledge, multiple vendors communication and communication effectiveness. CARELON SUBROGATION RESPONSE Please refer to Carelon Subrogation's response to section E.5.A. above.	5 points

C. Describe your staffing management plan as specified in Section 2.4.8.C of the RFP. Please refer to section E.1 A for Performant's staffing management plan.	5 points
D. Describe your Risk Management approach as specified in Section 2.4.8.D of the RFP. Performant has a formally document Risk Management Program. Performant conducts a risk assessment at least annually as well as proactive interim risk assessments that are conducted as needed for when new vulnerabilities are identified. Risks are quantified using the concept measuring the Likelihood and Impact equals Risk, e.g., ranging Very Low to Extreme, following government guidance provided by NIST 800-30 risk management framework. For each identified risk, the mitigating controls are defined, and if also needed, appropriate Plan of Actions & Milestones are created and tracked for vulnerabilities that need additional mitigation and/or remediation. All risks and mitigating controls must be reviewed and formally accepted by Executive Management. The risk assessment also addresses risks under HIPAA as they pertain to the security and privacy of PHI.	5 points
E. Describe your Systems Security and Privacy Plan as specified in Section 2.4.11 of the RFP. Performant would provide State of Arkansas its current Systems Security and Privacy Plan (SSPP) to State of Arkansas in the MARS-E template. Performant's current SSPP already aligns with frameworks to include CMS Acceptable Risk (ARS) V5.1 (i.e., aligning with MARS-E) as well as frameworks such as NIST 800-53 and HITRUST and NIST 800-53. Performant would provide the SSPP to The Plan defines the implementation of all control requirements for Security and Privacy. Performant's implementation of the controls defined with in the SSPP are independently tested by third party auditors. The Plan addresses Performant's approach of layered mitigating controls for all of the following: a. Network security controls b. Perimeter security c. System security and data sensitivity classification d. Penetration testing e. Intrusion management f. Monitoring and reporting g. Host hardening h. Remote access i. Encryption j. Integration with Statewide active directory services k. Interface security l. Security test procedures m. Managing network security devices n. Security patch management and remediation o. Secure communications over the Internet p. Logging Independent testing of Performant's alignment with HIPAA was recently conducted and concluded with our HITRUST audit in January 2024, whereby no corrective actions were needed. Performant is not a provider of hosting solutions; therefore, integration with other solutions as referenced in 2.4.11 of the RFP are not applicable. Performant has implemented numerous security systems and solutions to protect it data storage and processing environment.	5 points
F. Describe your plan to meet the security requirements as specified in Section 2.4.11 of the RFP. Performant's current security requirements are implemented. Any non-compliance is tracked and monitored via Plan of Actions & Milestones. Performant would do that quarterly as indicated by the RFP.	5 points

Overseeing the implementation of and compliance with the security requirement is done by Performant dedicated Information Security team comprising security engineers and information security analyst led by an Information System Security Officer (ISSO). Working in tandem with the security team, Performant employs a dedicated Compliance Team led by the VP, Legal and Compliance, who is also has the role of Privacy Officer and owner of Performant's formal Privacy Protection Program.	
G. Describe your plan for interfacing with DHS' Systems including MMIS as specified in Section 2.4.10 of the RFP. PERFORMANT HEALTHCARE SOLUTIONS RESPONSE Performant will establish all required links to data sources including Defense Enrollment Eligibility Reporting System (DEERS), Department of Humana Services, and Social Securing Administration to ensure the Master Resource file is populated correctly and in its entirety. Performant will ensure that all data match criteria is met, establish an automated means of transmitting data and updates to MMIS which will all be approved by AR HHS as part of our implementation. Performant will ensure that the insurance information remains current and accurate by conducting a reconciliation process at least monthly to re-verify insurance coverage information. The Contractor will send frequent monthly updates, as frequent as daily, but no longer than monthly (adds, changes, terminations) to MMIS. CARELON SUBROGATION RESPONSE Carelon Subrogation would coordinate with Performant/client on this issue as required.	5 points
H. Describe your plan for Disaster Recovery Business Continuity (DRBC) as specified in Section 2.4.12 of the RFP as specified in Section 2.4.12 of the RFP. Performant's formally documented Disaster Recovery Business Continuity (DRBC) addresses disaster declaration, distribution lists for immediate contacts and approved notifications and methods for communications. If State of Arkansas has unique needs communications, these can be provided to Performant for update to the DRBC. The DRBC supports each core business process. The Business Impact Analysis is conducted annually. All key stakeholders are involved in maintenance of the DRBC plans. A Corporate Support Action Committee comprises all key stakeholders, including a Corporate Continuity Coordinator ensures the document maintenance is conducted annually and coordinates the planning of annual tabletop exercises. Within the RFP, the intent of #10. "Plan for replacement of personnel", Performant ensures that roles of internal personnel are re-assigned in the event personnel needs to be replaced for some reason. If #10, however, means something else, then Performant is open to discussion with State of Arkansas upon winning the contract.	5 points
I. Describe your plan for record retention and access as specified in Section 2.4.13 of the RFP. Performant performs over 45,000 complex reviews per month. We have a proven, high-scale infrastructure to support medical record requests, retrieval and storage for the required 6 years past the close of the contract. To eliminate single points of failure, critical hardware components are configured (where supported) for high availability. All critical systems and applications are monitored 24/7 through an enterprise monitoring and alerting system. Any outages automatically generate tickets that are assigned to the various support teams (systems, network, application, security) for resolution. For any issues specific to hardware, hardware maintenance support is in place for all production equipment and is audited annually to ensure ongoing compliance.	5 points

All systems are backed up daily and stored locally (on-site) for 30 days and then replicated to a secondary (off-site) location for long-term storage and archival (as dictated by contractual retention requirements). All backups are tracked via internal mechanisms and are encrypted both at rest and in transit. LARGE VOLUMES OF DATA Performant has extensive experience storing and securing confidential data by leveraging multiple, best-in-class enterprise storage arrays. Our storage arrays currently have 56TB of available (free) capacity to accommodate additional uncompressed data. This does not include our ability to add additional capacity at a later date (if required). We protect confidentiality, integrity, and availability by utilizing FIPS 140-2-compliant commercial grade encryption systems to ensure data at rest and in transit are protected.	
E.6 PROJECT CLOSURE AND TURNOVER	
A. Describe your plan to complete all the duties required for transition at end-of-contract. Performant will transfer knowledge and lessons learned from experience in current engagement and commercial health plans. These cost-saving advantages will accelerate AR HHS' return on investment, while mitigating risks associated with onboarding a new vendor. Efforts will be further enhanced by increasing the scope of improper payment exploration and analysis, improving audit precision and recovery with minimal provider burden, and protecting the integrity of the Medicare budget paid for by U.S. taxpayer dollars.	5 points
Provide a general end-of-contract transition plan which addresses the key components outlined in the RFP During the Exit Transition Period, Performant shall work cooperatively with DHS and the new contractor and shall provide program information and details specified by DHS. Within the Exit Transition Period, Performant shall prepare and submit an Exit Transition Plan and Schedule of Activities to facilitate the transfer of responsibilities, information, computer systems, software and documentation, materials, URLs, telephone numbers, specifications, reports, all data etc., to a new contractor and/or DHS. Performant's Exit Transition Plan shall include the minimum necessary items as addressed in this RFP. 1) The Contractor's proposed approach to the transition. 2) Complete and update system and user documentation. 3) The Contractor's tasks, subtasks, and schedule for all transition activities. 4) An organizational chart and staffing matrix of the Contractor's staff (titles, phone, fax) responsible for transition activities. 5) A detailed explanation of how the Contractor will begin work with a new Contractor and/or DHS within ten (10) days of receipt of notice from DHS that another contractor has been selected to provide Third Party Liability Services. 6) Operational tasks and procedures as necessary to support ongoing operations and solutions. 7) Lessons learned report. 8) List of incomplete tasks, such as open or pending cases and activities and solution modifications or enhancements. 9) A detailed description of the services that would be required by another Contractor to fully take over business or system functions outlined in the Contract.	5 points